NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 23 NOVEMBER 2011

TIME: 9:30 A.M.

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

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

AGENDA

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* = paper attached
# = paper to follow
v = verbal report
3.7. Edinburgh Community Health Partnership Sub-Committee Minutes of the Meeting held on 5 October 2011

3.8. Midlothian Community Health Partnership Sub-Committee Minutes of the Meeting held on 29 September 2011

3.9. West Lothian Community Health and Care Partnership Sub-Committee Minutes of the Meeting held on 1 September 2011

3.10. West Lothian Community Health and Care Partnership Board Minutes of the Meeting held on 16 August 2011

4. Chairman’s Report

5. Annual Review Update

6. Chief Executive’s Report

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

7.1. Quality Report

7.2. NHS Lothian: Report on the 2010/11 Audit

8. Policy & Strategy (Indicative Timing 10:20 a.m. - 11:00 a.m.)

8.1. NHS Lothian Falls Prevention & Bone Health Strategy

8.2. Refreshing the Human Resources and Organisational Development Strategy

9. Performance Management (Indicative Timing 11:00 a.m. - 12:15 p.m.)

9.1. Financial Position to 30 September 2011

9.2. Delivering Waiting Times

9.3. Tackling Delayed Discharge

9.4. Quality and Outcomes Framework 2010/11

9.5. NHS Lothian Corporate Objectives 2011/12

9.6. Healthcare Associated Infection Update

LUNCH 12:15 p.m.

10. Other Items (Indicative Timing 12:45 p.m. - 2:00 p.m.)


10.2. Single Outcome Agreements 2010/11

10.3. Response to the Consultation on the Revised Specific Duties of the Equality Act 2010

10.4. Healthcare Environment Inspectorate: Care of Older People in Acute Settings

10.5. Alcohol (Minimum Pricing) (Scotland) Bill Submission

10.6. NHS Lothian Contribution to South East And Tayside Group Work

10.7. Committee Memberships
11. Presentation - Community Mental Health - Dr Tim Wheeldon, Consultant Psychiatrist, Royal Edinburgh Hospital.

12. Communications Received

13. Resolution to Take Items in Closed Session

14. Date, Time and Venue of Next Meeting: Wednesday 25 January 2012 at 9:00 a.m. in “Space 3” at the Howden Park Centre, Howden, Livingston, West Lothian EH54 6AE.

Dates of Meetings in 2012:

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* Special meeting to consider the Annual Accounts

# Trustees Meeting preceding Board Away Day
LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 28 September 2011 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Executive Directors: Professor J J Barbour (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mrs P Dawson (Representing Mrs M Hornett, Nurse Director); Mrs S Goldsmith (Director of Finance); Dr A K McCallum (Director of Public Health and Health Policy); Dr S Mackenzie (Representing Dr D Farquharson, Medical Director); Professor A McMahon (Acting Director of Strategic Planning and Modernisation) 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 J Cochrane; Mrs T M Douglas; Councillor P Edie; Professor J Iredale; Mr P Johnston; Professor P Murray; Mrs J McDowell; Councillor P McLennan; Mr B Peacock; Professor M Prowse; Mr S G Renwick; Mr G Walker; Mr I Whyte and Dr R Williams.

In Attendance: Mr A Glauch (For item 74); Mrs A Meiklejohn (Shadowing Professor P Murray); Mrs E Rankine (For Item 74); Dr F Watson (For Item 74); Mr D Weir and Mr S Wilson.

Apologies for absence were received from Mr E Egan (Vice-Chair), Dr D Farquharson, Mrs M Hornett and Dr A Tierney.

Declaration of Financial and Non-Financial Interest

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

Welcome and Introduction

The Chair welcomed members of the public and the press to the meeting. He advised copies of a survey questionnaire had been distributed for members of the public to complete and the completed returns would help the Board to understand whether participants had found the meeting to be helpful.
57. **Chair's Introductory Comments**

57.1 **Condolesences** – the Board extended its condolences to the Vice-Chair and Mrs Egan on their recent bereavement. The Chair reported the Board had been represented at the funeral by himself and the Chief Executive.

57.2 **Board Membership** – the Chair advised this would have been Dr Tierney’s last meeting as a Board member, although it had been known for some time she would be unable to attend the current meeting because of a longstanding commitment arranged before she had agreed to extend her membership period. The Chair reported he would be asking Dr Tierney to join the Board Development Day dinner in October to formally mark her contribution as a Board member over a number of years.

The Chair reported Councillor Paul McLennan, Leader of East Lothian Council had been appointed as a new Stakeholder Board member and would join the meeting later in the morning as he had a longstanding commitment he had to attend.

57.3 **Shadowing** – the Chair advised Mrs Alison Meiklejohn would be shadowing Professor Murray in her role as Chairman of the Area Clinical Forum, in order to augment her understanding of the work of the Board.

58. **Minutes of the Previous Meeting of Lothian NHS Board held on 27 July 2011**

58.1 The Minutes were approved as a correct record, subject to the following amendment:-

Minutes 42.4 – delete the final sentence and substitute: ‘Professor McMahon highlighted that a survey undertaken into why parents took their children to A&E at the Royal Hospital for Sick Children had shown that there was a preference to do this despite an awareness of alternative provision.’

59. **Committee Minutes for Adoption**

59.1 The Chair encouraged Board members to raise specific issues arising from the review of Board Committee Minutes.

59.2 **Area Clinical Forum – Minutes of the Meeting held on 18 August 2011** – the Board adopted the Minutes.

59.3 **Audit Committee – Minutes of the Meeting held on 21 June 2011** – the Board adopted the Minutes. Mr Renwick advised the main focus at the meeting had been to consider the annual accounts to allow formal adoption by the Board.

59.3.1 Mr Renwick reported as reflected in the previous Board Minutes work was underway to have other Committee Minutes received by the Audit Committee to
ensure as complete coverage as possible. He advised the Operational Audit Committee had examined the issue of staff working elsewhere whilst on sick leave from NHS Lothian and this had been referred to the Staff Governance Committee for further consideration.

59.3.2 Mr Renwick commented he was working with Professor Murray to take risk management under the remit of the Audit Committee, as was the case elsewhere in Scotland. The Chair supported this alignment with practice elsewhere in Scotland.

59.4 Finance and Performance Review Committee – Minutes of the Meeting held on 17 August 2011 – the Board adopted the Minutes, subject to Minute 29.1.15 being slightly amended. Mr Walker reported there had been a further meeting of the Finance and Performance Review Committee to look at the Royal Hospital for Sick Children and Department of Clinical Neurosciences project and the Minutes of that meeting would come forward to the November Board meeting.

59.4.1 Mrs Douglas sought an update on the position in respect of primary care indicators, which had been discussed at the 8 June meeting. Professor McMahon reported the Primary Care Forward Group and Public Health were looking at discharge letters, patient safety and prescribing with the issue scheduled for further discussion at the next meeting on 4 October 2011. Following this, an update report would be provided to the Finance and Performance Review Committee linking with key colleagues.

59.5 Healthcare Governance and Risk Management Committee – Minutes of the Meeting held on 2 August 2011 – the Board adopted the Minutes.

59.5.1 Dr Williams sought an update in respect of the introduction of dabigatran a replacement drug for warfarin commenting he felt the Board needed to be aware of the potential financial implication of the drugs implementation.

59.5.2 Professor Murray reported a systematic approach to the introduction of dabigatran was being taken both nationally and locally with work underway to fully understand the impact of its introduction. She advised the drug would be introduced in a controlled manner following liaison with consultants and General Practitioners and only for a specifically identified cohort of patients.

59.5.3 Dr Mackenzie commented whilst the drug had been supported by the Scottish Medicine Consortium (SMC) it had not been approved by the National Institute for Clinical Effectiveness (NICE). He advised the issue was due to be discussed in detail at a consensus conference being arranged by Health Improvement Scotland (HIS) with the intention being to clarify guidance on appropriate clinical use by the end of October. Dr Mackenzie reported the NHS Lothian Formulary Committee would receive an update on dabigatran later in the day but would not be asked to approve it until further guidance was available.

59.5.4 The Chief Executive advised he had attended the SMC meeting where dabigatran had been approved and assured the Board a very detailed and
rigorous process of scrutiny had been undertaken with an objective view reached on the benefits of the drug. The cost implications for the NHS as a whole were considerable and the Chief Executive advised that further consideration needed to be given across the NHS in Scotland on how such costs should be.

59.5.5 The Chief Executive reported that SMC members had agreed that the Chair of the SMC should write to the Scottish Government Health Department (SGHD) stressing the need to look at the national prioritisation process and to what extent additional funding could continue to be committed to drugs against other investments. The Chief Executive commented he had also raised a similar issue at the Scottish Partnership Forum stating if the health system continued to spend at the current rate on pharmaceuticals it would require to run the rest of the service with less people.

59.5.6 Dr Williams advised he was re-assured by the update which reflected his understanding of the position and that a robust national process was in place for the introduction of new drugs.

59.5.7 Professor Murray advised she and Dr Farquharson had established a Committee to look at difficult decisions around pharmaceuticals with the inaugural meeting being held on 11 October.

59.6 Service Redesign Committee – Minutes of the Meeting held on 27 June 2011 – the Board adopted the Minutes.

59.6.1 Professor Iredale commented the Committee was considering introducing quality assurance kite mark standards for Committee papers with a view to rolling this out to other Committees. Professor Iredale suggested there was a need for the Board to identify an individual to champion strategic development at Executive level.

59.6.2 Mr Renwick commented good linkages were in place between the Audit Committee, the Service Redesign Committee and the Finance and Performance Review Committee. He was particularly pleased to see the Transport and Access Committee Minutes featured on the Service Redesign Committee agenda.

59.7 East Lothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 29 June 2011 – the Board adopted the Minutes. Mr Whyte reported the Sub-Committee had considered Standard Business Cases in relation to Gullane GP practice reprovision and Edenhall project phase 1, both of which would enhance services to the community.

59.7.1 Mr Whyte reported he had asked the General Manager to pull together performance aspects of strategies to allow simple and effective monitoring to demonstrate strategies were bearing fruit to the population.

59.8 Edinburgh Community Health Partnership Sub-Committee – Minutes of the Meeting held on 3 August 2011 – the Board adopted the Minutes. Mr Anderson commented the Audit Scotland report on the role of CHPs had been discussed
with the view taken that the outcome did not do justice to the work of local CHPs. He advised a regular agenda item had been established for the primary care contracting organisation and a useful presentation had been received from Mr Duncan Miller. Mr Anderson advised the Sub-Committee maintained a continuing focus on health inequalities. He reported that valued input continued to be received from the public partnership fora and from the voluntary sector, as well as from colleagues in NHS Lothian and the City of Edinburgh Council.

59.9 **Midlothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 28 July 2011** – the Board adopted the Minutes.

59.9.1 Councillor Aitchison advised any further housing development in Gorebridge would be dependent upon the building of the Edinburgh-Borders rail link as the current road infrastructure was inadequate.

59.10 **West Lothian Community Health and Care Partnership Board – Minutes of the Meeting held on 28 June 2011** – the Board adopted the Minutes.

59.10.1 Mrs Douglas drew the Board’s attention to the production of the ‘Listen to Us’ DVD which had been developed following a residential meeting in 2009 where there had been discussion on what it was like for young people requiring healthcare. As a result, the Young Health Forum had decided to produce a DVD to ensure GP practices and other health and care professionals understood how their attitudes could affect young people’s experiences of using the services they provided.

59.10.2 Mr Renwick noted that all three CH(C)Ps had discussed the Audit Scotland report on CHPs and he felt, given the Scottish Government Health Department’s comments, there would be merit in producing a corporate response. Professor McMahon advised he was collating such a response on behalf of NHS Lothian, which would take account of individual CH(C)P discussions.

59.10.3 The Chair commented in general if Board members or Committee Chairs did not feel issues were being progressed adequately through internal systems and processes, they were entitled to ask himself as Chair to consider raising the issue as a Board agenda item.

### Chair’s Report

60.1 The Chair advised he had attended a number of important service openings, which reflected NHS Lothian’s ongoing commitment to provide quality services to the population as a whole.

60.2 The Chair advised he had also attended the launch of the Novalis TX linear accelerator where the Cabinet Secretary had performed the opening ceremony.

60.3 The Chair advised he had joined Mr Anderson, Chair of Edinburgh CHP Partnership at the opening of the City’s fourth new publicly owned care home at Inchview in Gilmerton. He commented staff had explained to visitors how the
centre was geared up to deal with dementia with over half of the 60 residents having that condition. Mr Anderson commented the relationship between the residents in the home and the pupils at the school next door was excellent, with each group providing support to the other.

61. Chief Executive’s Report

61.1 The Chief Executive advised he had visited St John’s Hospital as part of his regular programme of visits and had, in particular, focused on the head and neck directorate, as well as the department of plastic surgery and burns. He had also visited the ear, nose and throat service, which was a regionally based service having transferred from Edinburgh in 2009.

61.2 The Chief Executive commented overall this had been another excellent visit and all the staff he had met had considerable pride in their services, which continued to develop as part of the continuing growth and investment in St John's Hospital.

61.3 The Chief Executive advised he had attended the second international conference on compassionate care hosted by NHS Lothian and partners in Edinburgh Napier University. The event had attracted over 250 delegates from the United Kingdom, Europe, Africa and America. He advised this event was now established as an important part of NHS Lothian’s continuing efforts to make compassionate care the hallmark of all its services.

61.4 Professor Prowse advised the conference was a flagship event for NHS Lothian, particularly in respect of the potential rollout of the non-registered workforce and it had been useful to obtain formal recognition of this as an established project which would help to address public anxieties.

62. Quality Report

62.1 Dr Mackenzie drew Board member’s attention to the change in format of the report. The focus of the current report was on diabetes.

62.2 Dr Mackenzie commented the diabetes effectiveness measures were broadly in line with those in Scotland as a whole. However, there remained room for improvement and he outlined some examples of actions in place to address this.

62.3 The Chairman commented there was a need to be consistent about the designation headings used in charts. He commented the improving rate of reporting was to be welcomed. Dr Mackenzie advised he was considering how best to start to report ‘near misses’.

62.4 Mrs McDowell recalled at the previous meeting data had been provided on the incidences of falls, although this did not appear to be included in the current paper. She questioned what progress had been made to prevent falls since the last Board meeting. Dr Mackenzie reminded the Board the papers were...
thematic and focused on a specific service area, hence the lack of reference to falls in the current paper. The Chief Executive commented that reducing falls was a priority area for NHS Lothian and was regularly discussed at the Executive Management Team and other Board Committees. Mrs Dawson advised a falls strategy would be brought to a future Board meeting for approval, which would set out the measures being taken to address this important issue. She advised the Board that Falls Co-ordinators had been appointed with positive results. The Chair asked as part of the strategy document that Mrs Dawson include a simple dashboard indicator.

62.5 Professor Murray commented from a Healthcare Governance and Risk Management Committee perspective that falls, violence and aggression and medical errors remained the three common factors requiring further focus. Discussions were ongoing with Dr Farquharson on how to progress.

62.6 Dr Mackenzie advised the Board that diabetes was a priority area which affected around 4% of the population and accounted for a significant amount of NHS spend. He advised Lothian performed on a par with the rest of Scotland, although there was always room for improvement. In that respect, it was important to note a new Chair had been appointed for the Managed Clinical Network who was a clinician at St John’s Hospital.

62.7 Professor Iredale reported the Service Redesign Committee had discussed obesity, which was the one of the major health challenges along with smoking and alcohol. Good preventative inputs would have a significant impact. Dr McCallum advised 80% of people on the diabetes register were either overweight or obese and the diet and exercise approach needed to extend beyond the traditional advice given to diabetics.

62.8 The Chair advised he was also the Chairman of Edinburgh Leisure and he felt sure there was scope for investment in obesity interventions which could demonstrate benefit. Dr McCallum commented work was in place with the City of Edinburgh Council to make the City more ‘walkable’ and this was starting to have an impact.

62.9 Mrs Douglas commented she would have welcomed more reference to the particular issues affecting ethnic minority groups in respect of diabetes. Dr McCallum advised the risk and incidences of diabetes was greater in the South Asian population, and Professor Raj Bhopal was engaged in a large randomised control trial with good engagement and support. Dr McCallum further advised the Keep Well project included anticipatory care for people in ethnic minority groups and this would be reflected in future reports to the Healthcare Governance and Risk Management Committee once robust data was available.

62.10 Dr Mackenzie commented changes made to the management of diabetes would assist with improved health inequalities as services were targeted to those most at risk. He reminded the Board diabetes was largely manageable.

62.11 The Board noted the quality impact report and the positive progress being made in diabetic services.
63. **Report from the Organ Donation Committee 2010/11**

63.1 The Chair advised Dr Williams would present this report in the absence of Dr Alison Tierney, who was the Chair of the Organ Donation Committee.

63.2 Dr Williams thanked Dr Tierney for her sterling efforts as Chair of the Committee since 2009 and commented through her enthusiastic approach, NHS Lothian had engaged positively in improving organ donation levels. He commented appreciation should also be paid to the clinical leads and senior nurses for organ donation based at the Royal Infirmary of Edinburgh, Western General Hospital, St John’s Hospital and Royal Hospital for Sick Children.

63.3 Dr Williams advised there had been a marked increase in the percentage of the population on the organ donation register, with Lothian’s position being 44% against the national rate of 33%. He reminded colleagues the target for the Organ Donation Committee was to reach a level of 50% of the population on the organ donation register.

63.4 Dr Williams advised the level of donations after brain death in Lothian was above the national average. However, in respect of donations after cardiac death, the referral rate was low reflecting a more cautious approach in Lothian, which had the positive impact of increasing the likelihood that a donation would have a high conversion rate. Dr Williams commented he was clear this was the correct approach and this view was supported by Dr Mackenzie, who stressed organ donation was taken very seriously within NHS Lothian.

63.5 Dr Williams commented there had been a number of innovative approaches to increasing participation in the organ donation register through the Communications Team and this positive work would continue.

63.6 The Chair welcomed the huge success of the work in Lothian advising he had received supportive letters back from employers in response to a letter signed by himself encouraging organ donations.

63.7 Mrs McDowell questioned whether the system was adequately resourced to take benefit from the increased level of donations and, given there were more people on the register, whether this would translate to increased numbers of transplants. Dr Williams commented whilst this issue had not been within the remit of the group, there was a clear probability of increased numbers of transplants that would need to be resourced.

63.8 Professor Iredale advised the retrieval of organs was the responsibility of the receiving department and robust processes were in place via national protocols to deal with the staffing and resourcing of transplants. He commented evidence from the United States of America suggested increased rates of donations led to increased numbers of transplants.

63.9 Mrs Sansbury commented this issue had been discussed at the Board Chief Executives’ meeting and it would be important to maintain progress. She
stressed, however, there was a need to consider impacts on critical care and, in particular, the Liver Unit.

63.10 Professor Prowse commented in terms of communications, October was ‘Will Aid’ month and there were opportunities to make linkages with the organ donation process.

63.11 The Board noted the progress being made by the Organ Donation Committee and thanked Dr Tierney for her chairmanship of this Committee since 2009.

64. Clinical Strategy

64.1 Professor McMahon advised the Board the circulated paper had evolved from discussions held at the Board Development Day in June. He advised the Board demographic growth in Lothian would be significant for the next 10-20 years and would result in an increase in some conditions, for example, cancer, long-term conditions amongst the elderly, diabetes, children with obesity issues, all of which would need to be addressed against the backdrop of a tightening financial position.

65.2 Professor McMahon commented a successful public/patient engagement session had been held on 31 August and it had been clear participants had understood the drivers around the need for the strategy, including those around the medical workforce. He advised the themes that would need to be addressed had been tested and participants had understood these needed to be covered under the strategic framework. Professor McMahon reported it was being suggested the title of the strategy should be changed to ‘Our Health, Our Future’ which aligned with the title of the Director of Public Health’s report. This suggestion received a mixed reaction from Board members and Professor McMahon would progress outwith the meeting as part of the development of the strategy.

65.3 Professor McMahon commented the engagement of staff through different forums would also be important with more meetings being scheduled. He advised the schedule of meetings would include community planning partnership forums, as well as appropriate links with local authorities.

65.4 Professor McMahon provided the Board with details of the themes identified through both public and staff engagement.

65.5 Professor McMahon commented the next step in the process would be to present to the Service Redesign Committee on 17 October and thereafter to bring forward an update to the Board Development Session in October, with a fuller more formal report being submitted to the Board at its meeting later in the year.

65.6 Mr Renwick commented it would be important to be clear about the audience for this strategy and to be able to demonstrate what difference its implementation would make. He commented the proposed strategy struck at the core of the existence of the organisation and should be regarded as a
corporate rather than a service strategy. He commented there was nothing about housing within the paper, as well as no mention of consultation with Councillors except those who served on CH(C)Ps.

65.7 Professor McMahon commented the framework was being taken forward on a strategic corporate basis and would build on and be underpinned by existing strategies. The consultation process was extensive and the consultation list attached to the paper should not be regarded as exhaustive, although it would cover housing and other local authority aspects referred to by Mr Renwick.

65.8 The Chief Executive commented irrespective of the title of the strategy moving forward, its focus was about developing a narrative that would explain to patients and the public in easily understood and relevant terms what the drivers for change were and how these would be responded to by NHS Lothian. In order to make future service provision achievable, sustainable and affordable, it would be important to ensure existing patterns of care changed through the development of supporting strategies. The Chief Executive commented a key outcome of the ongoing work would be to develop a clear understanding amongst all relevant partners on the future model of care. He advised the Medical Director would lead this work on behalf of the Board and emphasised the importance of developing a narrative that was clear and cogent in respect of desired outcomes. The Chief Executive commented issues around the nomenclature of the strategy could be addressed as part of the ongoing process.

65.9 Mr Anderson suggested an additional theme should be around communication with patients and public and patients with the service. Professor McMahon would address.

65.10 Mrs Allan commented it would be useful to hear feedback from the audiences consulted and questioned whether an action plan would be developed, as there would be a need to work with groups in respect of how progress was measured. Professor McMahon commented the intended audience was wide-ranging both national and locally and would include staff, patients, public and other key stakeholders. He advised progress would be able to be demonstrated through the key indicators contained within the metrics and this exercise would be taken forward through an implementation plan.

65.11 Mr Johnston commented the views expressed by Mr Renwick and the Chief Executive were important. He was of the view the proposed strategy would be the most important document the Board would consider for some time and he was pleased to note community planning partnership engagement. Mr Johnston felt the implementation of the strategy would be fundamental to how NHS Lothian and partners continued to deliver services in future.

65.12 Professor McMahon commented after the 17 October meeting of the Service Redesign Committee, the key drivers would be posted on the website and would be set out in a way that encouraged feedback from the public.

65.13 Mr Burley felt the proposed strategy was extremely important commenting it was easy for complex services to focus on sites of excellence whilst the key
issue should be around what happened at the boundaries. He felt the strategy should represent a moving framework. Mr Burley commented it would be important to ensure appropriate communication documents were produced for both public and staff.

65.14 Professor Iredale commented he and the Chief Executive had held discussions around this issue prior to the Board meeting. The NHS was not always good at explaining the rationale behind decisions, with these some times being perceived by the public as a fait accompli. He agreed with previous comments about the importance of ensuring adequate communication in order to ensure the message was clearly understood.

65.15 The Chair commented it was important people understood the strategy would touch on all parts of the organisation.

65.16 Dr Mackenzie commented a key thrust of the strategy would be an emphasis on quality and value, as well as highlighting the benefits of preventing disease rather than treating disease.

65.17 The Board noted the progress being made in respect of the development of the Clinical Strategy noting it would be discussed in further detail at the Board Development Day in October. The Chair commented it would be important to give further thought to the strategy strap-line as it currently did not have the support of all Board members.

66. Financial Position to 31 July 2011

66.1 Mrs Goldsmith commented the initial results of the outcome of the spending review were now known and would be detailed in a report to the Finance and Performance Review Committee in October, as well as to the Board Development session later in the same month. She advised the headline position represented a 2.9% uplift for Scotland in financial year 2012/13 and 3.3% and 3.1% in subsequent years, equating to a total figure of £826m over the 3 year period.

66.2 Mrs Goldsmith reminded the Board the budget proposals still required to be voted on by Parliament and were, therefore, still in draft. However, the position in respect of Lothian represented an increase in funding of £39.4m representing an uplift of 3.7% of which £10.8m (1%) related to funding around access to support waiting times, which had already been committed as well as £4m in respect of the transfer of prison healthcare. Mrs Goldsmith commented the proposed uplift demonstrated some progress towards NRAC parity, which had moved from a position of £58.2m down to £50.5m. Mrs Goldsmith commented provision for NRAC movement had been included in the SGHD budget and she would work with SGHD colleagues to ensure NHS Lothian’s demographic changes were supported.

66.3 Mrs Goldsmith advised she and her team would subject the draft budget to further analysis within the Executive Management Team and discuss this in more detail at the October Board Development Session.
Mrs Goldsmith reported on the financial position to 31 July 2011 advising the August financial report was now available and would be discussed by the Executive Management Team the following week. She commented performance had improved from month 3 with months 4 and 5 demonstrating sustained improvement. She commented the month 5 out-turn was posting an overspend of just under £2.7m and this position included support from NRAC in recognition of costs approved, in principle, and had been fed into at this stage on a non-recurrent basis until due diligence had been undertaken to convert this into a recurrent position.

Mrs Goldsmith commented a current area of focus was that in July the non-recurrent support to prescribing areas had moved significantly from the financial plan. However, the quarter 1 financial review continued to demonstrate NHS Lothian would be able to deliver financial break-even for 2011/12, hence the ability to feed in non-recurrent support into the current financial position.

Mrs Goldsmith commented both LRP and prescribing had moved significantly in quarter 1 with there being a shared potential overspend in respect of prescribing of around £6m. Mrs Goldsmith advised this related in part to changes in the pricing structure not benefitting NHS Lothian as a consequence of it already being a low cost drug user combined with some shortages of drugs impacting on the price, as well as some volume increases.

Mrs Goldsmith commented a series of actions to address the drug prescribing situation were being taken forward at CHP level and would be discussed with the Primary Care Forward Group with a view to proposing an enhanced payment to General Practitioners in respect of enhanced pharmacy support. She commented as well as the Primary Care Forward Group, a range of these actions would require to be discussed and approved through the Difficult Decisions Group, which had been established by the Medical Director.

Mrs Goldsmith reported good progress towards the full year target of £50m of efficiency savings, with continuing progress required in the second half of the year.

The Chair commented it was positive to note the improving financial position which predicted the system was on trajectory to break-even at the end of the financial year. Mrs Goldsmith confirmed this position advising the quarter 1 review had identified a range of recovery plans which had allowed the positive outcome for the month 5 period. However, she did not think the system would fully recover the prescribing position or UNPACS position and action plans would require to be developed which covered a period beyond the current financial year. Mrs Goldsmith stressed, however, work was in place to support the overspend.

Professor Murray commented the cost and value of some drugs had risen. She advised NHS Lothian’s performance was still best in class around prescribing and a prescribing recovery plan would link with efficiency and productivity schemes. She commented, looking ahead, there was a need to continue to be
vigilant, as well as to identify invest to save schemes. As Director of Pharmacy, she would be directly engaged in this work.

66.11 Mr Walker commented an increase in value of prescribing of between 5% and 6% was significant and questioned whether it was possible to have more control over that rate. Mrs Goldsmith commented traditionally values increased by between 3% and 4% each year and this reflected back to earlier discussion about the use of medicines and treatment of chronic diseases. She advised there was some anecdotal evidence that the introduction of free prescriptions had had an impact. She commented growth was evident across all categories of drugs, although there were some areas capable of targeting and it was absolutely key that General Practitioners worked with CHPs and herself to reverse the current volume trends.

66.12 Professor Murray commented primary care pharmacists were looking at the impact of free prescriptions, as well as looking at mechanisms by which repeat prescriptions were generated. Part of this exercise would be to identify whether there were any unnecessary prescriptions. Professor Murray commented a polypharmacy project was being undertaken under the aegis of the Harvard/Napier leadership programme, which was seeking to identify whether or not older people were receiving the appropriate amounts, level and category of prescriptions.

66.13 Mr Walker questioned whether growth was being under-estimated as a consequence of the success of initiatives such as the smoking intervention programme. He commented there was a need to make appropriate linkages between this potential phenomenon and the point around inappropriate prescribing described by Professor Murray.

66.14 Mr Renwick commented it appeared that delays in receiving information about pharmaceutical costs from the Prescribing Services Division (PSD) were worsening in terms of the time lag and this position had been discussed at the Audit Committee. He was aware another Health Board would be writing to PSD to express their disquiet about this position.

66.15 Mr Renwick commented in respect of Service Level Agreement income with other Health Boards, it was important steps were taken to ensure other organisations were paying the correct amounts for services to their patients. He advised a view would require to be taken about when to extend leverage to ensure payment was received. Mrs Goldsmith advised there remained two Scottish mainland Health Boards who did not agree with the costing model and had not paid their invoice on that basis. She had written to the Boards affected stressing the need for payment. Mrs Goldsmith advised if payment was not forthcoming a grievance would be raised against the Boards through the Scottish Government Health Department.

66.16 Mr Renwick questioned whether it would be desirable to move to a more formal contract-basis with other Boards in order to mitigate against a repeat of current difficulties in future years. The Chair suggested the Audit Committee should look at this position in more detail.
The Board noted the financial performance of NHS Lothian to 31 August 2011 and Mrs Goldsmith’s confirmation that financial break-even would be achieved.

67. Delivering Waiting Times

67.1 Professor McMahon provided the Board with an outline of NHS Lothian’s largely positive performance on waiting times. He advised cancer performance was well above the Scottish average for both the 31 and 62 day targets. The previous issue raised at the Board meeting in respect of cervical performance had been investigated and the percentage variances had been confirmed as a consequence of the small number of patients involved and he assured the Board all patients were being appropriately managed.

67.2 Professor McMahon commented the 18 weeks RTT performance was ahead of the standard and the challenge moving forward would be about sustaining and delivering the target at the year-end. He advised challenges were being experienced in respect of inpatients and outpatients, although performance would be back on-line by the end of October.

67.3 Professor McMahon commented drug and alcohol targets were ahead of trajectory with a lot of positive output emerging from the Kaizen events. In respect of diagnostics and scopes, there was still evidence of an increasing demand on the back of the screening programme and colorectal remained an issue with a positive action plan in place to bring performance back on to target. Professor McMahon advised that A&E performance had achieved 98% in August and this had moved NHS Lothian from eighth best to the fourth best Board in Scotland. He commented the position in respect of audiology was showing improvement, with it being anticipated the stretch target would be met by the end of the calendar year.

67.4 Professor Prowse commented in respect of colonoscopies whether it would be possible to train staff quicker to undertake these procedures as patients would find this an anxious period. Professor McMahon commented actions were taking place, including replacing staff who had left the service and it was anticipated that through these actions performance would improve.

67.5 The Board noted the positive performance in respect of waiting time targets.

68. Tackling Delayed Discharge

68.1 Professor McMahon commented at the census point in July and August, NHS Lothian continued to report high numbers of patients delayed, and with 26 patients delayed over the 6 weeks national standard, this was significantly higher than previous months. He advised the main reason identified by local
authority colleagues continued to be the downstream effects of the closure of the Elsie Inglis Care Home in Edinburgh, which had removed 65 beds.

68.1 Professor McMahon commented as a consequence of change fund monies it had been possible within the City of Edinburgh to increase the number of providers for care packages from nine to eighteen. Night capacity was also being addressed, all of which would make re-enablement available to wider groups of patients. Professor McMahon advised these initiatives would start to impact during October and he would anticipate an improving position thereafter. He advised delayed discharge performance in East, Mid and West Lothian was positive with the Edinburgh Partnership being committed to meeting the local target by the end of October.

68.2 Professor McMahon commented NHS Lothian still compared favourably against other areas of Scotland for overall numbers of delays. The latest nationally published data for July 2007 demonstrated Lothian to be above the Scottish average on overall delays. Lothian’s performance in comparison to other Boards in relation to complex coding delays once again demonstrated Lothian as being one of the better performing Boards. This reflected continuing attention to this group of patients.

68.3 Mr Anderson commented in respect of the Edinburgh position that the impacts of the closure of the Elsie Inglis Nursing Home continued to have an effect, and had destabilised the system. He was confident staff from Edinburgh CHP and the City of Edinburgh Council were working to resolve this position. Councillor Edie advised the City of Edinburgh Council had injected significant resources to address demographic issues. He advised there had been significant increases over the past 4 years in usage of both weekend and evening services. Councillor Edie anticipated the current Edinburgh position being a short-term blip.

68.4 The Chair invited Mr Gabbitas, who was in the public audience, to provide any relevant comment. Mr Gabbitas commented there had been a significant improvement in respect of the availability of packages of care with ten new providers having been registered by Social Care and Social Work Improvement Scotland (SCWIS) and would be operational by 1 October. He advised care home capacity was a current issue and area of focus with short-term options being considered. Mr Gabbitas commented there had been a £30m investment in this area over the previous 3 years with the focus being to shift to a position of supporting people to home care, hence the investment in care at home packages.

68.5 Councillor Edie advised plans for the Drumbrae Care Home had been approved by Planning and this was a positive step within the wider context of the delayed discharge agenda.

68.6 Mr Burley sought an update on the Southern Cross position. Professor McMahon advised the position was being monitored on a weekly basis. To
date there had been no deviation in occupancy rates. He advised all nursing homes in Lothian now had a new operator in place and registration was progressing through SCWIS. He advised as part of the registration process, SCWIS were now looking at the financial viability of new providers.

69. Healthcare Associated Infection Update

69.1 Dr McCallum advised there had been 26 episodes of staphylococcus aureus bacteremia recorded in August 2011 (4 meticillin resistant staphylococcus aureus, 22 meticillin sensitive staphylococcus aureus), compared to 16 in July 2011 (1 meticillin staphylococcus aureus, 15 meticillin sensitive staphylococcus aureus). She advised currently NHS Lothian was on trajectory to achieve the Health Efficiency Access Treatment target of 0.26 cases or fewer per thousand acute occupied bed days by March 2013. Dr McCallum advised this translated to no more than 265 cases of staphylococcus aureus bacteremia in 2011-12 and no more than 213 in 2012-13.

69.2 Dr McCallum advised in respect of Clostridium difficile infection there had been 25 episodes of Clostridium difficile infection in patients aged 65 or over in August 2011, compared to 23 in July 2011. Currently, NHS Lothian was on trajectory to achieve the Health Efficiency Access Treatment target of 0.39 cases or fewer per thousand acute occupied bed days by March 2013. Dr McCallum advised this translated 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.

69.3 Dr McCallum advised that hand hygiene hand performance continued to improve, although there were recurrent themes in a small number of areas where improvement was slower than desired. Dr Mackenzie advised he was personally taking up issues around hand hygiene and the dress code with medical staff.

69.4 Dr McCallum commented excellent performance was being reported in respect of the MRSA national screening programme, although compliance with perineal screening had been lower due to a number of more elderly patients declining to be screened. In respect of anti-microbial management, she and Professor Murray were working together to improve further on the generally positive position.

69.5 Dr McCallum commented the Health Environment Inspection report on the unscheduled visit to the Royal Infirmary of Edinburgh had been embargoed until Noon and she commented the report highlighted areas where issues were still improving but had not yet reached the standard to which NHS Lothian aspired. She advised the areas highlighted by the Inspector, in general, were already areas where there had been internal focus and appropriate actions were in place to address recommendations. Dr McCallum advised the national support team would meet with NHS Lothian colleagues at the end of October and, at that point, it would be demonstrated that appropriate action plans were in place and were being implemented.
69.6 Mrs Sansbury, while acknowledging that some aspects of the report were unsatisfactory, commented it was important to recognise the inspection report had said the hospital was clean. She advised discussions were underway with Consort to talk about the timing of cleaning and cleaning regimes. Mrs Sansbury confirmed an action plan had been submitted back to Health Environment Scotland and implementation of recommendations was well advanced.

69.7 Dr Williams advised his recollection was that at the Operational Audit Sub-Committee there had been comment about compliance on the use of scrubs, and that in a questionnaire a number of staff had commented there had been a number of breaches not recorded on DATIX. Mrs Sansbury undertook to address outwith the meeting with Mr Renwick.

69.8 The Board noted the positive progress in respect of managing healthcare associated infection.

70. **Webcasting and Communications with Key Partners and the Community**

70.1 Mr Boyter referred to the circulated paper and expressed his gratitude to Mr Wilson and the Communications Team for picking up the issues discussed at the previous Board meeting. Mr Boyter commented, to date, no other Health Board in Scotland was webcasting their Board meetings, although Highland Council were already doing so.

70.2 Mr Boyter commented there were three options detailed in the paper and he suggested it would be prudent, irrespective of whatever the preferred option was to progress on a pilot or trial basis and review benefits after a few meetings before making any final decision.

70.3 Mr Boyter advised the Communications Team were also working with colleagues from public involvement in order to improve attendance at Board meetings. He commented public attendance usually only increased if there was a contentious or sensitive issue on the agenda. Mr Boyter advised further work was underway in respect of working with key partners and a more detailed paper would be brought forward to a future Board meeting.

70.4 The Chair reminded colleagues it was important to remember Board meetings were meetings in public and not public meetings. He reminded colleagues public representation was already in place through the pilot Board members, namely Mr Peacock and Mrs Allan. He reminded Committee Chairs he would welcome them offering agenda items on emergent issues. He would also welcome public/patient forum colleagues having more energetic engagement with Mr Peacock and Mrs Allan in order to bring issues to the Board table.

70.5 Dr McCallum commented the paper was helpful, although she doubted whether many members of the public would welcome the prospect of sitting through a full Board meeting. In that regard, she suggested there might be benefit on focussing on a specific area of the agenda, for example, the clinical presentation that might be of wider interest.
70.6 Mrs Allan commented there were already parts of the public who engaged with the Board and she felt it would be useful to engage with existing groups as there was currently a disconnect between their engagement and what happened at the Board. Mrs Allan and Mr Peacock would feed any views into Mr Boyter for consideration in the paper scheduled to come forward to a future Board meeting.

70.7 Councillor Edie commented attendance at NHS Board meetings and local authority Board meetings were polar opposites. He advised Council meetings received regular deputations whilst this was almost unknown at NHS Board meetings. The Chair reminded colleagues the Lothian NHS Board papers were published on the internet in advance of the meeting.

70.8 The Chair felt the proposals around webcasting were positive and sought confirmation that none of the Board members would find webcasting personally intrusive. Mr Renwick commented, whilst this was important, he had not seen any evidence people actually wanted Board meetings to be webcasted in this way.

70.10 Mrs Douglas stressed there was a need to be clear about how to define success before any pilot could commence. Mr Boyter commented he and Mr Wilson would give thought to some appropriate measures.

70.11 Mr White commented in respect of Highland Council, it was important to bear in mind the wide geographical spread of the Council area and a measure of success would be people being able to access Council meetings without requiring to travel. He felt the proposals before the Board would be worthwhile on an experimental basis, although it would be important to keep costs low whilst addressing issues around the fact Board meetings were not conducive to watching on a PC. In that regard, he felt there would be a need to ensure the webcasting was in an appropriate form and he suggested splitting the agenda into discrete sections.

70.12 Mrs McDowell commented it was important to bear in mind the current purpose of Board meetings and to ensure that appropriate business continued to be undertaken. If webcasting was being undertaken to engage with the public that was a different purpose from the statutory requirements around Board meetings and it would be important to ensure a focus was maintained on the day-to-day corporate business. Mrs McDowell commented the best outcome would be if connections could be made between the Board agenda and public concerns.

70.13 Councillor Edie felt the benefits of the proposals were that they demonstrated and encouraged open decision-making. It was worth experimenting with the availability of new technology and he commented, although this was not currently being undertaken formally within the City of Edinburgh Council, he was aware journalists were videoing and webcasting Council business, albeit outwith strict Council rules. Councillor Edie felt it would be beneficial if there were more public engagement around the business of NHS Lothian.
70.14 Dr Williams commented if the pilot was to progress, this would need to be done on a low cost and non-intrusive basis as there was evidence behaviours changed when people were aware they were being filmed.

70.15 Mrs Allan commented she appreciated the need to experiment with new ways of conducting business and the new use of technology, although she was clear there was a need to create the audience of people who would be able to advise whether or not current abilities for engagement was an issue.

70.16 Mr Walker felt the pilot would be worth pursuing, although he agreed with the points raised by Mr Whyte about the need to sectorise the agenda, as there would be no point in providing an unstructured lengthy webcast. He concurred with the views of Mrs Allan in that the audience needed to be created and there was a need for a plan on how to communicate and get people to engage with the Board otherwise the pilot would not work.

70.17 Mrs Douglas commented care would be needed in order not to create inequality in respect of equal access, particularly where English might not be participants’ first language. She commented the process would require to be subjected to a health inequality assessment.

70.18 The Board agreed, in principle, to piloting Board meetings on a webcast basis, although it sought further detail on the proposed implementation and what success would look like. Mr Boyter undertook to bring forward further details dovetailed into more detailed thought on how to encourage better public engagement.

71. Committee Memberships and Terms of Reference

71.1 The Board agreed the appointment of :-

- Councillor P Edie as a member of the Finance and Performance Review Committee in place of Dr A Tierney
- Mr S Renwick as Vice-Chair of the Finance and Performance Review Committee
- Mrs Shulah Allan as a member of the Mutuality and Equality Governance Committee in place of Mrs T Douglas and the West Lothian Community and Health Partnership Board in place of Mr R Burley
- Ms C Kenwood, Associate Clinical Director to replace Mr J Hendry, Mr S Murdoch to replace Mr J Alexander as representative from the Scottish Ambulance and Ms M Niven to replace Mr G Ford, Senior Officer from Education Services on West Lothian Community Health and Care Partnership Sub-Committee.

71.2 The Board also agreed the amended terms of reference for the Finance and Performance Review Committee, as well as the amended terms of reference for the Staff Governance Committee.
71.3 Professor Murray advised Dr Tierney had also been the Vice-Chair of the Healthcare Governance and Risk Management Committee and would require to be replaced. The Chair invited Professor Murray to nominate a replacement to him for his consideration.

71.4 The Chair advised he had held a meeting with the Vice-Chair and members of the Secretariat to ensure the Board would be able to fulfil its Committee structure during the period when some existing Board members left the Board and decisions were made about the appointment of new members.

72. **Better Together Adult Inpatient National Survey 2010**

72.1 Mrs Dawson advised this was the second national survey in the Better Together patient experience programme. She advised 4,252 people who had stayed overnight on a specific date in one of eight NHS Lothian hospitals had been sent a survey. The findings demonstrated NHS Lothian was the most improved of any mainland Board having moved from being a top performer in three of the indicators to a top performer in ten in the current cycle when compared to other Boards.

72.2 Mrs Dawson commented the report showed improvement around the dignity and respect of patients with further work still required to review the inequalities figures. Overall, the national figures demonstrated older people were more positive about their care, although there were issues of improvement required in respect of some of the smaller Lothian sites.

72.3 Mrs Dawson commented there had been two areas where performance had reduced. The first was in respect of whether people were told how long they would wait in accident and emergency and the second was around food and drink.

72.4 Councillor McLennan questioned whether an action plan would be brought forward to the Board for consideration in respect of the bottom five areas commenting it would be interesting to see a comparison between the previous years and current data. Mrs Dawson advised she and colleagues had been disappointed that the bottom five areas in the previous year had remained the same in the current survey period. Mrs Dawson re-assured the Board significant work was undertaken to address issues raised in the questionnaire through the development of action plans. Mrs Dawson advised progress against action plans would be highlighted through the Healthcare Governance and Risk Management Committee and escalated, if necessary.

72.5 Mrs Allan questioned why patients who had used the Royal Edinburgh Hospital were not included in the survey. Mrs Dawson advised this was as a consequence of the survey covering adult inpatients, who had stayed in an acute hospital for more than 24 hours and had explicitly excluded people in a mental health hospital. However, NHS Lothian had run its own survey of
people who had stayed in mental health facilities and this was an area which might emerge nationally.

72.6 Dr McCallum commented in respect of mental health patients at the point when the survey had been proposed research ethics approval had not included working with people with incapacity and who could not consent and had also not covered children. She commented, therefore, local action had been taken to address this through the survey at the Royal Edinburgh Hospital referred to by Mrs Dawson.

72.7 The Chair commented it would be important to demonstrate to the public the outcomes of their input into the questionnaire process. The Board noted the findings and the healthcare experience indicator 2010-2011 report for all Boards in Scotland.

73. **NHS Lothian Contribution to South East and Tayside Group Work**

73.1 Professor McMahon updated the Board on the contribution made to the work of SEAT through the NHS Lothian’s Chief Executive, Employee Director and Executive Management Team colleagues in driving work forward on a regional basis.

74. **Managed Service in Partnership with Community Pharmacy**

74.1 The Board received an informative presentation on community pharmacy providing person-centred care to patients with substance misuse problems from Ms Elaine Rankine, Lead Pharmacist, Substance Misuse Service and Mr Alan Glauch, Community Pharmacist and Chair of the Lothian Pharmacy Contractors’ Committee. Dr Fiona Watson, Clinical Lead also attended for the presentation.

74.2 The Chair questioned what steps were being taken to drive down the use of methadone. Dr Watson commented there was a process of active management in respect of individual patients and there was now more of a focus in managing people to a point of abstinence than had previously been the case. Dr Williams advised General Practitioners were also signed up to undertake enhanced work with clear guidance being in place about dose reduction in order to avoid people reverting back to methadone usage if the dosage was reduced too quickly.

74.3 The Chief Executive commented some years ago he had seen analysis of this issue on a practice-by-practice basis, which had demonstrated that there was a variation in methadone prescribing practice. He was aware of evidence that suggested if individual interventions with patients were accompanied by intensive support the outcomes were much more likely to be successful.

74.4 Dr McCallum commented in Muirhouse work had demonstrated there was more than one patient group to be considered. In some instances, people only abused on a short-term basis whilst other had the equivalent of a chronic
disease and needed 24-hour supportive care to live and participate in life. She commented the key issue was to remain focussed on the longer term goals as a society and Lothian had benefitted from this approach.

74.5 Professor Iredale commented even within the sphere of alcohol abuse, it was evident there were two populations affected, albeit that these were not equal groups. He commented child care issues had to be considered and society was now in a position where people could be offered long-term contraception through a single healthcare visit. Professor Iredale stressed the importance of ensuring people using methadone and other substances were provided with this advice, as there were child deformity issues to be considered. He questioned whether patients who contacted pharmacy would be steered towards advice on contraception and sexual health in general.

74.6 Mr Glauch advised 80% of emergency contraception was delivered via pharmacists who were trained to engage with patients. Professor Iredale questioned whether there was a second part of consultations where people were actively steered towards other appropriate services. Mr Glauch confirmed this was the case and issues such as infection were discussed.

74.7 Dr Williams advised GPs undertook the majority of work in this area and physical, social and psychological assessments were undertaken and included areas around contraception as part of the holistic service.

74.8 Mr Whyte stressed the need to ensure the safe disposal of injecting equipment and. Ms Rankine advised patients were encouraged to return equipment and this was monitored through an ISD data base. She advised in pharmacy practices processes were in place for dealing with used equipment.

74.9 Ms Rankine in response to a question from Mrs Allan around the transfer of prison health services advised she was part of a local implementation group addressing the whole range of pharmacy services, including those around drug dependency.

74.10 The Chair thanked Ms Rankine, Mr Glauch and Dr Watson for their insightful presentation.

75. Communications Received

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

76. Resolution to Take Items in Closed Session

76.1 The Chair sought permission to invoke Standing Order 15.2 to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke Standing Order
15.2. The requirement arose from the need to discuss items of patient and commercial confidentiality not appropriate at a meeting in public.

77. Date and Time of Next Meeting

77.1 The next meeting of Lothian NHS Board would be held on Wednesday, 23 November 2011 at 9.00am in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
### 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.

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<tr>
<th>Action Required</th>
<th>Lead</th>
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<tr>
<td>• Mrs Goldsmith to provide a report to the December Committee on the transfer of the staff lottery from the exchequer.</td>
<td>SG</td>
<td>6/12/10</td>
<td>The 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. In addition, discussions have been held with the NHS Credit Union to explore the possibility of the Union providing banking facilities for the Lottery, which may be possible from Spring 2012.</td>
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<td><strong>Corporate Governance (12 April 2011)</strong></td>
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<td>Technical Brief Overview – Audit Scotland 2011/1</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>The Head of Financial Services and the Corporate Governance &amp; VFM Manager are reviewing this. The outcome of the review will be presented to CFAG in December.</td>
<td>In progress</td>
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<td><strong>Operational Audit Sub-Committee (21 June 2011)</strong></td>
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<td>Minutes of the Operational Audit Sub-Committee held on 28 March 2011</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>
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<td>Healthcare Governance &amp; Risk Management Committee – Minutes of 5 April 2011</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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<td>Counter Fraud Services – Patient Exemption Checking – Annual Reporting Package 2010/11</td>
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<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 working with Counter Fraud Services on this subject, and this includes revisiting the extrapolation that leads to the reported figures for estimated fraud and estimated potential fraud.</td>
<td>In progress</td>
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<td>General Corporate Governance (21 June 2011)</td>
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<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><strong>2010/11 Healthcare Governance Committee Annual Report to Lothian NHS Board</strong></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>
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<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>
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<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>
<td>This process has started with an initial consideration of the requirements of the Scottish Government Audit Committee Handbook.</td>
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<td><strong>Orthodontic Investigation, Payment Verification and Clinical Governance (11 October 2011)</strong></td>
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<td>• Mr Miller’s OASC paper on payments to independent contractors to be circulated to the members of the Audit Committee.</td>
<td>LB</td>
<td>1/12/11</td>
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<td>• Director of Finance to write to the Chief Dental Officer for Scotland, highlighting the Committee’s concerns that the current payment verification system for Orthodontists was not fit for purpose and open to fraud, and that the letter should highlight the necessary qualities of a revised system.</td>
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<td><strong>External Audit Reports (11 October 2011)</strong></td>
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<td>NHS Lothian – 2010/11 Audit eHealth Service Delivery</td>
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<td>• This report to be presented at the next Operational Audit Sub-Committee.</td>
<td>AP</td>
<td>28/11/11</td>
<td>The OASC will receive the report on 28/11/11.</td>
<td>In progress</td>
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<td><strong>NHS Lothian – Annual Report on the 2010/11 Audit</strong></td>
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<td>• It was noted that the Board had not received this report. This report to be</td>
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<td>23/11/11</td>
<td>The Board will receive the report at its meeting of 23/11/11.</td>
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<td>forwarded to the Director of Communications before it is widely circulated.</td>
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<td><strong>General Corporate Governance (11 October 2011)</strong></td>
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<td>Royal Hospital for Sick Children / Department of Clinical Neurosciences</td>
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<td>• The RHSC/ DCN Project Board to provide assurance to the Committee as to how</td>
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<td>issues raised in the PwC report are being addressed.</td>
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<td>• Director of Finance to bring a paper to a future private session of the Boards,</td>
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<td>considering the Committee’s concerns, and expressing the key risks to the Board</td>
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DRAFT

LOTHIAN NHS BOARD

AUDIT COMMITTEE

Minutes of the NHS Lothian Audit Committee Meeting held at 9.00am on Tuesday, 11 October 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

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

In Attendance: Ms A Cummings (PhD Student); Mrs S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D McConnell (External Auditor - Audit Scotland); Mr D Miller (General Manager, Primary Care Contracts); Mr M Pearson (Director of Operations); Mr A Perston (External Auditor - Audit Scotland); 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 Mr Boyter.

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

20. Minutes of the Previous Meeting

20.1 Minutes of the Previous Meeting held on 21 June 2011– previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 21 June 2011 were approved as a correct record subject to correction of the following minor typographical error;
• Item 13.1.2 - Scottish Futures Trust.

21. Matters Arising

21.2 Running Action Note as at 6 October 2011 – the Committee noted the previously circulated paper detailing the matters arising from previous Audit Committee meetings, together with the action taken and the outcomes.

21.2.1 Mr Payne gave a brief overview of the action note specifically advising on the progress on the actions in relation to fictitious pension payments, compliance with policies & procedures, and patient exemption checking.
In reply to a question from Mr Egan regarding the progress of the previously discussed Maternity Medical Services Mr Miller advised the Committee that work with Short-life Working Group tasked locally to review this service and make recommendations for consideration locally and nationally was ongoing.

21.3 The Chair advised the Committee that he and Professor Murray would collaborate to bring forward a recommendation to the Board that the remit of the Audit Committee be expanded to include risk.

21.3.1 In response to Mr Egan’s concerns Professor Murray assured the Committee that clinical risk would remain within the remit of the Healthcare Governance and Risk Management Committee and that adding risk to the remit of the Audit Committee would be an additional layer of assurance. The Committee requested that the proposal be considered by both the Audit and Healthcare Governance and Risk Management Committees before it is presented to the Board.

22. Operational Audit Sub-Committee

22.1 Minutes of the Operational Audit Sub-Committee held on 30 May 2011 – the Committee noted the previously circulated minutes of the meeting of the Operational Audit Sub-Committee held on 30 May 2011.

22.1.1 The Chair flagged the internal audit report on Death in Hospital as a timely reminder of the importance of a robust communication interface with General Practitioners and the Scottish Ambulance Service.

22.1.2 The Committee agreed to adopt the minutes of the Operational Audit Sub-Committee meeting held on 30 May 2011.

22.2 Update on the Operational Audit Sub-Committee held on 27 September 2011 – the Chair advised the Committee that the 27 September 2011 meeting of the Operational Audit Sub-Committee had focused on Primary Care and verification of payments to independent contractors. He highlighted the recent Audit Scotland review of Community Health Partnerships and reminded colleagues to be vigilant following the disbandment of the Primary and Community Partnership Committee.

22.2.1 In response to the Committee’s concerns surrounding influencing national contracts, Mr Miller advised that following discussions with the Cabinet Secretary there may be an opportunity to contribute to the development of a Scottish approach or element

23. Orthodontic Investigation, Payment Verification and Clinical Governance

23.1 Mr Miller gave a detailed overview of the recent orthodontic case highlighting the lessons learnt and the Board’s ability to ensure that the incident was not
repeated. Future work would focus on monitoring the level of spend and development and implementation of the payment verification matrix.

23.2 Mr Egan raised significant concerns in relation to breaches of the Staff Governance Standard in this case, and advised the Committee that he intended to explore it further at the Staff Governance Committee.

23.3 Members agreed that Mr Miller’s recent paper to the Operational Audit Sub-Committee should be circulated to the Committee as a source of assurance in relation to all independent contractors.

23.4 The Committee agreed that the Director of Finance should write to the Chief Dental Officer for Scotland, highlighting the Committee’s concerns that the current payment verification system for Orthodontists was not fit for purpose and open to fraud, and that the letter should highlight the necessary qualities of a revised system.

23.5 Ms Woolman welcomed the Committee’s proactive approach and readiness to escalate these issues to Government level, before reflecting on the importance of early education and preventative measures to ensure a change in attitude within the independent contractors.

Mr Miller left the meeting.

24. Linkages with Other Board Committees

24.1 Finance & Performance Review Committee - Minutes of the Meetings held on 8 June and 17 August 2011 - the previously circulated minutes of the Finance & Performance Review Committee meeting held on the 8 June and 17 August 2011 were received.

24.2 Healthcare Governance & Risk Management Committee - Minutes of the Meeting held 7 June and 2 August 2011 - the previously circulated Minutes of the Healthcare Governance & Risk Management Committee meeting held on the 7 June and 2 August 2011 were received.

24.2.1 Mr Egan reiterated concerns that he had observed significant gaps in the communication of risk to the Chair of the Healthcare Governance and Risk Management Committee. He proposed that an audit of the systems in place was required to identify where the gaps lay and how the lines of communication could be strengthened.

24.2.2 Dr Winstanley highlighted the impending shift within the prison service and health responsibilities that would transfer to NHS Lothian; he also proposed an internal audit of the service. The Chair agreed that the topic should be considered when the coming year’s audit plan is being drafted.

24.2.3 The Committee noted the Healthcare Governance and Risk Management Committee minutes of 7 June and 2 August 2011 and the information therein.
24.3 **Staff Governance Committee - Minutes of the Meeting held 30 March 2011** - the previously circulated Minutes of the Staff Governance Committee meeting held on the 30 March 2011 were received.

24.3.1 Following Mr Egan’s concerns surrounding the lack of funds for retirement awards, Celebrating Success and monies donated at ward level, Ms Goldsmith advised that Dr Farquharson and Ms Hornett had written to all Consultants and Charge Nurses concerning the security of funds received at ward level, following instances of cash going missing. The receipt of cash on wards was suggested as a possible future audit topic.

24.3.2 Dr Winstanley advised the Committee that holding monies for staff benefits was not within the remit of the Foundation. The Trustees had taken a view that supporting the Celebrating Success awards would ultimately benefit patients through promoting a positive working environment and increasing morale. He expressed the importance of recognising the difference between donations to ward level specific funds that are governed by the charity, and the separate issue of staff benefits funds.

25. **Internal Audit Reports**

25.1 **Internal Audit – Progress Report September 2011**

25.1.1 Mr Woods gave a brief overview of progress with the audit plan, and highlighted recent fraud activity detailed within the report. The Committee noted the unsuccessful outcome in relation to the appeal about auditors’ job gradings and the impending final appeal process.

25.1.2 Mr Woods advised that a recent FOI request from a journalist had led to 17 internal audit reports being made available. Subsequent debate about the format and style of audit reports has led to a new process whereby the Director of Communications and the Director of Human Resources & Organisational Development are to be copied with all draft and final internal audit reports. Mr Woods pointed out the need to bear in mind the Standing Orders which state Internal Audit’s right to perform work and issue reports free from interference, including issuing reports without obtaining approval from directors or senior managers. Also, Mr Woods mentioned the Government Internal Audit Standards’ insistence on Internal Audit’s independence. Mr Woods added that no cause for concern has arisen, but he considered it appropriate to brief the Committee. The Chair advised that he had discussed the matter with the Director of Communications, and the new process would in no way interfere with Internal Audit’s right to produce independent reports. The Chair confirmed that Internal Audit’s independence as set out in the Standing Orders would not be affected.

25.1.3 Professor Murray queried whether the Freedom of Information request report had been notified to the relevant Directors. Ms Goldsmith reported that the issue had been raised at Directors Informal and EMT meetings. Directors would be informed as early as possible of any expected newspaper articles.
25.1.4 The Committee noted that the issue surrounding the certification of property transactions now appears to have been resolved and that Ms Goldsmith had proposed using the Deaconess House transaction as an example of good practice.

25.1.5 The Committee noted the previously circulated Internal Audit Progress Report September 2011 and the assurances therein.

25.2 **Counter Fraud Services Quarterly Report – June 2011**

25.2.1 Mr Woods presented the Counter Fraud Services quarterly report underlining Operations GENOME and LUMEN from NHS Lothian. Also, Mr Woods noted the new format of the report which now includes statistics about fraud cases. Mr Woods advised that figures and analysis specific to NHS Lothian are presented to the Operational Audit Sub-Committee, Counter Fraud Action Group and Executive Management Team, and commented that analysis of NHS Lothian’s fraud cases mirrored the NHS Scotland figures set out in CFS’s report.

25.2.2 The Chair advised the Committee that the Operational Audit Sub-Committee had received a specific report on fraud cases associated with staff working whilst on sickness absence. The report had been produced following a request for the Counter Fraud Action Group to identify fraud themes. The report has been referred to the Staff Governance Committee.

25.2.3 The Committee agreed to accept the CFS Quarterly Report – June 2011.

25.3 **Fraud Intelligence Alerts**

25.3.1 The Committee noted the previously circulated Counter Fraud Services intelligence alert, reference number 08/2011, which referred to a non-presented cheque fraud.

25.3.2 Mr Woods reassured the Committee that the alert had been raised with the relevant senior managers within NHS Lothian.

25.3.3 Members were advised that an alert in respect of misuse of uniforms had been received from another anti-fraud organisation and circulated to the appropriate responsible Directors.

26. **External Audit Reports**


26.1.1 Ms Douglas questioned what role Audit Scotland would have in assisting the Community Health Partnerships with the Best Value toolkits and processes.
In response Ms Woolman advised that this was being progressed by management, as had been set out in the action plan to the external audit annual report.

26.1.2 In response to Mr Egan’s query about overview reports Ms Woolman reported that Audit Scotland colleagues continued to strive to get the message out concerning shared services.

26.1.3 The Members were assured that Audit Scotland’s systems and process complied with professional standards.

26.1.4 The Committee agreed to accept the report.

26.2 NHS Lothian – 2010/11 Audit eHealth Service Delivery – the previously circulated report on the 2010/11 Audit of eHealth Service Delivery from Ms Woolman was received.

26.2.1 Ms Woolman took the Committee through the details of the report highlighting the scope of the audit outlined in paragraph 4 and the actions that followed. The Chair thanked Ms Woolman for the helpful overview and asked that the report be brought to the next Operational Audit Sub-Committee.

26.2.2 The Committee agreed to accept the report.

26.3 NHS Lothian – Annual Report on the 2010/11 Audit – the previously circulated report on the NHS Lothian Annual Report on the 2010/11 Audit from Ms Woolman was received.

26.3.1 Ms Woolman took the Members through each page of the NHS Lothian Annual Report on the 2010/11 Audit highlighting the key messages within, the achievement of the financial targets for 2010/11 and the decision taken by Audit Scotland to issue an unqualified opinion.

26.3.2 The Committee noted that the report had not yet been presented to the Lothian NHS Board, as had been the case in previous years. Members agreed that a copy of the report should be forwarded to Mr Wilson, Director of Communications prior to its circulation.

26.3.3 In response to Dr Winstanley’s question Ms Woolman and her colleagues advised that the review of staff earning over £100,000 had been an exceptional case requested by the Cabinet Secretary. Following a short discussion surrounding the response times Ms Goldsmith advised that there had been some confusion in respect of the sample size and in future these crucial details should be explicit to ensure that delays were not incurred later.

26.3.4 Ms Woolman acknowledged the development of guidance in respect of heritage assets, the wider issue surrounding consolidation of the accounts and the potential challenges of consolidating the accounts of the Edinburgh & Lothians Health Foundation.
27. General Corporate Governance

27.1 Royal Hospital for Sick Children/Department for Clinical Neurosciences – Ms Goldsmith gave detailed verbal update highlighting that the main areas of risk were associated with the project: Project governance; the role of the Scottish Futures Trust; NHS Lothian’s role as the sovereign accountable body for the project; duplication of work; multiple fees and protection of clinical dependencies throughout the process. She then opened the conversation to the members present.

27.1.1 Members agreed that they needed further assurance in respect of the following risks:
- Consort and securing the land to build the additional car park and the Royal Hospital for Sick Children/Department of Clinical Neurosciences.
- Accountability of the Scottish Futures Trust, NHS Lothian and the Scottish Government and the associated reputational and political risks.
- The decision making process currently in place including a clear audit trail of decisions taken.
- Additional support for lead Directors during the term of the project.
- That the Board had explored all PFI opportunities prior to going ahead with the new build.
- That funding could be secured given the current financial climate.
- That during the transitory period clinical risk was monitored closely. Particular assurance regarding the hand over period and the fact that the RHSC was a tertiary site was required.
- Ensuring that the timetable and programmes remain on track and were not delayed.

27.1.2 Ms Goldsmith explained that a recently received PricewaterhouseCoopers report had highlighted a number of areas to address including project resources, duplication of advisors, whether the Board was confident that the advisors appointment were Private-Public Partnership proficient and clarification of roles and responsibilities of the Scottish Futures Trust and NHS Lothian. Members agreed that assurance should be sought from the Project Board in respect of their response to the report.

27.1.3 The Committee were reassured that the reporting lines between the Project Board and the Finance and Performance Review Committee had been formalised.

27.1.4 Ms Goldsmith agreed to bring forward a Board paper addressing the Committees concerns, and clearly expressing the key risks for the Board associated with the Project. This would be brought to a future private session of the Board.

27.2 Audit Scotland Technical Bulletin – the previously circulated report to brief the members on the latest releases from Audit Scotland 2011/2 dated June 2011 and 2011/3 dated September 2011 was received.
27.2.1 Mr Martin gave a brief overview of the report highlighting:
- The potential conflict of the consolidation of the Endowment Funds and the production of the 2013/14 annual account; he reassured the Committee that a separate set of accounts would remain to be produced for the Endowment Funds.
- That he had shared the insert into the Finance manual with regard to severance schemes with the Director of Workforce Planning to ensure that the required action was taken forward.

27.2.2 The Committee noted the relevant highlights of the technical bulletin detailed within the report.

27.3 **Overseas Patients** – the Committee received the report that provided an update on the arrangements to recover income from liable overseas patients for the provision of clinical care.

27.3.1 The Director of Finance updated the Committee of the current position in respect of arrangements for overseas patients, the challenges that staff were facing and that a further Private & Overseas Patient Officer was being recruited.

27.3.2 In response to Dr Winstanley’s question the Chair advised that the General Practitioners had been approached however they were not willing to take on the responsibility of being gatekeepers to services. It was noted that this decision was supported by the British Medical Association.

27.4 **SFR 18 Paper** – The Committee noted the previously circulated report that provided an opportunity to review the summary of losses and compensation payments incurred throughout 2010/11 and information therein.

27.5 **Follow Up of Audit Recommendations** – Mr Payne briefed the Committee on the 6 month update in relation to the current status of the follow up process as requested at the 12 April 2011 meeting. From the figures in the report, Mr Woods noted that 92% of management actions are not being completed by agreed target dates (10% are up to 2 months late, 44% between 2 months and one year late, and 38% more than one year late).

27.5.1 Following a brief discussion the Committee agreed that a report should be brought back in 6 months, in the meantime these actions would continue to be pursued through the follow-up process. If a significant change in the response rate had not occurred it was agreed that a letter would be drafted to the Chief Executive highlighting the Committee’s concerns.

28. **Any Other Competent Business**

28.1 The Committee noted that there were no other items of competent business.
29. **Date of Next Meeting**

99.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Tuesday, 13 December 2011 at 9.00am in Waverley Gate, Edinburgh.
### Management of Drug Spend (9 June & 28 October 2010, 13 April and 12 October 2011)

- A further report on progress on LRP in drugs spend should be submitted

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<td>SG/PM</td>
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<td>Report from Difficult Decisions' Group awaited</td>
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### Royal Hospital for Sick Children (12 October 2011)

- Seek the support of the Edinburgh Partnership Board for the project
- Ask the Executive Management Team to carefully consider the necessary resources to support Mrs Goldsmith and Mrs Sansbury in taking this project forward
- Examine the resource requirements in order that the most appropriate support can be identified
- Raise the issue of support with the Chief Executive

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<td>JKS/SG</td>
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<td>A paper on resource requirements for the Project is to be considered by the Project Board</td>
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### Financial Position (9 February & 13 April 2011)

- Include corporate income figures in the next financial update

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### Digitisation of Health Records Business Case (12 October 2011)

- Circulate the eHealth Strategy to members
- Find out whether General Practitioners are following the same digitisation route for their medical records

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<td>Property - Asset Management and the Strategic Framework for Developments (13 April 2011)</td>
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<td>• Provide regular updates on the strategic direction in asset management and future capital developments</td>
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<td>Delivery of Local Reinvestment Programmes in 2011/12 (8 June 2011)</td>
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<td>• Working towards a set of primary care activity indicators</td>
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<td>Performance Management (, 8 June 2011)</td>
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<td>• Include quality indicators/headings and stretch targets if appropriate in future reports</td>
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<td>• Bring a further report to the Committee identifying areas where specific action is needed</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>
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<td>• Keep the Director of Communications informed of the position and include progress updates in future reports to the Committee as well as a report on the cost of advisers</td>
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Minutes of the Meeting for the Finance & Performance Review Committee held at 2.30pm on Tuesday, 13 September 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:  Mr G Walker (Chair); Mr R Y Anderson; Mr R Burley; Mr E Egan; Dr D Farquharson; Mrs S Goldsmith; Professor J Iredale; Professor A McMahon; Professor M Prowse; Mrs J K Sansbury; Dr A Tierney; Mr I Whyte and Dr C J Winstanley.

Present:  Mr B Currie; Mr I Graham; Ms L Khindria; Ms C Potter; Mr P Reith and Mr S Wilson.

Apologies for absence were received from Councillor J Aitchison, Professor J J Barbour, Mr A Boyter, Councillor P Edie, Councillor P Johnston, Dr A McCallum and Mr S G Renwick.

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. Royal Hospital for Sick Children and Department of Clinical Neurosciences Reprovision Outline Business Case Update

28.1 The Committee received a previously circulated report and a presentation giving an update on progress of the Royal Hospital for Sick Children and Department of Clinical Neurosciences Outline Business Case.

28.2 Mrs Goldsmith advised the Committee that, if the 2016 completion was to be achieved, the project would need to be taken to the market in November 2011. The purpose of the present meeting was to provide Committee members with an update on the different aspects of the project, including the development of the reference design, the negotiations with Consort and the financial implications for both revenue and capital.

28.3 Mrs Goldsmith advised that a briefing would be provided to the September Private Board meeting and the draft Outline Business Case would be submitted to the Executive Management Team for consideration at its meeting on 5 October 2011. The Finance & Performance Review Committee in October
would then consider the Full Outline Business Case and would make a recommendation to a Special Private Board meeting to be held on 26 October 2011.

28.4 Mr Currie informed the Committee that it was hoped to place an advert in the online journal of the European Union in November 2011 seeking bidders from whom three would be selected in order to start the competitive dialogue process in April 2012. It was anticipated this process would take until 2013 and would conclude with one bidder being approved and starting work on site at the end of 2013.

28.5 A number of members expressed concerns at the very tight timescale to complete the Outline Business Case in order to achieve the November deadline. The Chair asked Mrs Goldsmith to take this into account in her report to the September Board meeting.

28.6 Mr Egan asked that it be made clear to the public that responsibility for the delays lay with the change in funding arrangements and the additional governance requirements laid down by the Scottish Futures Trust.

28.7 Mrs Sansbury advised that the Cabinet Secretary had been fully briefed and was comfortable with the proposed date in 2016.

28.8 Mr Anderson reminded members that the presentation by the Chief Executive of the Scottish Futures Trust had been proposed for the next Board meeting, and Mrs Goldsmith advised that as the NHS Lothian Chief Executive and the Scottish Futures Trust Chief Executive had both been on leave it had not yet been possible to agree a date.

28.9 Dr Winstanley emphasised that the previous concern of the Committee had been that the role of the Scottish Futures Trust be made clear as soon as possible.

28.10 Mrs Goldsmith undertook to contact the Chief Executive of the Scottish Futures Trust to arrange a date for him to speak to the Board. Current chronology was that the Outline Business Case would be discussed at the Board on 28 September with the detail being considered at the Executive Management Team on 5 October followed by detailed consideration by the Finance & Performance Review Committee on 12 October and formal submission to the Board on 26 October 2011.

28.11 Mrs Sansbury gave a detailed presentation outlining the process being gone through and providing detail of the reference design. She explained that NHS Lothian was working fully with the Scottish Government so no surprises were expected and the clear benefits for bringing the two buildings together had been demonstrated. It was a Scottish Government requirement that all soft facilities management services were to be delivered in-house.

28.12 Dr Tierney questioned the inclusion of the helipad on top of the building and Mrs Sansbury confirmed that this was the only viable location and patients
would be taken straight to either the Department of Clinical Neurosciences or the Royal Hospital for Sick Children.

28.13 The Committee noted that updated clinical models had been used and that the facilities in the new Royal Hospital for Sick Children and Department of Clinical Neurosciences would be separate from those provided for the Royal Infirmary of Edinburgh.

28.14 Mrs Sansbury explained the differences between gateway and key stage reviews and explained that she was working with other Boards and stakeholders to ensure that any difficulties were ironed out.

28.15 The Committee agreed to support the update and the ongoing work on the Outline Business Case.

29. **Royal Hospital for Sick Children/ Department of Clinical Neurosciences Project – Financial Assumptions**

29.1 The Committee noted a previously circulated report and a presentation providing an overview of the financial assumptions underpinning the Outline Business Case for the Royal Hospital for Sick Children/Department of Clinical Neurosciences project.

29.2 Mrs Goldsmith outlined the funding scope of the project and confirmed that the Scottish Government would provide revenue funding to support the non-profit distribution agreement for 100% of construction costs, 100% of private sector developments costs, 100% of financing interest and fees, 100% of special project vehicle running costs and 50% of life cycle costs. The revenue funding for the non-profit distribution agreement would be capped at the levels detailed in the Outline Business Case.

29.3 The Committee noted that significant non-profit distribution capital investment would still be required for the provision of medical and non-medical equipment, clinical enabling works within the Royal Infirmary of Edinburgh, external enabling works on the Little France site, town planning requirements on the Little France site and the reference design itself.

29.4 Mrs Goldsmith reiterated that a sum for the Project had been set aside by the Scottish Government in their spending review.

29.5 The Committee agreed that the Director of Finance should calculated whether the additional costs of following the current path out-weighed the additional funding being provided by the Scottish Government. It was also agreed that the Director of Finance should ensure that appropriate importance was assigned to the potential risks in respect of final cost comparisons, in light of the length of time to completion of the building. The Committee also agreed to seek Scottish Government assistance in obtaining other Board’s commitments to the regional services to be provided in the new hospital.

SG
30. **Royal Hospital for Sick Children and Department of Clinical Neurosciences Reprovision Consort Commercial Negotiations**

30.1 The Committee considered a previously circulated report from the Director of Finance giving an overview of the key points for negotiation and agreement with Consort and received a presentation outlining the objective of the negotiations, their scope and arrangements for risk management as well as the recommendations.

30.2 The Committee agreed that the Director of Finance should ask Consort to validate the design and remind members that the non-profit distribution agreement would be the budget and would be an agreed contract.  

30.3 Mrs Sansbury commented that the existing contract had a track record of reducing the ultimate costs identified in the Outline Business Case.

Professor Iredale and Professor Prowse left the meeting.

30.4 The Committee discussed options for dealing with the roads on the site and agreed that all the roads should be brought under the same ownership.  

30.5 The Committee expressed concern over the timeline for the supplementary agreement and it was noted that the Scottish Futures Trust would be part of the team negotiating with Consort.

30.6 Dr Winstanley reminded the Committee that the Director of Communications would need to be fully briefed on the position and the Chair suggested that simplified tables with a simple timeline should be produced for the benefit of the Board.  

31. **Date of Next Meeting**

31.1 It was noted that the next meeting of the Finance & Performance Review Committee would be held on Wednesday, 12 October 2011 at 9.00am in meeting room 7, Waverley Gate, Edinburgh.

31.2 The Chair thanked members for attending and the meeting closed at 5.35pm.
Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 12 October 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (Chair); Mr R Y Anderson; Councillor J Aitchison; Mr A Boyter (For Items 32, 33 & 34); Mr E Egan; Dr D Farquharson; Mrs S Goldsmith; Professor A McMahon; Professor M Prowse; Mr S G Renwick; Mrs J K Sansbury; Mr I Whyte and Dr C J Winstanley.

In Attendance: Mr P Reith; Ms J Harnes; Mrs L Khindria; Ms K Leath and Mr F McJannett

Apologies for absence were received from Professor J J Barbour, Mr R Burley, Councillor P Edie, Councillor P Johnston and Professor J Iredale.

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. Mr Egan declared an interest in agenda item 4.3 “Digitisation of Medical Records Business Case” as his brother was Director eHealth.

32. Minutes of the Previous Meeting

32.1 The previously circulated Minutes of the meetings held on 17 August and 17 September 2011 were approved, subject to the following amendments:-

Minute 30.2 - ‘depot’ should read ‘depots’.

33. Matters Arising

33.1 Management of Drug Spend – Mrs Goldsmith commented that she was conscious that a report on progress on the Local Reinvestment Plan in Pharmacy was outstanding but whilst a lot of work had been done, it had not yet been concluded. Dr Farquharson advised that the Difficult Decisions Group had met the previous day and a number of immediate actions identified.
33.1.1 Mr Egan commented that there appeared to be significant opt-outs from the formulary in general practice whilst at the same time incentives were being paid to General Practitioners to switch to the formulary. In spite of this, the prescribing budget was still overspent and it did not appear that prescribing patterns were changing.

33.1.2 Mrs Goldsmith commented that prescribing volumes were up by over 5% and it was not yet clear why this should be. She confirmed it was possible to break down the available data by British National Formulary category and an analysis of this could be conducted.  

33.1.3 Mr Renwick commented that the Audit Committee had been considering this problem and there appeared to be a conflict between the independent status of General Practitioners and the requirement for corporate control of expenditure.

33.1.4 Professor Prowse commented that with the number of variables predictive modelling should be applied. It would be possible to model backwards from 2015 to gain some idea of the extent of the problem.

33.1.5 Dr Farquharson advised that it was hoped that the Difficult Decisions Group would have some recommendations by the end of 2011, and it was agreed that a report should be brought back to the February meeting of the Committee.

34. Shared Services Position Update

34.1 Mr Boyter introduced a previously circulated report giving an update focused on the forward plan and anticipated timescales for the next stage of the work.

34.2 Mr Boyter advised that following a data collection exercise, work was concentrating on identifying areas where it would be sensible to share services with a final report anticipated in March 2012 for implementation in 2012/13. Mr Boyter commented that he had been encouraged by the attitude of Local Authority partners and the only original partner no longer participating was Heriot-Watt University.

34.3 Dr Winstanley commented that he had hoped that there would have been some pilots up and running by this stage and he would have liked to have seen more progress, especially on patient transport which he understood was now being taken forward by the Scottish Ambulance Service.

34.4 Councillor Aitchison advised that the ethos of shared services had been agreed by all parties, however, there were problems with implementation and the degree of progress with local authorities would depend on the outcome of the local authority elections in 2012.

34.5 Mr Egan commented that the possibility of the privatisation of the City of Edinburgh Council’s fuel depots would preclude their inclusion in the exercise. He also commented that progress amongst the members of SEAT in agreeing shared services between Health Boards was not making any progress.
34.6 Mr Boyter undertook to bring an update report to the next meeting of the Committee on the position with SEAT and the Committee agreed that shared services should become a standing item on the agenda until further notice.

34.7 The Committee agreed to note the plan agreed at the second meeting of the Group with partners invited to start scoping possibilities for shared services across the wider public sector, which had been held on 27 September 2011.

35. Initial Agreement for the Redevelopment of the Royal Edinburgh Hospital Campus

35.1 A previously circulated report, containing details of the Initial Agreement for the redevelopment of the Royal Edinburgh Hospital campus was received.

35.2 Mrs Sansbury advised the Committee that each phase of the redevelopment would require a separate Business Case. The current report was a statement of strategic intent to develop the Royal Edinburgh Hospital campus incrementally, as agreed at the meeting on 9 August 2010.

35.3 Mrs Sansbury commented that the Service Redesign Committee had expressed concern about the earlier proposals to sell off land on the Astley Ainslie Hospital site and presently agreement was only being sought for the first phase of the redevelopment. Mrs Sansbury outlined the linkages between the rehabilitation and psychiatric services and reminded the Committee that NHS Lothian was still providing services on too many sites and from too many ageing facilities no longer fit for purpose.

35.4 In response to a question from Mr Whyte, Mrs Sansbury confirmed that discussions had been held with the City of Edinburgh Council on their involvement in the use of the Royal Edinburgh Hospital site and reiterated that there could be opportunities for different models of care as the redevelopment progressed.

35.5 Mr Egan expressed his full support for the Initial Agreement and the review of the number of sites on which services were provided. He suggested that the same rigour that had been applied to Bangour Village Hospital should be used and expressed some concern at the number of Committees to which the redevelopment proposals were being submitted.

35.6 Mr Anderson commented that public transport access to the site was an issue and Mrs Sansbury advised that an additional entrance would be added to increase access from different parts of the area.

35.7 Mr Renwick asked about funding for the additional cost for the project team and questioned the future of the Scottish Ambulance Service building on the site.

35.8 Mrs Sansbury advised she had been informed that the Scottish Ambulance Service would be moving off site within the next 18 months and that currently capital support, as well as revenue, was being used for funding the project team and would be part of the financial plan coming forward.
Professor Prowse questioned the future of the SMART Centre at the Astley Ainslie Hospital and Mrs Sansbury confirmed that this would be retained as it was a new facility.

Dr Winstanley questioned the extent of service redesign that might be possible on the site and Mrs Sansbury advised that a significant amount of service redesign had already been carried out. The psychiatric services model required to go through the redesign process and there would be significant opportunities for redesigning the rehabilitation services at the Astley Ainslie Hospital as well. A number of elements of service redesign were presently underway.

The Committee agreed to broadly support the intention to develop the Royal Edinburgh Hospital site on an incremental phased basis over approximately 10 years, subject to funding; acknowledged and approved the strategic intention to reprovide existing mental health and learning disability services accommodation currently on the Royal Edinburgh Hospital site and to further explore the relocation of services from the Astley Ainslie and Liberton Hospitals to the site. The Committee emphasised that additional work would be required before consideration could be given to the move of services from the Astley Ainslie Hospital and emphasised that opportunities should be explored to provide services with other partners.

The Committee noted that there were concerns about the scale of such a project moving forward and becoming difficult to change course as services evolved and the potential difficulties in affordability if the proceeds of future land sales could not be used to fund new developments.

Royal Hospital for Sick Children/ Department of Clinical Neurosciences

The Committee received a previously circulated confidential report on the progress on the Royal Hospital for Sick Children and Department of Clinical Neurosciences project.

Mrs Goldsmith gave an update to the Committee on the current position of the negotiations and indicated that the Scottish Futures Trust had provided a list of actions required. It was noted that the final report from the Scottish Futures Trust could not be concluded until the financial information, currently being revised, was available.

Mr Egan expressed concern at the amount of work Mrs Goldsmith and Mrs Sansbury were having to devote to this project and emphasised that additional staffing resources would require to be co-opted once the Business Case was agreed by the Scottish Government.

It was noted that University of Edinburgh support for the project was being sought and Dr Winstanley suggested that the support of the Edinburgh Partnership Board should also be obtained.
36.5 The Committee agreed to ask the Executive Management Team to carefully consider the necessary resources to support Mrs Goldsmith and Mrs Sansbury in taking this project forward. The Committee further agreed to ask Mr Currie to look at the resource requirements in order that the most appropriate support could be identified. Dr Winstanley and Mr Egan undertook to raise the issue of support with the Chief Executive.

36.6 The Committee agreed to note the progress made with Consort and ongoing work on the Outline Business Case.

37. Digitisation of Health Records Business Case

37.1 Dr Farquharson spoke to a previously circulated report, recommending a proposal to initiate the large-scale digitisation of relevant paper health records.

37.2 Dr Farquharson advised that option 2b in the circulated confidential paper was the preferred option.

37.3 In response to a question from Mr Renwick, Dr Farquharson advised that the security aspects of digital storage had been raised with the Director of Public Health, who had confirmed that such arrangements would be perfectly satisfactory from a security perspective.

37.4 Mrs Goldsmith indicated that the financial plan was currently being scrutinised for the necessary non-recurring investment to achieve the digitisation of medical records.

37.5 Mr Renwick commented that evidence to support the future proofing, security and funding of the project would be required and reminded members that the financial plan had not yet been seen.

37.6 Mrs Sansbury emphasised that the digitisation of medical records was essential for future provision of healthcare as the new Royal Victoria Hospital and the proposed redevelopment of the Royal Hospital for Sick Children did not include any room for paper files.

37.7 Professor Prowse commented that she would prefer to see specific provision for eHealth rather than an ad-hoc approach.

37.8 Mrs Sansbury advised that the Royal Victoria Hospital would be a pilot for the digitisation of medical records as a number of systems would be brought together and Dr Farquharson emphasised that all the necessary components were in place.

37.9 Dr Farquharson undertook to circulate the eHealth Strategy to members and undertook to find out whether General Practitioners were following the same digitisation route for their medical records.
The Committee agreed to approve the selection of option 2b as the preferred option in the previously circulated paper, subject to the provision of evidence on the level of privacy, security, future proofing and funding.

38. **Financial Position to 31 August 2011**

38.1 The Committee received a previously circulated report providing an overview of the financial position of NHS Lothian for the first five months of the financial year 2011/12.

38.2 Mrs Goldsmith advised the Committee that the financial position had improved on the previous month with the overspend being reduced from £3.1m to £2.655m as at the end of August 2011. Now that the financial year was more advanced, a step change in Local Reinvestment Plan delivery was expected and areas of increased activity were being closely examined.

38.3 Mr Egan commented that some areas of overspend at the University Hospitals Division were because nurses had not been paid properly and once the error had been corrected significant sums of back money had to be paid. He commented that the continuing significant increase in critical care had to be taken account of in the financial plan and reminded the Committee that forthcoming industrial action by the Trades Unions in respect of Government proposals for NHS pensions could impact on the level of support Trades Unions were able to give to the achievement of Local Redevelopment Plans.

38.4 Mrs Goldsmith advised that a number of programmes would require some level of project support and it was noted that this was being provided by the use of redeployed staff.

38.5 Mr Renwick commented that it would be useful to see figures for income as well as expenditure in future reports.

38.6 Mrs Goldsmith indicated that where possible corporate income figures would be included in the next financial update.

39. **Capital Investment Programme 2011/12**

39.1 The Committee received a previously circulated report giving an update on progress against the agreed capital programme for the current year, including the expenditure position to August 2011.

39.2 Mrs Goldsmith indicated that the rules around the management of the capital budget were still being discussed with the Scottish Government and the ongoing uncertainty made it difficult to make investment decisions around any slippage identified.

39.3 The Committee agreed to note that the balanced capital position forecast position for 2011/12 was dependent on the successful delivery of a number of
assumptions paid around the funding of the programmes. These assumptions had been shared with the Scottish Government Health Directorates.

39.4 The Committee agreed that delegated authority be granted to the Director of Finance to approve a settlement of up to £0.4m in respect of Chalmers Sexual Health Centre; to approve the issue of a new project request to South East Scotland hubCo for the proposed Firrhill Partnership Centre and to note expenditure of £27.2m on the agreed capital programme for the first 3 months of the financial year.

39.5 The Committee agreed that the Director of Communications should be kept informed of the position and that progress updates on these matters should be included in future reports to the Committee as well as a report on the cost of advisers.

40. Performance Management

40.1 Professor McMahon introduced a previously circulated report giving an updated on the most recently available NHS Lothian performance data as reported through local and national systems.

40.2 Professor McMahon advised the Committee that a meeting had recently been held with the Scottish Government on the new HEAT target for admissions of people over 75. Discussions had been held about the way in which the target was being defined and counted (i.e. that length of stay of up to one year was considered with an emergency admission). The Scottish Government had been asked to review this. Delayed discharges were under sustained pressure and the possibility of using bank staff at band 2 to help care homes was being considered as care home capacity was becoming a problem.

40.3 Mr Egan advised that he had some concerns over local authority support for social work assessment for discharge as reductions in this area had caused increases in the number of patients remaining inappropriately in hospital.

40.4 Professor McMahon advised that performance metrics were being examined every week now and Mrs Sansbury indicated that monitoring should help in better understanding the situation.

40.5 Mr Egan reminded the Committee that failure by the City of Edinburgh Council to assess patients had led to increased costs for NHS Lothian and suggested that this cost should be identified.

40.6 Professor McMahon advised that current legislation did not allow NHS Lothian to charge local authorities for delays in carrying out the necessary assessments.

40.7 The Chair noted that concern was being expressed over paediatric services at St John’s Hospital. Mrs Sansbury advised that NHS Lothian were fully committed to the provision of Paediatric Services at St John’s and were
currently out to advert for Specialty Doctors at St John’s to support the paediatric unit.

40.8 The Committee agreed to note the concerns and the action being taken to address them.

40.9 The Committee further agreed to note the actions being taken on behalf of responsible Directors where performance was currently off trajectory. It was also agreed that a further report should be brought to the Committee identifying areas where specific action was needed.

41. **Workforce Efficiencies within NHS Lothian**

41.1 The Chairman welcomed Mrs Khindria to the meeting.

41.2 Mrs Khindria spoke to a previously circulated report giving an update on progress to date in regard to the planned workforce reductions and reviewing the performance management of sickness absence.

41.3 The Committee noted that local redevelopment schemes had identified 632 reductions in substantive established posts allowing the achievement of the targeted 734 whole time equivalent reductions in staff. In addition, workforce costs would also be reduced by £1.62m because of changes in skill mix. In total, workforce reductions would release £32.3m per annum.

41.4 Mrs Khindria also advised that good progress continued to be made in keeping sickness absence to below 4%.

41.5 The Committee agreed to note the reduction of 414.8 whole time equivalent staff in post hours since 1 April 2011 to 31 August 2011 against the annual target of 734 whole time equivalents. The Committee also noted the position in regard to sickness absence and the sickness rate of 3.46% for July 2011.

42. **Scottish Government Spending Review – September 2011**

42.1 Mrs Goldsmith introduced a previously circulated report giving an overview of the Scottish Government’s draft budget announcement on 21 September and the financial planning implications for NHS Lothian for 2012/13 and beyond.

42.2 The Committee noted that the proposed increase to NHS Lothian forthcoming revenue budget was £39.4m, which included a baseline uplift of £10.5m. It was also noted that additional NRAC funding of £12.2m had been allocated to NHS Lothian, which moved NHS Lothian from £58m to £50.5m below parity in relation to other NHS Boards.

42.3 The Committee noted that access to support monies of £10.8m in 2011/12 had been added to the Board’s recurring revenue budget for 2012/13 but had not attracted an inflationary uplift from the Government. It was further noted that additional funding of £4.4m would be provided to NHS Lothian to support the
revenue consequences of the transfer of responsibility for prison healthcare and that the change fund allocated to NHS Lothian had been increased by £1.4m.

42.4 Mrs Goldsmith commented that no indication had been made as to how much of the additional funding had been reserved for policy initiatives.

42.5 Dr Winstanley queried the absence of any reference to the primary care budget in the Scottish Government’s figures and Mrs Goldsmith undertook to raise the profile of this issue with the Scottish Government.

42.6 The Committee agreed to note the reported positions.

43. **Date of Next Meeting**

43.1 It was noted that the next meeting of the Finance & Performance Review Committee would be held on Wednesday, 14 December 2011 at 9.00am in meeting room 7, Waverley Gate, Edinburgh.
<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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<tbody>
<tr>
<td><strong>Adults with Incapacity (Scotland) Act 2001 – Part 5 (February 2011)</strong></td>
<td>AMcM</td>
<td>February</td>
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<tr>
<td>• The Chair also requested an update report in 2012.</td>
<td>AMcM</td>
<td>February</td>
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<td><strong>Meticillin Resistant Stapylococcus aureus Screening</strong></td>
<td>AKM</td>
<td>December</td>
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<td>• 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.</td>
<td>AKM</td>
<td>December</td>
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<tr>
<td><strong>NHS QIS Pre-JAG Endoscopy Assessment Visits (October 2011)</strong></td>
<td>AKM</td>
<td>December</td>
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<td>• Dr McCallum advised that the decontamination action plan for the Royal Infirmary of Edinburgh and the Western General Hospital had not yet been finalised but would come to the next meeting in December. She explained that the Scottish Government was reviewing the governance structure and priorities for decontamination services, with a view to asking Health Boards to focus on reducing avoidable harm from infections associated with decontamination.</td>
<td>AKM</td>
<td>December</td>
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<tr>
<td><strong>Business Continuity Management (June/October 2011)</strong></td>
<td>JD</td>
<td>December</td>
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<td>• Mr Egan raised concern regarding a 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.</td>
<td>JD</td>
<td>December</td>
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<td>• Committee members expressed concern regarding the resource capacity for business continuity and the support for Ms Drysdale. The Committee felt that it would be helpful to invite Professor McMahon to the next meeting to discuss this issue. There followed some discussion on the internal audit report on business continuity management. Dr McCallum raised concern</td>
<td>AB/AMcM</td>
<td>December</td>
<td>As part of the Business Continuity Internal Audit (July 2011) the following management actions will be undertaken;</td>
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<td>• A formal reporting process requiring directors and General Managers to provide annual reports on compliance within their areas is to be established</td>
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regarding the way that the internal audit was conducted – and agreed to discuss this with the Chief internal Auditor.

- An escalation process is also being put in place to help address instances of non-compliance, such as plans not being reviewed or remaining outstanding for a significant period of time. The escalation process will include timeframes and points of contact for each stage of escalation, with a corresponding entry added to the corporate risk register Actions required to address the risk will be allocated to the relevant director or General Manager.

<table>
<thead>
<tr>
<th>Framework for the Management of Public Health Incidents (August 2011)</th>
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<tr>
<td>• 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.</td>
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<tr>
<th>NHS Lothian Public Protection Services Update (August 2011)</th>
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<tr>
<td>• 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.</td>
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<thead>
<tr>
<th>Report of the Triennial UK Confidential Enquiry into Maternal Deaths (August 2011)</th>
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<tr>
<td>• 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.</td>
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<td><strong>Nursing Home Update (October 2011)</strong></td>
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<tr>
<td>• It was suggested that the Care Inspectorate Scotland be invited to a meeting of the Committee to give a presentation on the work of the Care Inspectorate Scotland in relation to care homes.</td>
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<tr>
<th><strong>Prison Healthcare Implementation Plan (October 2011)</strong></th>
<th>AMcM/AS</th>
<th>February 2012</th>
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<tr>
<td>• The Committee noted the concerns listed below and requested an update report to the February 2012 Committee meeting. It was noted that there would be resource implications to improve the outcomes through increased interventions and better through care into community settings – the Committee commented that this should be made clear in the report. The Chair also added that the role of the Accountable Officer for Controlled Drugs should be referred to in the report.</td>
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<tr>
<th><strong>Inspection at the Royal Infirmary of Edinburgh by the Healthcare Environment Inspectorate on 18/08/2011 (October 2011)</strong></th>
<th>SBS/AKM</th>
<th>In progress</th>
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<tr>
<td>• Mr Boyter pointed out that the inspection was being treated as a critical incident and was being investigated by Mrs Ballard-Smith. It was agreed that the findings from this investigation should be presented to the Committee at a future meeting. Ms Faulkner pointed out that there were also issues around staff training and staff resources that would need to be addressed.</td>
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<tr>
<th><strong>NHS Lothian Incident Report (October 2011)</strong></th>
<th>DF</th>
<th>December 2011</th>
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<tr>
<td>• The Committee referred to the data for East and Mid Lothian CHP and requested more information on the incidents that were related to substance misuse. Dr Farquharson agreed to look into this and feed back to the next meeting.</td>
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<tr>
<th><strong>Medication preparation and administration (October 2011)</strong></th>
<th>PD</th>
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<tr>
<td>• It was noted that the tabards for nurses to wear during medication preparation and administration to reduce interruptions were not consistent across NHS Lothian. Mrs Dawson agreed to look into the tabards used and ensure consistency across Lothian.</td>
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<tr>
<th><strong>Review of Governance Arrangements for Anticipatory Care Enhanced Service (October 2011)</strong></th>
<th>NW/DF</th>
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<tr>
<td>• The Committee agreed to support the direction of travel but agreed there were still a few issues to iron out regarding the escalation process and links with the Care Inspectorate Scotland.</td>
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<tr>
<td>NHS Lothian Public Protection Services Update (October 2011)</td>
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<td>----------------------------------------------------------</td>
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<td>• The Committee noted the report. Mr Egan requested an update on the additional resources required for child protection advisers.</td>
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<td>MH</td>
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CHAIR’S REMARKS

The Chair welcomed members to the meeting and members introduced themselves.

33. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF THE PREVIOUS MEETING: 2 AUGUST 2011

33.1 The minutes of the previous meeting on 2 August 2011 were approved as a correct record. The Chair referred to the cumulative action note from the previous meeting and asked members for any updates on the items. Mr Egan referred to the business continuity action and requested that the word “possible” be removed from the following sentence “Mr Egan raised concern regarding a possible backlog in maintenance work”.

34. MATTERS ARISING

34.1 NHS QIS Pre-JAG Endoscopy Assessment Visits

44.1.1 Dr McCallum gave a verbal update to the Committee. She advised that the decontamination action plan for the Royal Infirmary of Edinburgh and the Western General Hospital had not yet been finalised but would come to the next meeting in December. She explained that the Scottish Government was reviewing the governance structure and priorities for decontamination services, with a view to asking Health Boards to focus on reducing avoidable harm from infections associated with decontamination.
44.2 Nursing Home Update

44.2.1 Mrs Dawson gave a brief verbal update to the Committee. She reported that the police investigation into the Elsie Inglis care home was continuing. Mr Egan commended the district nurse that raised concern regarding the standard of care in the Elsie Inglis Care Home. It was also noted that all but one of the Southern Cross Care Homes had found new owners.

44.2.2 There followed some discussion on NHS Lothian links with the Care Inspectorate Scotland. It was suggested that the Care Inspectorate Scotland be invited to a meeting of the Committee to give a presentation on the work of the Care Inspectorate Scotland in relation to care homes.

MH/PD

44.3 Prison Healthcare Implementation Plan

44.3.1 Mr Short attended the meeting to speak to the report on the prison healthcare implementation plan. He highlighted the key objectives of the transfer:

- 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
- Support the work in reducing health inequalities as well as contributing to the wider work on reducing re-offending
- Ensure operational stability is maintained before, during and after transfer
- Implement the transition process as seamlessly as possible for both staff and prisoner/patient groups

44.3.2 He explained that work was underway to map out the current and clinical policies and standards in place within the Scottish Prison Service and to see how these would converge with NHS Lothian polices. He reported that NHS Lothian incident reporting and management policy and procedures would be implemented and arrangements were in place to provide access to the DATIX system. The Chair asked about business continuity arrangements. Mr Short explained that work was underway to consider business continuity and emergency planning. Ms Allan asked about the Patient Rights Act and how this would apply to prisoners. Dr McCallum reported that additional work was being taken forward on this issue with the Scottish Government. The Committee referred to item 8.1 and noted that there had been no engagement with the prisoners. Mr Short reported that this had been the advice from the Scottish Prison Service. He emphasised that it was important to ensure operational stability is maintained before, during and after transfer.

44.3.3 There followed some discussion on resource implications, it was noted that there would be resource implications to improve the outcomes through increased interventions and better through care into community settings – the Committee commented that this should be made clear in the report. The Chair also added that the role of the Accountable Officer for Controlled Drugs should be referred to in the report.
44.3.4 The Committee thanked Mr Short for the report and noted the progress made to support the transfer of prison healthcare. The Committee noted the concerns listed above and requested an update report to the February 2012 Committee meeting. AMcM

44.4 EMERGING ISSUES

44.4.1 Mrs Dawson informed the Committee that Healthcare Environment Inspectorate (HEI) were expanding to include inspections of the care of older people – acute settings and recently published dementia standards. She reported that the self assessment against the standards was to be completed by 17 November 2011 and that it was likely that NHS Lothian would be one of the first Boards to be inspected. She explained that these visits would also inspect the visual cleanliness and environment standards. She informed the Committee that these inspections would not only take place in older people’s wards but all care areas for older people.

45. SAFE CARE

45.1 Healthcare Associated Infection Update

45.1.1 Dr McCallum spoke to the report on Healthcare Associated Infection. She highlighted that there were 26 episodes of *Staphylococcus aureus* Bacteraemia recorded in August 2011 – of these 14 were out of hospital infections. The bimonthly national hand hygiene audit report published on 27/07/11 indicated that NHS Lothian was achieving hand hygiene compliance of 96%. It was noted that there were still some issues with compliance amongst medical staff groups, however the report to be published on 28/9/11 indicated an improvement in medical staff compliance. It was noted that the compliance with perineal screening had been lower due to the number of patients refusing the screen.

45.1.2 The Committee went on to discuss the unannounced inspection at the Royal Infirmary of Edinburgh by the Healthcare Environment Inspectorate on 18/08/2011. The final report highlighted several areas for action. Dr McCallum explained that the timing of the inspection was unfortunate as staff had been working on improvement programmes but the improvement process had not been completed when the inspection took place. The Committee commented that the report was disappointing. The Committee felt that the outcome of this report was not down to individuals but a whole system issue – both staff attitude and culture needed to change. Mr Boyter pointed out that the inspection was being treated as a critical incident and was being investigated by Mrs Ballard-Smith. It was agreed that the findings from this investigation should be presented to the Committee at a future meeting. Ms Faulkner pointed out that there were also issues around staff training and staff resources that would need to be addressed. SBS
45.2 NHS Lothian Incident Report

45.2.1 Dr Farquharson presented the NHS Lothian incident report April – June 2011. He highlighted that the main themes were patient falls (27% of incidents), violence and aggression (16% of incidents) and medication incidents (10% incidents). He explained that this data did not show the impact of the falls bundle. He went through the report and highlighted the key information for the top three reported incidents. There followed some discussion on violence and aggression incidents and members noted that staff training on violence and aggression was an issue as staff were sometimes unable to go to training due to lack of resources in their own areas. It was agreed that this should be raised with Jackie Sansbury, Chief Operating Officer. It was also suggested that Amanda Langsley, NHS Lothian Violence and Aggression Advisor, be invited to do a presentation to the Committee on violence and aggression incidents. The Committee referred to the data for East and Mid Lothian CHP and requested more information on the incidents that were related to substance misuse. Dr Farquharson agreed to look into this and feed back to the next meeting.

DF

45.2.2 Ms Faulkner referred to medication incidents and reported that there were a number of issues to be aware of such as nurses being interrupted when preparing medicines – it was noted that the tabards for nurses to wear during medication preparation and administration to reduce interruptions were not consistent across NHS Lothian. Mrs Dawson agreed to look into the tabards used and ensure consistency across Lothian.

PD

45.2.2 Ms Allan asked how the incident reports were reviewed and disseminated. Dr Farquharson explained that incident reports were reviewed at the Executive Management Team meetings and action plans were prepared to address any issues. Clinical Management Teams were also sent a local report.

45.3 Business Continuity Management Update

45.3.1 The Committee welcomed Ms Drysdale to the meeting. Ms Drysdale went through the key information in the report. Committee members expressed concern regarding the resource capacity for business continuity and the support for Ms Drysdale. The Committee felt that it would be helpful to invite Professor McMahon to the next meeting to discuss this issue. There followed some discussion on the internal audit report on business continuity management. Dr McCallum raised concern regarding the way that the internal audit was conducted – and agreed to discuss this with the Chief internal Auditor.

AKM/AMcM/DF

45.4 Surgical Profiles

45.4.1 This report was presented by Dr Farquharson. It was noted that the surgical profiles demonstrated a high quality service was provided by all surgical sub specialities. He drew attention to the response provided in appendix 1. Mr Egan commented that it would be helpful to have data on surgical readmissions. Ms McFarlane enquired about Deep Vein Thrombosis and asked about the possibility
of screening patients when they were admitted to hospital. Dr Farquharson reported that this could be considered in the future.

45.5 Death of Patients Deemed Fit for Discharge

45.5.1 Mr Short reported that this report was produced following a letter from the Cabinet Secretary for Health and Wellbeing on the subject of delayed discharges and patients who died while awaiting discharge. The proportion of patients of the same age who died within the same period but who had been discharged was examined. He reported that the figures covered the period 1/6/2010 – 31/5/2011. The data was collected using EDISON (Electronic Discharge Online). NHS Lothian had a total of 129 patients added to EDISON that died before they were discharged. Of the 129 patients 53 had become unwell again and had been suspended from EDISON – therefore NHS Lothian had 77 patients who died while waiting discharge – this would represent 2.4% of the total number. The Committee noted the table at point 3.5 which set out the cause of death for all 129 delayed patients. He highlighted that it was not possible to determine whether delays in discharge were a contributing factor to an increased likelihood of death. It was noted that the majority of these patients were very frail and elderly with multiple underlying health issues.

45.6 Review of Governance Arrangements for Anticipatory Care Enhanced Service

45.6.1 Dr Williams presented the report on recent action to review governance arrangements for the Anticipatory Care Enhanced Service provided by General Practitioners for patients in care homes. He reported that the process for reviewing routine data returns, GP practice surveys and Care Home surveys had been reviewed and improvements made so that issues of potential concern could be identified and passed to CH(C)Ps for review by Clinical Directors. The practice monitoring template had been reviewed and was now a mandatory return. The Service Level Agreement (SLA) for 2011/2012 had been amended to make use of the Lothian generic electronic ACP (eACP) and would include a specific performance monitoring framework. Guidance would be provided by the Care Home Review Group for GPs on identification for training needs for care home staff and provided advice to care home managers. Mr Egan asked about whether the Care Inspectorate Scotland would be involved in the review process if potential concern had been identified. Dr Williams reported that initially the clinical director would review the concerns and if significant, the concerns would be referred to the Care Inspectorate Scotland. This information was clear in the guidance for care homes and for GPs. There was some discussion on the escalation process and it was noted that this was yet to be approved. Ms McFarlane asked if the care home resident would have the option to remain with their original GP. Dr Williams reported that it was the choice of the patient but added that the lead practice for the care home would make more proactive visits to the care home on a regular basis. Ms Allan pointed out that it would be useful to include a link to an independent advocate service on the report. The Chair asked how the mandatory returns would be reviewed. Dr Williams explained that they would be reviewed by Primary Care Contractors Organisation (PCCO) and the Associate Medical Director.
45.6.2 The Committee agreed to support the direction of travel but agreed there were still a few issues to iron out regarding the escalation process and links with the Care Inspectorate Scotland.

NW

46. EFFECTIVE CARE

46.1 NHS Lothian Public Protection Services Update

46.1.1 The Committee noted the report. Mr Egan requested an update on the additional resources required for child protection advisers.

MH

46.2 Improving Risk Register Management across NHS Lothian

46.2.1 The Committee noted the April – June 2011 corporate risk register. Dr Farquharson highlighted that Internal Audit had identified the need to improve the horizontal and vertical management and consistency of risk registers across NHS Lothian. The Committee noted the response to the recommendations and the feedback from key stakeholders. He drew attention to the revised risk register template at appendix 2 and explained that this template had been successful in NHS Lanarkshire.

46.3 Clinical and Staff Governance in General Practice

46.3.1 Dr Williams introduced the report to inform the Committee of the action taken to promote local implementation of the Scottish Government guidance Clinical and Staff Governance for General Practice in Scotland 2010. He reported that there was high reported compliance with legal and contractual requirements. The Committee went on to consider the data on professional responsibilities. Concern was raised regarding some of the issues outlined in the report. Dr Williams reported that this could have been due to the terminology in some of the questions.

47. PERSON CENTRED CARE

47.1 Mrs Dawson gave a verbal presentation on the Better Together Adult Inpatient National Survey 2010 noting the improvement in NHS Lothian compared to last year’s survey and as the most improved mainland Board in Scotland.

48. OTHER MINUTES: EXCEPTION REPORTING ONLY

48.1 The Committee noted the following sets of minutes:

- Minutes of NHS Lothian Health and Safety Committee: 19-07-11
- Minutes of the Area Drug and Therapeutics Committee: 03-06-11
49. EXCEPTION REPORTING ONLY

49.1 The Committee approved the following items:

- Quality Improvement Programmes - Annual Report 2010/11
- Healthcare Improvement Scotland - Local Report Sexual Health Services Standards
- Local Supervisory Authority – Annual Report to the Nursing and Midwifery Council 2010-2011
- Healthcare Improvement Scotland – Draft Healthcare Quality Standard
- Healthcare Improvement Scotland – Standards for HIV Services
- NES Quality Improvement Education Curriculum Framework
- Clinical Policy Group Annual Report 2010-2011
- Organ Donation Committee Annual Report 2010-2011
- Bowel Screening in NHS Lothian 2010/2011
- Better Together Adult Inpatient National Survey 2010 and Participation Standard Report

31. ANY OTHER COMPETENT BUSINESS

31.1 There was none.

32. DATE OF NEXT MEETING

- 15 December 2011 from 2pm – 4pm – please note change of time and date
  To be held in Room 7, Waverley Gate from 1pm.

Dates for 2012 Meetings:

- Tuesday 7 February 2012
- Tuesday 3 April 2012
- Tuesday 5 June 2012
- Tuesday 7 August 2012
- Tuesday 2 October 2012
- Tuesday 4 December 2012

All to be held in Meeting Room 7 from 9am – 11am
## LOTHIAN NHS BOARD

**SERVICE REDESIGN COMMITTEE**

**RUNNING ACTION NOTE**

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Releasing Time to Care</strong> (27 June 2011)</td>
<td>SG</td>
<td></td>
<td>Costings provided to meeting on 12/09/11.</td>
<td>Report noted.</td>
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<tr>
<td>• Pick up the unconfirmed cost figures of the project with the Scottish Government Health Directorate’s Director of Finance.</td>
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<tr>
<td>• Provide a further update on Releasing Time to Care in 2012</td>
<td>MH</td>
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<tr>
<td><strong>Lanfine Unit – Review and Redesign of Service to People with Progressive Neurological Conditions</strong> (27 June 2011)</td>
<td>AMcM</td>
<td>12/12/11</td>
<td>This report is now expected to be available for the December meeting</td>
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<tr>
<td>• Bring a plan to Committee 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.</td>
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<tr>
<td>• Offer structured guided tours for the public/patient representatives 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.</td>
<td>LT</td>
<td></td>
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<tr>
<td><strong>Improving Care, Investing in Change</strong> (18 April 2011)</td>
<td>ALL</td>
<td>07/10/11</td>
<td>To be discussed with Chairman prior to October Meeting</td>
<td></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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<tr>
<td><strong>Demographic Trends</strong> (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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<tr>
<td>Action Required</td>
<td>Lead</td>
<td>Due Date</td>
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<td><strong>Future Direction</strong> (18 April &amp; 12 September 2011)</td>
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<tr>
<td>• Provide a briefing paper on kite-marking with key bullet points</td>
<td>AKM</td>
<td>07/10/11</td>
<td>A report will be provided to the committee</td>
<td>On agenda for October meeting</td>
</tr>
<tr>
<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><strong>Location of GP Practices in Lothian</strong> (27 June 2011)</td>
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<tr>
<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>
<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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<tr>
<td><strong>Sutherland Ward - Progress of the Review and Redesign of Services</strong> (27 June 2011)</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>
<td>AMcM</td>
<td>07/10/11</td>
<td>This will be provided for the October meeting</td>
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<tr>
<td><strong>Reshaping the Medical Workforce</strong> (12 September 2011)</td>
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<tr>
<td>• Consideration deferred to October meeting.</td>
<td>DF</td>
<td>07/10/11</td>
<td></td>
<td>On agenda for October meeting</td>
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<tr>
<td><strong>Initial Agreement for the Redevelopment of the Royal Edinburgh Hospital Campus</strong> (12 September 2011)</td>
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<tr>
<td>• Re-examine the presentation of the strategy to take account of the comments made</td>
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<td><strong>NHS Lothian Transport and Access Committee</strong> (12 September 2011)</td>
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<tr>
<td>• Convey the Committee’s views to the Scottish Ambulance Service.</td>
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Minutes of the meeting of the Service Redesign Committee held at 2.00pm on Monday, 12 September 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, Edinburgh.

Present: Professor J Iredale (Chair); Dr B Agrawal; Mr R Burley; Ms L D’Arcy; Councillor P Edie; Dr D Farquharson; Mr J Forrest; Dr J Hopton; Mrs M Hornett; Ms L Khindria; Dr A K McCallum; Professor A McMahon; Mrs J K Sansbury; Ms L Tait; Dr A Tierney and Dr C J Winstanley.

In Attendance: Professor S Ralston; Ms E Reid; Mr P Reith; Ms S Sinclair and Mr S Wilson.

Apologies for absence were received from Ms J Anderson, Professor J J Barbour, Mr A Boyter, Mrs S Egan, Mr D Forbes, Mrs S Goldsmith, Dr B McKinstry, Professor P Murray and Dr J Steyn.

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.

20. Minutes of the Previous Meeting

20.1 The Minutes of the previous meeting of the Service Redesign Committee held on 27 June 2011 were approved, subject to the following amendment:-

Para 12.2 – add an additional paragraph 12.2.7 “Dr Agrawal suggested that structured guided tours for the public patient representatives to the relevant sites of services under discussion at the Committee should be offered. Sites such as the Sutherland ward, Lanfine Unit and other facilities taking part in Releasing Time to Care would be appropriate.”

21. Matters Arising from these Minutes

21.1 Kitemarking – the Chair advised the Committee that a briefing paper on kitemarking would be circulated.
21.2 Update on Releasing Time to Care – Mrs Hornett advised the Committee that the licence fee paid for the use of the intellectual copyright material was £37,206 for the outpatient material and £38,385 for the inpatient material. This sum was part of a national agreement and was paid by the Scottish Government and not NHS Lothian.

22. NHS Lothian Clinical Strategy 'How We Treat People'

22.1 Professor McMahon gave a presentation on the NHS Lothian Clinical Strategy ‘How We Treat People’.

22.2 Professor McMahon outlined the strategic approach being adopted of developing the strategic framework for the next 5-10 years concentrating on the core business functions of the organisation and the three main drivers of finance, demography and the medical workforce. The object was to plan, coordinate and implement a radical redesign of clinical services and the infrastructure to support this.

22.3 The Committee noted that financial drivers included real reductions in the Scottish Government’s departmental expenditure limit of around £42bn anticipated between 2009/10 and 2015/16. It was not expected that the levels of available funding would return to those of 2009/10 until 2025/26.

22.4 Professor McMahon explained that the NHS would continue to face pressures from inflation, increasingly expensive technology and new medicines. To fund such pressures, £50m in savings would be available to invest in 2011/12 and this situation was likely to continue.

22.5 In terms of demography, there would be a 20,000 increase in over 65s by 2016 and then again by 2021. Against each of these increases, 13,000 would have at least one long-term condition; an additional 1,000 cases per annum of cancer could be expected and dementia was predicted to increase by up to 70% over the next 20 years. In addition, lifestyle would impact on these figures, particularly obesity.

22.6 The medical workforce would see reductions in the numbers of medical trainees from 2011/12 arising from Modernising Medical Careers, which would compound difficulties with providing safe and legal services levels of care around the clock.

22.7 Professor McMahon advised that it was proposed NHS Lothian move towards means-based services providing effective, seamless and safe care with an emphasis on efficiency and focus on outcomes. The organisation would have to be innovative and learning working in partnership and improving health, as well as addressing inequalities.

22.8 Professor McMahon outlined the proposed timescale for the production of a plan for consultation and indicated that progress reports would be presented to Lothian NHS Board.
22.9  Councillor Edie asked about actions to be taken to empower patients including the provision of Committee agendas to the public, as well as giving patients a role in deciding on services to be provided.

22.10 Professor McMahon re-assured the Committee that the policies and their development and agreement was being carried out in a transparent manner but emphasised that there were a number of major challenges ahead.

22.11 The Chair commented that, in his experience, quality was the most important issue to patients and Professor McMahon agreed. He indicated that a number of areas were being examined for benchmarking and the Chair commented that the way in which dis-engagement should be undertaken was through openness and participation.

22.12 Dr Agrawal asked if there were any proposals to increase support for self-management of cases at home and Professor McMahon advised that there was an emphasis on keeping people at home and the issue of re-balancing care was one that required to be addressed.

22.13 Dr Tierney commented that consumer orientation did not appear to come out in the presentation and suggested that this should be more explicit. Although the timescale was to 2021 ongoing continuity of improvement, as well the major changes being introduced should be made clear. The Committee would need to look at the longer running big issues.

22.13 Mr Burley emphasised the need for locations, buildings and sites to be brought together as part of the overall strategy.

22.14 Mrs Sansbury advised that the Estates Strategy was being revised in line with the Board’s policy of providing acute care on three major sites whilst consolidating on fewer sites overall on the grounds both of cost and providing the required levels of consultant and specialist staffing for rotas.

22.15 The Chair commented that there would be more detailed discussions on the issues facing NHS Lothian Estates in future.

22.16 Dr Winstanley suggested that the exercise offered members the opportunity to challenge colleagues and take radical approaches whilst going through the appropriate channels.

22.17 The Chair thanked Professor McMahon for his presentation.

23.  Bone Health and Falls Strategic Discussion

23.1 Evidence-Based Bone Health – the Chair welcomed Professor Ralston to the meeting. Professor Ralston gave a presentation on the Lothian Osteoporosis service outlining the fracture liaison service model and how this worked in Lothian. Professor Ralston explained how efficacy could be improved through the use of annual injections of one medical, which, although notionally more
expensive had significant advantages with potentially high levels of reduction in re-fractures and potential savings of £1.1m.

23.1.1 Dr Agrawal commented that patients could now download guidelines and asked if these were being updated. Ms D’Arcy asked if consideration had been given to providing treatment to at risk women before they had a fracture and Professor Ralston advised that this course of action had not been found to be cost effective.

23.1.2 In response to a question from the Chair, Professor Ralston advised that the use of steroids was proving an effective treatment but other treatments were not achieving such good results.

23.1.3 The Chair thanked Professor Ralston for his presentation.

23.2 Falls Prevention and Bone Health – the Chair welcomed Ms Douglas to the meeting.

23.2.1 Ms Douglas explained the background to falls prevention and bone health in NHS Lothian and outlined the systematic approach to falls and fracture prevention being followed in NHS Lothian.

23.2.2 Ms Douglas advised the Committee that the potential existed for a 30% reduction in amenable falls in the community with a subsequent reduction in emergency admissions. The acute falls bundle was anticipated to achieve a 20% reduction in year one, reaching a 50% reduction by year five with an associated cost reduction per ward of £170,798 or £467,048 over the whole system.

23.2.3 The Committee noted that it was proposed that the strategy be ratified by October 2011 and noted that pockets of excellence had already been established. There was a short, medium and long-term implementation plan, together with a strong centre of excellence and new falls prevention and bone marrow health research group (including international collaborators) which would have a significant impact on emergency admissions in future years.

23.2.4 It was noted that new technology was being utilised wherever possible and that the strategy would be presented to the Board in November 2011.

23.2.5 Ms Douglas emphasised that alternatives to admission to hospital for people who had not been injured were being examined and Dr Tierney commented that osteoporosis was not inevitable and work was underway to identify actions that could be taken whilst patients were younger.

23.2.6 The Chair thanked Ms Douglas for her presentation.

23.3 Community Falls Prevention – Presentation by Ms Reid – Ms Reid gave a presentation on the Board’s policy for preventing falls in order people and it was noted that falls intervention could reduce the fall rate by 30% and that the number of referrals for falls assessments had increased by 40%. New technology, including telecare was being used to provide a pick-up service for
those that had fallen and could not get up reducing the number of referrals to hospital. Further targets to reduce the numbers of patients presenting at A&E were being developed and training was being provided to ensure that care home residents received falls assessment and care planning.

23.3.1 The Chair thanked Ms Reid for her presentation.

23.4 Mr Forrest advised the Committee that work was being undertaken in West Lothian to look at the sort of technology that could be used to support the strategy and, with effect from 3 April 2012, NHS Lothian and West Lothian Council would be looking to target over 65s to ensure the number of hospitalisations could be reduced.

23.5 Dr Winstanley asked what work was being done on anticipatory care and Ms Douglas commented that emphasis was placed on going out to patients as much as possible, and it was noted that resources would be placed on both the intranet and internet.

23.6 The Chair thanked all the speakers for contributing towards these discussions.

24. Reshaping the Medical Workforce

24.1 It was agreed to defer consideration of this item to the next meeting. DF

25. Initial Agreement for the Redevelopment of the Royal Edinburgh Hospital Campus

25.1 Mrs Sansbury introduced a previously circulated report seeking support for the redevelopment of the Royal Edinburgh Hospital Campus Initial Agreement, which described the high-level plan of strategic intent to develop the Royal Edinburgh Hospital campus incrementally. Development of the Initial Agreement would involve a broad cross-section of stakeholders including service users, carers, third sector providers and professional staff and managers involved in service delivery.

25.2 Mrs Sansbury advised that there had been a number of attempts to achieve a viable plan acceptable to the public and approval was now being sought for the Initial Agreement in order that the full consultation process could be started. Once the Initial Agreement had been approved, Outline Business Cases would be developed for each subsequent phase, which would be funded through Hubco.

25.3 Dr Winstanley commented that references to land for disposal should be removed from the plans as the Finance & Performance Review Committee had already agreed that land would not be disposed of.

25.4 Mrs Sansbury advised that a deal was being proposed with the City of Edinburgh Council over the use of one of the sites for the redevelopment of Boroughmuir High School.
25.5 Mrs Sansbury commented that a number of options were being examined and advised that the disposal of surplus property was not linked to the reprovision of the Royal Edinburgh Hospital.

25.6 Mrs Sansbury commented that older people services were not just provided at the Royal Edinburgh Hospital and Professor McMahon advised that the presentation of the strategy would be re-examined to take account of the comments made.

25.7 The Committee agreed to acknowledge and support the intention to fully develop the Royal Edinburgh site on an incremental phased basis over approximately 10 years, subject to funding, and acknowledged and supported the strategic intention to reprovide existing mental health and learning disability services accommodation currently on the Royal Edinburgh Hospital site and to further explore the relocation of services from the Astley Ainslie and Liberton Hospitals to the site. The Committee also agreed to acknowledge and support the intention to move to Outline Business Case for phase 1 (mental health, acute and intensive psychiatric care inpatient services) with an Outline and Full Business Case being brought forward for the subsequent phases.

26. Good Practice and Lessons Learned from Patient and Public Engagement in Service Redesign

26.1 The Committee received a previously circulated report from the Mrs Hornett, Nurse Director giving the evaluations of recent engagement exercises with patients and public in the development of two strategies (Lothian Sexual Health and HIV Strategy 2011-16 and the Lothian Mental Health and Well Being Strategy: Sense of Belonging 2011-16)

26.2 Ms Sinclair introduced the paper and in response to a question from Dr Tierney advised that discussions with staff working in the field was being used to obtain answers on improving communications to patients.

26.3 The Committee agreed to note the good practice and lessons learned from the recent engagement exercises with patients and public in development of the two strategies and that this learning should be shared across NHS Lothian.

27. Health and Sport Committee Inquiry into Regulation of Care for Older People

27.1 The Committee noted the response submitted on behalf of NHS Lothian to the Health and Sport Committee Inquiry into Regulation of Care for Older People, copies of which had been circulated.

27.2 Professor McMahon advised that NHS Lothian had worked closely with all four Councils on this response.

27.3 The Committee agreed to endorse the response on behalf of NHS Lothian.
28. Lothian Hepatitis C Managed Care Network Annual Report 2010/11

28.1 Following discussion of the previously circulated annual report for 2010/11 of the Lothian Hepatitis C Managed Care Network, it was agreed to receive the annual report and note progress achieved on prevention, testing and treatment during 2010/11.

29. NHS Lothian Transport and Access Committee

29.1 The Committee noted the previously circulated Minutes of the meetings of the NHS Lothian Transport and Access Committee held on 19 May and 4 August 2011.

29.2 Dr Winstanley advised the Committee that discussions about concerns with the ambulance service had been held with the Scottish Ambulance Service who were looking to create a mixed economy where they would be able to trade services with NHS Boards. Professor McMahon undertook to convey the Committee’s views to the Scottish Ambulance Service.  

30. Dr Alison Tierney

30.1 The Committee noted that this was Dr Tierney’s last meeting and the Chair thanked her for her service on the Committee and her help to him on assuming the Chair of the Committee.

30.2 The Committee endorsed the Chair’s thanks and good wishes to Dr Tierney.

31. Date of Next Meeting

31.1 It was noted that the next meeting of the Committee would be held on Monday, 17 October 2011 at 2.00pm in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
NHS LOTHIAN

SERVICE REDESIGN COMMITTEE

Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday 17 October 2011 in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Councillor P Edie (In the Chair); Dr B Agrawal; Ms J Anderson; Mr A Boyter; Mr R Burley; Dr D Farquharson; Mr J Forrest; Dr J Hopton; Mrs M Hornett; Dr S Mackenzie; Dr A K McCallum; Professor A McMahon; Dr J Steyn and Ms L Tait.

In Attendance: Dr R Bohmer; Dr B McKinstry and Mr P Reith.

Apologies for absence were received from Professor J J Barbour, Professor J Iredale, Mrs L D’Arcy, Mr D Forbes, Mrs S Goldsmith 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.

32. Minutes of the Previous Meeting

32.1 The Minutes of the Service Redesign Committee held on 12 September 2011 were approved.

33. Matters Arising from these Minutes

33.1 Quality Assurance Kite Mark Proposals – the Committee received a previously circulated paper listing key issues that had been identified to date which the Committee would like service redesign proposals to explicitly address. These included rationale for the health need of change, including demography and inequalities; the impact of proposals on efficiency, productivity and best values; the evidence base that underpinned the proposal; the impact on the workforce; the impact of patient/public participation; the evaluation framework and the strategic fit.
34. **Clinical Strategy - Our Health, Our Future**

34.1 Dr Farquharson outlined the process to date and reminded the Committee that seven themes had been discussed in June. These were needs-based services; effective, seamless and safe care; efficient services, outcome-focussed; innovative, learning organisation; partnership working; health improvement and address inequalities.

34.2 Dr Farquharson emphasised that the philosophy underpinning the framework built on strategies already in place, was clinically owned and driven, evidence-based and capitalised on expertise at the front line. Leadership was based at pathway level and success was assessed through movement in the quality outcome measures. Dr Farquharson emphasised that the framework was working within the agreed financial envelope.

34.3 Dr Farquharson explained that there was to be an over-arching Programme Board ensuring the consistency of message across the whole system and would be supported from Strategic Planning. There would have to be a rethinking of how existing resources were used and support from corporate departments with targeted development programmes. Communications were the key.

34.4 Dr Farquharson indicated that he next steps would be the formalisation of the governance arrangements with the creation of the Programme Board, agreeing the criteria/outcomes and prioritisation of what was done first, selection of initial areas of redesign, a phased approach, agreeing the framework of performance reporting and specification of the development programme. Dr Agrawal questioned whether the process would be evidence-based and if so, which of the many available evidences (SIGN, NICE, etc.) would be used.

34.5 Dr Farquharson explained that it would be up to individual services to decide which evidence base was most appropriate.

34.6 The Chair questioned what this would mean for services and Dr Farquharson indicated that the services would be leading the redesign process and would be examining previous perceptions and he confirmed that the 24-hour use of theatres would be amongst the possibilities under consideration.

34.7 Professor McMahon commented that it was hoped that the Scottish Government Health Directorates would provide a steer indicating preferred approaches.

34.8 Professor Bohmer emphasised that the important part of the exercise was working out how to move from the evidence that had been gathered to the type of service that needed to be provided. This would involve connecting demand, together with optimal use of resources to the revised service model.

34.9 Dr Mackenzie emphasised the importance of quality and the need for an overall approach to be taken, rather than fixing individual problems piecemeal.

34.10 Dr Bohmer commented the present model had care following the resource whereas a more appropriate model would be resource following care.
34.11 The Chair asked whether any of the progress in genetics would be manifesting in treatments and Professor Bohmer advised that some work on genetic susceptibility to certain drugs was currently underway.

34.12 Dr Farquharson emphasised that the clinical framework was work in progress and further reports would be forthcoming.

34.13 The Chair thanked Dr Farquharson for his presentation.

35. Reshaping the Medical Workforce in Scotland: Consultation on Specialty Training Numbers 2012 and Beyond

35.1 A previously circulated report, detailing the key issues contained within the Reshaping the Medical Work in Scotland: Consultation on Specialty Training Numbers 2012 and Beyond paper and highlighting the key emerging issues for NHS Lothian, was received.

35.2 Dr Mackenzie introduced the paper and advised the Committee that the Scottish Government was seeking feedback from Health Boards on the methodology for determining trainee numbers. Within Lothian, it had been disseminated amongst Associate and Divisional Medical Directors for feedback and the collated NHS Lothian response was detailed in the paper.

35.3 Dr Mackenzie emphasised that some specialties were finding it very hard to recruit, in spite of the fact that more doctors were being trained than should be required. A higher proportion of the doctors qualifying were women and there would be a greater demand for flexible working, part-time working, maternity, etc.

35.4 Dr Mackenzie emphasised that it would be necessary to plan the medical workforce in order to use doctors where they could be more effective and there would be a need for an increasing use of non-medical staff in some areas where a consultant input was not essential. Dr Mackenzie explained because a large number of trainees were in their early to mid 30’s when they became consultants, it would be a number of years before they would require to be replaced and, therefore, fewer trainees would be required. Previously the UK trained significantly more doctors than it used and many trainees had come from other countries to which they returned after their training.

35.5 The Committee noted that a revised ratio of trainees to consultants would need to be adopted and if this did not happen, there would not be sufficient funding to employ a larger number of trainees. Dr Mackenzie commented the south east of Scotland was in a better position than most parts of the United Kingdom because of demand for the high quality training provided there.

35.6 Dr McKinstry suggested that, as consultants tended to admit fewer patients to hospital than junior doctors, there could be some benefits in the subsequent reduction of the number of trainees and it was noted that certain key specialties with a higher proportion of women doctors tended to be the losers in trainee numbers.
35.6 Dr Mackenzie emphasised that it would be an increasing problem to keep safe levels of supervision in certain specialties and this would require constant monitoring.

35.7 Dr Agrawal asked if there was consensus within the NHS on what specialty doctors should do and Dr Mackenzie advised the Government had not been able to establish a consensus within the profession and this varied between specialties. Junior doctors tended to undertake more complex procedures in acute specialties and fewer in less acute specialties.

35.8 Dr Farquharson emphasised the importance of using a mixed economy of workforce to deliver care and suggested the challenge would be in teasing out those things that consultants required to carry out and those things that could be undertaken by other, appropriately trained, NHS staff.

35.9 Dr Bohmer commented that other countries with less well-developed professional bodies used non-consultant staff for a number of procedures such as delivering babies by caesarean section, which differed from the UK model.

35.10 Dr Mackenzie commented that there was likely to be resistance from the public and the media, as well as the profession to changes in the traditional role played by consultants.

35.11 Mrs Hornet emphasised the need for consideration to be given to the rest of the workforce, particularly nurses, allied health professionals and administrative staff who could take on significant elements of work presently undertaken by consultants and junior doctors.

35.12 Dr McCallum commented that if there were only so many doctors then they could take decisions without necessarily having to take the action themselves and there was a need to think about the regulatory process as well as what staff were called.

35.13 Ms Anderson commented assumptions were being made about what the public would think and consideration needed to be given as to how the necessary changes could be addressed with both the workforce and the public.

35.14 The Committee agreed:-

- the response to the Scottish Government consultation paper and that the Medical Director and Regional Workforce Director maintain engagement with the national reshaping groups to get clarity around the Government's intentions
- that the Medical Director and Divisional Medical Director complete the risk assessment and action planning process within all service areas to ensure any detrimental impact on service provision was both identified and minimised
- that the NHS Lothian Medical Workforce Group be required to review all plans to ensure they were achievable and affordable and ensure there was
consistency of approach across all the plans, assessing the wider impact of individual service plans across the whole medical workforce and monitoring the use of returned funding to ensure it was efficiency and effectively

- that the NHS Lothian local Medical Workforce Group provide the link between NHS Lothian and the Regional Medical Workforce Group and the national reshaping programme.

36. Revised Human Resources Strategy

36.1 Mr Boyter gave an update on the review of the Human Resources and Organisational Development Strategy, emphasising that it required to link in with the Clinical Strategy.

36.2 Mr Boyter indicated that 53 out of the 54 recommended actions in the current strategy had been completed with the final recommendation to make recruitment arrangements more ‘slick’ was no longer deemed necessary in the current economic and employment situation.

36.3 Mr Boyter emphasised the living values of employability and social responsibility and the need to promote organisational values and an aspirational culture that enhanced staff engagement and ensure that both the system and the staff reached their maximum potential.

36.4 Mr Boyter indicated that in engaging leadership the best practices in leadership, staff governance, performance management and compliance were being utilised and that in delivering quality, work was underway in workforce redesign, modernisation and enhancing productivity. The provision of effective expert Human Resource and Organisational Development and Occupational Health and Safety Services and systems was essential to this. Mr Boyter emphasised that the review would be looking at refreshing the current approach rather than re-inventing everything and particular emphasis was being placed on ensuring everything was being done to break the links between poverty and ill health. NHS Lothian now had eleven different projects helping youngsters who, through no fault of their own had become excluded from society, into the workforce.

36.5 Mr Boyter advised the target of 734 whole time equivalent posts being reduced each year over a 2 year period was well in hand but it had been accepted that such a reduction could not continue indefinitely.

36.6 Mr Boyter indicated that there was a need to examine how money was spent on training and ensure that a competence-based approach involved actually finding out who the best people were and selectively applying training.

36.7 The Chair drew attention to recent statements by the Royal College of Nursing concerning the proportion of school leavers that would need to be employed in the NHS over the coming years, and Mr Boyter indicated that the particular extrapolation depending on continuing to work in the same way as before. He emphasised that there would need to be a radical redesign of the way in which
services were delivered, in light of the anticipated financial and demographic environment.

36.8 Mr Boyter reminded the Committee that whilst Scotland used to train more doctors than it needed, England was now self-sufficient in doctors and Scotland no longer had the luxury of not having to confront workforce flexibility issues or addressing the qualification gap.

36.9 Mr Boyter advised that the opportunity gap between staff with a degree and those without such a qualification was a major problem that required to be addressed, and Mrs Hornett and Ms Anderson were leading on proposals for Healthcare Technician grades.

36.10 Ms Anderson commented that the Knowledge and Skills Framework provided a fundamental tool that should be used to focus on more than simply saving money. There were a number of roles that less qualified people could move into and progress through leading to a culture of ‘growing our own’ qualified staff. Mrs Hornett emphasised the need to challenge the qualification requirement for the workforce and to pay attention to new technologies that could improve efficiencies, such as electronic prescribing.

36.11 Dr Bohmer emphasised that workforce redesign should go hand-in-hand with work redesign and there was a role for the Service Redesign Committee to ensure that this happened.

36.12 Mr Burley emphasised the importance of good communication, both with the public and staff in achieving successful and effective redesign.

36.13 The Committee agreed to note the progress made in the review of the Human Resources and Organisational Development Strategy.

37. **NHS Lothian Transport and Access Committee**

37.1 The Committee noted the previously circulated Minutes of the meeting of the NHS Lothian Transport and Access Committee held on 15 September 2011.

38. **Date of Next Meeting**

38.1 It was noted that the next meeting of the Committee would be held on Monday 19 December 2011 at 2.00pm in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the Meeting of the Staff Governance Committee held at 9.30am on Wednesday, 29 June 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr E Egan (Chair); Mr R Y Anderson; Mr A Boyter; Councillor J Cochrane; Mrs T Douglas; Ms L Falconer; Dr D Farquharson; Mrs M Hornett; Mrs J McDowell; Mr I Whyte and Dr C J Winstanley.

In Attendance: Ms J Brown; Mr G Curley; Ms J Ferguson; Dr C Kalman; Ms S Lloyd and Mr P Reith.

Apologies for absence were received from Mr R Burley.

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.

1. Minutes of the Previous Meeting

1.1 The Minutes of the previous meeting of the Staff Governance Committee held on 30 March 2011 were approved as a correct record.

2. Matters Arising

2.1 eKSF Update – Mr Boyter reported that the target of 80% of staff having been on eKSF by 30 March 2011 had not been met however the Scottish Government target had been achieved by the end of May. Work continued to ensure all staff had a Personal Development Plan, which was actually being addressed. He commented on the enormous amount of work from both management and staff side that had gone into achieving this position and commented that there appeared to have been far fewer appeals in NHS Lothian than in the rest of Scotland. The staff side contribution had been a major factor in achieving the position and he extended his thanks to Mr Egan and the staff side colleagues for their efforts.

2.1.1 The Chair commented that there were a number of challenges still to be addressed, including bringing a number of sections of the workforce into eKSF
and the establishment of an audit process to ensure that the requirements of eKSF were being fully implemented.

2.1.2 Ms Falconer commented on the importance of staff receiving a Personal Development Plan within the first six months and Mr Boyter indicated that the Napier equivalent was being examined to see if it would be suitable for use as a Personal Development Plan so that students in their final year of nurse training could move on to eKSF with a fully developed Personal Development Plan.

2.1.3 Mrs Hornett expressed her support for the need for such a system and suggested that it could easily feed into the guaranteed placement scheme. Dr Winstanley requested that a new induction format be brought back to the Committee to provide assurance that the necessary systems were in place. AB/MH

2.1.4 The Chair recorded his appreciation to Tracey McBurnie and Dave Grigor for their work in enabling the target to be met albeit after the due date.

2.2 Retirement Awards – the Chair reminded the Committee that this issue had been ongoing since the Endowments Advisory Committee had decided that this was not an appropriate cost to be met from Endowment funds.

2.2.1 Mrs Goldsmith commented that a proposal was required in order for a replacement scheme to be put into place. An annual retirement lunch for employees retiring had been suggested.

2.2.2 The Chair welcomed Ms Jane Fergus to the meeting who suggested that such an annual lunch could be aligned with the Celebrating Success awards and include a ceremony for staff who had retired. A proposal would require to be developed and submitted to the Trustees. Ms Ferguson explained that whilst the Trustees could not fund activities specifically for the benefit of individuals, they could fund activities that improved staff morale. Such a proposal would require to be supported by the Lothian Partnership Forum.

2.2.3 Dr Winstanley commented that although some of the funds within Endowments had been donated for the benefit of staff, it would be necessary to be confident that staff themselves wished such an activity to be funded.

2.2.4 The Chair suggested that there were two separate issues. Firstly, support for such an event for staff who had or were about to retire and secondly the issue of the funds donated for the benefit of staff which still required to be addressed. Ms Falconer commented that further thought needed to be given to how to recognise the contribution of staff to NHS Lothian over the previous 45 years.

2.2.5 Mrs Hornet expressed concern that utilising the Celebrating Success awards would dilute the effectiveness of that event and suggested that, as a first step, a letter from the Chair and Chief Executive should go to all retiring staff thanking them for their contribution to NHS Lothian.

2.2.6 Mr Boyter commented that the original move away from long service awards had been undertaken on the basis that such awards were, by definition,
discriminatory towards staff on the basis of age, and that this position had been confirmed by the Central Legal Office.

2.2.6 Mrs McDowell commented that she had understood that a proposal for funding such awards was awaited and suggested all other options should be exhausted before the matter was passed back to Endowments. She suggested that it would be helpful to know what other NHS Boards did and to obtain the view of staff themselves.  

2.2.7 Mrs Goldsmith advised the meeting that the only way in which the Board could receive donations was through the charity and Mr Egan advised that in the current economic climate Exchequer Funds could not justify the transfer of funding from healthcare to staff benefits.

2.2.8 Councillor Cochrane commented that the general consensus appeared to be not to hold a joint event but to seek the views of staff and see what they themselves would prefer.

2.2.9 The Chair commented that it was his understanding that whilst other NHS Boards did provide Endowment Fund retirement lump sum payments, other Boards did nothing to recognise the retirement of long-serving members of staff. At present, NHS Lothian now did nothing officially to recognise such service.

2.2.10 It was agreed that Mr Egan and Mr Boyter would arrange the consultation with staff on what their preferences would be and bring back a report to a future meeting.  

2.2.11 It was also agreed that Mrs Goldsmith would bring back a report on how money donated to wards for the benefit of staff should be dealt with.

2.2.12 It was further agreed that Mr Egan and Mr Boyter would co-chair a group to discuss options in order that proposals could be brought back to the next meeting.

3. Staff Governance Annual Report – Additional Section

3.1 The Chair advised the Committee that the Audit Committee had examined Staff Governance annual reports and had requested that these include a section highlighting key risks. Because the Staff Governance Committee annual report had already been accepted by the Board and formed part of the assurance process for the annual accounts, the key risks area would be included in the following year’s annual report.

4. Health and Safety Report

4.1 Dr Kalman advised the Committee that the NHS Lothian policy on violence and aggression had been approved and the concept of a new manual handling policy was being considered. He commented that the quality of reports coming
to the Health and Safety Committee had improved over the past year and that a Headquarters’ Health and Safety Committee had been established, chaired by Mr James Glover, Head of Equality and Diversity from the HR Department.

4.2 The Committee noted that Lothian was a leading Board in Scotland for healthy working lives and worked was progressing towards achieving the Gold award.

4.3 It was also noted that the health and safety policy and annual report would be submitted to the next meeting. CK

4.4 The Chair commented that he had raised a number of issues about the Health and Safety Committee and expected to see significant improvements in the future. He had met with every Health and Safety Committee Chair in Lothian in order to explain the Committee’s expectations. GC

4.5 Councillor Cochrane asked about the uptake of mandatory training and whether any progress had been made. The Chair advised that the figures were well up and Mr Curley commented that drop-in surgeries were now being held. Mr Curley accepted that even more could be done on manual handling training and he would ensure appropriate action would be taken.

4.6 Dr Kalman confirmed that whilst there was an issue concerning compliance with mandatory training requirements this was now being included in management objectives to ensure all managers acted to ensure compliance with policies.

4.7 Mr Whyte questioned what action would be taken if managers still did not implement policies and Dr Kalman explained that health and safety was really about the culture and, therefore, what work was being carried out to drive that type of culture through the organisation.

4.8 Mr Boyter indicated that both he and the Chief Executive had this as a key area and guidance had been given on putting the policies into objectives and managers would be required to evidence that they were carrying out the necessary work as part of their eKSF development review or annual appraisal.

4.9 The Committee noted that a paper would be submitted to the Board on the psychological contract with staff, which would include reference to working in a safe manner as part of the refreshed HR/OD strategy that was due to be presented to the board in November 2011. AB

4.10 Mr Boyter confirmed that instances where it was found that managers were consistently failing to take action to ensure the implementation of policies would be dealt with through the disciplinary or capability processes.

4.11 The Chair commented that whilst the policies were being implemented it would be necessary to empower all staff to raise issues of health and safety.

4.12 Ms Falconer commented that Health and Safety representatives had recently met to develop an algorithm to set out what should happen after any event.
4.13 Mr Boyter commented that there had been a very robust debate on this at the Health and Safety Committee and advised that members of the Staff Governance Committee were welcome to attend Health and Safety Committee meetings to see the work in action.

4.14 Mrs Douglas commented that she was pleased that the implementation of Health and Safety policies was going to be even more robust and asked if this exercise could include the CHPs/CHCP who also needed to obtain reassurance on health and safety issues.

4.15 It was agreed that the CHPs/CHCP and the University Hospitals Division should be asked to include a report on health and safety on relevant management team agendas.

5. **NHS Lothian Traffic Management Programme**

5.1 A previously circulated report giving an update on progress to date on implementing the NHS Lothian traffic management programme was received.

5.2 Mr Curley spoke to the report and outlined the action taken following the fatal accident at the Western General Hospital in 2009.

5.3 The Chair queried compliance at the Royal Edinburgh and Astley Ainslie Hospitals and Mr Curley confirmed that there was a direct route to managers to get action taken against staff who did not comply with local policies. Measures were also being further examined the Western General Hospital.

5.4 Dr Winstanley commented the paper should have included detail of the risks involved and risk register references in accordance with the Board template. This would be picked up in all future reports.

5.5 Mr Curley advised some areas of risk had been outlined and action was being taken to address them.

5.6 The Chair commented whilst sanctions were available, they were not necessarily being imposed and any failures to deal with such issues would need to be addressed.

5.7 In response to a question from Councillor Cochrane, Mr Curley advised that disabled parking was being addressed and NHS Lothian was in discussion with West Lothian Council over access to St John’s Hospital, although plans would have significant cost implications and a business case was in the process of being drawn up. He confirmed that parking by inappropriate people was not a major problem at present.

5.8 Ms Falconer confirmed that the Royal Infirmary of Edinburgh had a problem with people parking on yellow lines and it was noted that the Astley Ainslie Hospital and Royal Edinburgh Hospital had similar difficulties.
5.9 Noting that staff could experience problems with aggression from drivers being asked to move vehicles, Mr Curley confirmed that training in handling aggression was provided and that staff displaying aggression towards other staff members were escalated to management and followed up to ensure that appropriate disciplinary action was taken. Mr Curley confirmed two wardens were used at the Royal Infirmary of Edinburgh and that the Logistics department increasingly had to manage traffic issues.

5.10 The Committee agreed that a report containing details of the number of staff spoken to by managers and the action taken to stop inappropriate parking by staff should be brought to the November meeting. GC

6. Rogue Items at the Laundry

6.1 The Committee received a previously circulated report giving an update on a number of rogue items received at the Laundry.

6.2 The Chair confirmed that rogue items had started re-appearing in the Laundry at St John’s Hospital and the level of items being found in the Laundry had reached the stage when something serious required to be done.

6.3 It was noted that the use of alginate bags for all laundry and using equipment to identify any bags with metal objects was being explored.

6.4 Councillor Cochrane confirmed that staff in the Laundry at St John’s Hospital had been very tolerant and dealt with the problems with a lot of goodwill but inappropriate and sometimes dangerous objects were still appearing in the Laundry and it would be necessary to escalate the action being taken.

6.5 Dr Winstanley asked if anyone had been disciplined for sending out laundry containing rogue items within the last four years and whether tagging laundry bags was working.

6.6 Mr Boyter confirmed that he was not aware of any formal disciplinary action being taken against staff. Mr Boyter went on to say that steps were being taken to improve the traceability of laundry.

6.7 Mrs Hornett commented that she had never experienced this problem to this scale before and, whilst she supported disciplinary action where offenders could be identified, it was extremely difficult to prove negligence on the part of individual staff members.

6.8 The Chair advised the Committee that he had spoken to all the senior staff involved and all staff in the Laundry had been instructed to be polite when dealing with staff from wards from which rogue items had been received.

6.9 The Chair advised that this had become a significant health and safety issue and without a change in attitude from the staff sending rogue items the involvement of the Health and Safety Executive would be a potential outcome.
6.10 The Staff Governance Committee agreed to note the number of dangerous rogue items sent to the Laundry between 26 February 2011 and 19 June 2011 and the additional actions taken in partnership to ensure the safety of Laundry staff.

7. Revised NHS Lothian Incident Management Policy and Procedure

7.1 A previously circulated report highlighting the significant changes in the revised incident management policy and procedure, compared with the existing policy and procedure in place, was received.

7.2 The Committee noted that this policy was due for routine three yearly review and the changes had been informed by review of the management of all types of incident. It took into account the evidence demonstrated at the Scottish Patients Safety Programme Board On Board event in January 2011 and would ensure a consistent approach to management, on escalation of incidents and the lessons learned.

7.3 Dr Farquharson introduced the report and explained that its implementation was important and confirmed that it would include laundry services given the previous debate.

7.4 Mrs McDowell commented that the frequency of reports to the Mutuality and Equality Governance Committee, identified in paragraph 6.1.8 of the revised procedure, was insufficient and that reports should be made quarterly rather than annually.

7.5 Dr Kalman commented that RIDDOR reports were now also required so this should be included in the new policy. Dr Kalman undertook to provide the necessary details to Dr Farquharson.

7.6 Dr Farquharson confirmed that General Practitioners were covered under the policy and Dr Winstanley commented that the risk should have been detailed using the new format for Board and Committee papers.

7.7 Mr Boyter explained that NHS Lothian was trying to create an environment where people were encouraged to own up to errors so that the consequences could be dealt with quickly, without fear of recrimination so long as lessons were being learnt and implemented, and there was no intent to harm.

7.8 After some discussion, the Committee agreed to ask for the report to be resubmitted detailing who used the procedures and how they were working and agreed that an updated paper be submitted in 2012 so that the Committee could see how the policy and procedure was working.
8. **Sickness Absence Reviews Report**

8.1 A previously circulated report from the Director of Human Resources & Organisational Development giving an update on the findings of the sickness absence review in April 2011 was received.

8.2 Ms Brown spoke to the report and explained that the April figures were the lowest ever recorded for NHS Lothian but that the momentum required to be maintained. In order to achieve this, a second round of review panels was being proposed to look at staff with ten or more days absence year-on-year over the past three years.

8.3 Mr Boyter commented that there was a common theme throughout this of failure to comply with policy which, had it been implemented, would have obviated the need for review panels.

8.4 The Chair expressed his concerns about how the scheme was being promoted and commented that recent press coverage and a report in team brief had caused some difficulties. He emphasised the necessity of ensure full compliance with staff governance procedures and placing the emphasis on fairness to staff who were being over-worked through covering for other staff members who were inappropriately absent.

8.5 Mr Boyter apologised for any misunderstandings that had occurred and confirmed that this exercise was not aimed at genuinely sick people for whom NHS Lothian would be very supportive, but at dealing with inappropriate absence and he was grateful to the staff side for their support. Once the process of reviews had concluded responsibility for continuing to implement these policies would be returned to managers.

8.6 Dr Winstanley commented that this was a good example of staff and management working together in partnership.

8.7 Dr Kalman commented that the momentum of this exercise had generated a large number of management referrals to Occupational Health and he suggested that there were potential real benefits to staff themselves at the conclusion of this process.

8.8 The Committee agreed that a further report should be submitted to the next meeting.

9. **Staff Governance Self-Assessment Submission**

9.1 The Committee noted for information the previously circulated staff governance self-assessment audit tool for 2010/11.
10. Communication Strategy Update

10.1 A previously circulated report providing an update on the ongoing implementation of the communications strategy agreed by the Board in March 2008 was noted.

11. Community Nursing and Health Visiting Internal Audit Report – Issue 2

11.1 The Chair introduced a previously circulated Internal Audit report recently considered at the Operational Audit Sub-Committee.

11.2 The Chair commented that contained within this audit were some concerns in relation to required improvements within physical security for staff, including recording staff location particularly for lone working. The Operational Audit Sub-Committee had considered this to be a critical issue and highlighted a section on physical security of staff, particularly with reference to only 70% of nurses confirming attendance at relevant mandatory update training.

11.3 Mrs Hornett advised the Committee that these matters were being addressed and agreed to bring back a report to the next meeting covering all the points in the report. Mrs Hornett also undertook to circulate an updated version of the Audit report. MH


12.1 The Committee received a previously circulated report providing an update on the actions taken in response to the Internal Audit report, Compliance with Policies and Procedure (March 2011), which had been received by the Audit Committee on 21 June 2011 and which they had agreed should be shared with the Staff Governance Committee.

12.2 The Committee noted the approved action plan covering how policies and procedures were written, general communications arrangements when a new or amended policy was launched, the relationship between corporate direction and local management discretion, local management selection of policies for particular posts and the implementation of the policies in practice in developing systems of assurance.

12.3 The Committee agreed to note the report.

13. SEAT Shared Services Update

13.1 Mr Boyter advised the Committee that a full report on SEAT shared services had been submitted to the Finance and Performance Review Committee and that work was continuing in this area with partnership involvement.
14. **Management Steering Group Update**

14.1 The Committee noted a previously circulated report giving an update on the role and remit of the Management Steering Group and the issues recently being discussed.

1.42 The Committee agreed to note the update report.

15. **Health and Safety Committee Minutes**

15.1 The Committee noted the previously circulated Minutes of the Health and Safety Committee meetings held on 22 February and 12 April 2011.

16. **Date of Next Meeting**

16.1 It was noted that the next meeting of the Committee would be held on Wednesday, 31 August 2011 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the Meeting of the Staff Governance Committee held on Wednesday, 31 August 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr E Egan (Chair); Councillor J Aitchison; Mr R Burley; Councillor J Cochrane; Mrs T Douglas; Ms L Falconer; Dr D Farquharson; Mrs J McDowell; Mr I Whyte and Dr C J Winstanley.

In Attendance: Ms J Brown; Mrs P Dawson; Dr C Kalman; Mrs R Kelly; Mr M Pearson; Mr P Reith and Mr S Wilson.

Apologies for absence were received from Mr A Boyter and Mrs M Hornett.

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.

17. Minutes of the Previous Meeting

17.1 The Minutes of the previous meeting of the Staff Governance Committee held on 29 June 2011 were approved as a correct record.

18. Matters Arising

18.1 Minutes of the Meeting held on 30 March 2011 - the Committee noted that Lothian NHS Board had picked up two issues arising from the Minutes of the Staff Governance Committee meeting held on 30 March 2011 when these were adopted, at the Board meeting on 27 July 2011.

Paragraph from Ruth.

18.2 Retirement Awards – the Chair advised the Committee that the possibility of linking an event for retired staff with the Celebrating Success event had been discussed at the Lothian Partnership Forum but no firm conclusions had been reached and further discussions would be held. Mr Burley advised that whilst Endowments could provide funding for Celebrating Success, it could not spend money directly on retired staff, as this would conflict with its charitable
objectives. Ms Falconer informed the Committee that the Lothian Partnership Forum had agreed to consult staff as many would not wish to attend a single area-wide event, which would be less meaningful to them than something organised locally with colleagues.

18.2.1 The Chair commented that this issue had been under discussion for 6 years and there was still no consensus on how to recognise the contribution made by staff on their retirement. The previous Director of Finance had felt that it would be possible to identify funds donated specifically for the benefit of staff but this had not proved possible as these donations had not been appropriately accounted for and could not be distinguished from other donations. There was an immediate need for a system to be developed for properly dealing with donations made specifically for the benefit of staff, as well as explaining why the previously donated money could not be identified.

18.3 Sickness Absence Review Reports – Mrs Kelly advised the Committee that absence figures for July were 3.46% and had been consistently below 4% for some time. Information had been communicated to staff and managers confirming that staff who were genuinely ill were not the target of this review and had nothing to fear. Ms Falconer advised whilst there were still some pockets of absence patterns causing concern, the overall trend was showing the benefit of improved management of the sickness absence process.

18.3.1 The Chair advised that review panels had been set up but the publicity surrounding the earlier adverse publicity had led to some deterioration in staff side relations. Although the problem had been fixed, there were still some repercussions and he emphasised that there continued to be areas where managers were not conducting return to work interviews in line with Board policy. Dr Winstanley queried there was a need for a mechanism to ensure that all parts of the organisation followed policy, and the Chair advised that there was a full reporting system across the organisation. Ms Falconer suggested that it might be feasible to revisit the audit of sickness absence but that this could take some time. Ms Dawson reminded the Committee that many areas of the organisation were fully implementing the policy and providing examples of good practice.

18.3.2 Dr Kalman commented that earlier improvements had been due to dealing with long-term sickness absence and attention had now turned to short-term absence and rates of improvement would inevitably reduce as bad practice and poor adherence to policy was addressed. He emphasised that very few staff on the redeployment register failed to be redeployed. Mrs Kelly confirmed that managers were required to conduct return to work interviews and staff on the redeployment register who were appropriately qualified for the vacancy had to be slotted in, although the probationary period still applied. If managers were not satisfied with performance, the staff concerned could be returned to the redeployment register.

18.3.3 In response to a question from Mr Whyte on the action being taken to ensure that managers were following policy, Mrs Kelly advised that this had been incorporated into the objectives of relevant managers and compliance formed a part of their appraisal.
18.3.4 The Chair commented that whilst 60% of earlier review cases had not followed the correct procedures, the situation had significantly improved.

18.3.5 The Committee noted the report and the requirement of all NHS Lothian staff to comply with agreed policies.

19. **Prison Healthcare**

19.1 The Chair welcomed Allister Short to the meeting.

19.2 The Committee received a previously circulated report detailing the work being done locally to support the transfer of responsibility for prison healthcare within HM Prison, Edinburgh and HM Prison Addiewell from the Prison service to NHS Lothian. Mr Short emphasised that a key aspect of this exercise was the transferring of staff to the NHS.

19.3 Dr Winstanley confirmed that he had visited a number of prisons in Lothian and this exercise provided a huge opportunity for improvements in the service and in the pathway out of prison.

19.4 The Chair indicated that there were still some concerns about health and safety, particularly as earlier job descriptions had been poor. He emphasised that there were issues about banding and pensions and it was noted that a continuing dependency on an ageing staff was a cause for concern. The Committee agreed to note the progress made to support the transfer of prison healthcare to NHS Lothian and key actions in relation to staff governance.

19.5 The Chair thanked Mr Short for his contribution.

20. **Reshaping the Medical Workforce in Scotland: Consultation on Speciality Training Numbers 2012 and Beyond**

20.1 A previously circulated report detailing the key issues contained within the ‘Reshaping the Medical Workforce in Scotland: Consultation on Speciality Training Numbers 2012 and Beyond’ consultation paper issued by the Scottish Government was received.

20.2 Dr Farquharson outlined the key emerging issues for NHS Lothian and explained to the Committee that workforce planning amongst medical staff was notoriously difficult to achieve. There was a relatively high-level of attrition between numbers of medical students and consultants and one outcome of Modernising Medical Careers had been a ‘bulge’ of trainees which were moving through the system and would ultimately complete all their training over the next 18 months.

20.3 Dr Farquharson explained that there was no BMA support for further trainee grades, although this might change over the next 18 months as the number of consultant positions reduced.
20.4 Ms Dawson commented that there were a number of nurse practitioners and talks were being held at a regional level in close dialogue with higher education bodies. The capacity did exist to move to the next stage if funding was available.

20.5 Dr Winstanley questioned why specialist grade posts were not being established and sought re-assurance that nurse practitioners were being brought on to meet demand.

20.6 The Chair emphasised the importance of examining the workforce model to see what future requirements would be. He advised a 5x5x5 working group was examining this problem.

20.7 Mr Burley asked for a report on the overall design of the service and process by which this would be achieved and it was noted that Ms Khindria would be bringing a report to the next meeting giving an up-to-date position.

20.8 The Committee agreed:

- to note the previously circulated draft response to the Scottish Government consultation paper
- that the Medical Director and Regional Workforce Director maintain engagement with the national reshaping groups to get parity around the Government’s intention, including supporting work that would clarify the reductions in specialty trainee numbers in NHS Lothian
- that the Medical Director and Divisional Medical Director complete the risk assessment and action planning process within all service areas to ensure any detrimental impact on service provision was both identified and minimised. Where workforce plans already existed, they should be revised to ensure they addressed the key risks, were affordable and achieved within the required timescales
- require the NHS Lothian Medical Workforce Group to review all plans to ensure they were achievable and affordable and ensure there was consistency of approach across all the plans, assess the wider impact of individual service plans across the whole medical workforce and monitor the use of returned funding to ensure it was used efficiently and effectively
- require the NHS Lothian Medical Workforce Group to agree the NHS Lothian Medical Workforce Group provide a link between NHS Lothian and the Regional Medical Workforce Group and the national reshaping programme


21.1 The previously circulated Health and Safety Annual Report 2010/11, together with the NHS Lothian Health and Safety Policy were received. Dr Kalman spoke to the report and explained that the only change in substance was the inclusion of some line diagrams to simplify the understanding of the structure and governance. The documentation had been through the formal consultation process.
21.2 Dr Kalman commented that many positive achievements had been made in the past year and discussion was ongoing on further policies.

21.3 The Chair advised that whilst there had been significant improvements, rogue items were still arriving in the Laundry at St John’s Hospital. It was also noted that traffic management at the Royal Edinburgh Hospital and Astley Ainslie Hospital had improved but there was still room for further improvement.

21.4 Dr Kalman advised that he has asked for details of all staff who had failed to attend health and safety mandatory training and Ms Falconer suggested it might be helpful to ascertain the reasons why staff failed to attend training sessions.

21.5 Dr Winstanley requested a summary return to the Committee to show areas where problems occurred, together with indicators of compliance with health and safety arrangements and Mrs Kelly undertook to bring a paper to the next meeting showing the current attendance rates.

21.6 Ms McDowell questioned the absence of the Laundry from Annex D and Dr Kalman undertook to ensure that this was included.

21.7 Dr Farquharson advised it had been agreed to include a new field in the Datix system for staff injuries.

21.8 The Chair thanked Dr Kalman for his presentation and work.

22. Health and Safety Executive Cost Recovery Consultation

22.1 Dr Kalman advised the Committee that proposals for the Health and Safety Executive to recover costs was out for consultation. There were no more planned inspections and following the redundancy of the last medical advisor in Scotland there was now no employment medical advisory service, which was itself in breach of the Health and Safety at Work, Etc. Act 1974. The main area of concern was that the Health and Safety Executive would be able to cost recover by charging for inspections where fault was found. This was a complicated issue and full details were accessible on the Health and Safety Executive website.

22.2 Dr Kalman advised the NHS Lothian response would be going to the Executive Management Team prior to submission and subsequently to Lothian NHS Board.

22.3 The Chair commented that the staff side would also be commenting on these changes through their own organisations.
23. **Community Nursing and Health Visiting Internal Audit Report**

23.1 The Committee received a previously circulated report from Internal Audit on action following an Internal Audit of community nursing and health visiting.

23.2 It was noted that a new security system for lone workers was being implemented but the funding was yet to be clarified. Ms Kelly undertook to check if the purchase of the system had been signed off and consider the funding issue.  

[Signature: RK]

24. **A New College for Edinburgh – Consultation Document**

24.1 The Committee received a previously circulated consultation document from Stevenson College and Esk Valley College.

24.2 Members who had any comments on the proposals were invited to contact the Director of Human Resources & Organisational Development directly.  

[Signature: ALL]

25. **eESS Human Resources System Update**

25.1 A previously circulated report giving an update on the current position with the implementation of the new national Human Resources System eESS and highlighting some potential governance issues associated with the move to this national system was received.

25.2 Ms Kelly advised that NHS Lothian had been obliged to agree to participate in this system, which would be going live on 1 November and being rolled out thereafter. All risks were now included in the Corporate Risk Register and there was a risk if the implementation of this system was further delayed as was possible.

25.3 Ms Falconer commented that the project steering group had been uneasy about the new system and emphasised the need to hold the provider to account for its timeous delivery. The Committee agreed to note the concerns over the new system and receive further updates. Particular concern was expressed at the amount of business being externalised to a single company.

Mr Whyte left the meeting.

26. **Communications Strategy Update**

26.1 Mr Wilson spoke to a previously circulated report giving an update on the ongoing implementation of the communications strategy originally agreed by the Board in March 2008.
26.2 Mr Wilson advised that future reports would be produced using the new template and the detailed statistics in respect of the current report would be distributed electronically after the meeting.

26.3 Mr Wilson indicated that the entire communications framework on both an internal and external basis was being reviewed.

26.4 The Chair commented that there was some concern over the relatively small size of the communications team compared to the size of the organisation.

26.5 Mr Wilson advised that he wanted to promote stories of excellence rather than just commenting on press reports.

26.6 Ms Falconer welcomed Mr Wilson to his first meeting and commented that she was keen to see how the internal network could be improved with a particular focus on the staff side.

26.7 The Committee agreed to note the report.

27. Health and Safety Committee

27.1 The Committee noted the previously circulated Minutes of the Health and Safety Committee meeting held on 24 May 2011. Dr Kalman advised that a new Improvement Notice, which had been served by the Health and Safety Executive, was being resolved.

28. Implementation of Employee Relations Policies

28.1 The Chair advised the Committee that a complaint about unfair implementation of Employee Relations policies had been received and would be investigated with a report to the next meeting.

29. Date of Next Meeting

29.1 It was noted that the next meeting of the Committee would be held on Wednesday, 30 November 2011 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
NHS LOTHIAN
EAST LOTHIAN COMMUNITY HEALTH PARTNERSHIP

Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday 25th August 2011 at 2pm in the Quay Complex, Musselburgh.

Present: David Small, General Manager (DS)
Dr Ian Johnston, Medical Director (IJ) (Minute Item 32)
Ann McCarthy, PPF Representative (AM)
Gill Colston, PPF Representative (GC)
Sheena White, for Morag Barrow, Allied Health Professional Manager (MB)
Tony Segal, Carers of East Lothian (TS)
Ronnie Hill, East Lothian Council (RH)
Murray Leys, East Lothian Council (ML)
Liz Cregan, Chief Nurse (LC)
Lynne Hollis, Associate Director of Finance

In Attendance: Dick Fitzpatrick, Project Manager – Minute Item 32.1.
Ros Eccles – Falls Coordinator, Minute Item 32.2.
Andy Jackson, Assistant Director of Health, Minute Item 32.3.
Drew McErlean, Minutes (DMcE) – Minutes

Apologies: Iain Whyte, Chair of the CHP
Fiona Mitchell, Acute Sector (FM)
Morag Barrow, Allied Health Professional Manager (MB)
Dr Jane Hopton, Assistant General Manager (JH)

32. Welcome and Apologies

Apologies were noted as above.

In the absence of the Chair it was agreed that the meeting would be chaired by David Small, General Manager of the CHP. This means that any decisions made at the meeting will need to be homologated at the meeting of the CHP Sub Committee on 27th October 2011.

It was noted that Cllr Paul McLennan has been formally appointed to the role of East Lothian Council Health and Social Care Convenor. Cllr McLennan will be nominated to be a member of the NHS Lothian Board and so will become a member of the CHP Sub Committee.

Lindsay Howden has formally resigned from the CHP Sub Committee and a replacement from the Pharmacy sector will be required.

32.1 Royal Edinburgh Hospital Campus – Initial Agreement

The Sub-Committee considered a report from the Project Manager, 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 could be via Hubco.

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

If the developments go ahead they will allow NHS Lothian to rationalise the number of sites in use – e.g. Astley Ainslie, Royal Victoria and Liberton.

In response to a question from Dr Ian Johnston it was confirmed that this work will not delay the refurbishment of the ward in the Royal Edinburgh Hospital currently used by East Lothian patients.

Murray Leys noted the importance of developing a Learning Disabilities strategy which makes best use of all the facilities available.

Decisions

The Initial Agreement was supported for progression through the governance process. This decision will need to be homologated at the next meeting of the CHP Sub Committee on 27th October 2011.

32.2 Falls Pathway.

The Sub-Committee considered a report which had been circulated in advance of the meeting. Roz Eccles attended the meeting. The report noted progress on the performance of NHS Lothian against the Delivery Framework for Adult Rehabilitation – Prevention of Falls in Older People.

The report asked the CHP Sub Committee to note the background information and support an infrastructure to deliver the workstream.

The report noted that Emergency Services can no longer sustain a service for the fallen uninjured patient and described how the East Lothian Emergency Care Service would operate and also detailed the Care Home Telecare Project.

Murray Leys noted that there are about 100 calls per month to the Emergency Care Service and it is vital that processes are in place to
reduce and prevent hospital admissions unless they are absolutely necessary. Roz Eccles noted the work that has been and is being done in the area of falls prevention – both on a pro-active and re-active basis.

Change fund money will be used to target home safety checks as a means of reducing falls.

Decisions

The report was noted.

For the October meeting of the CHP Sub Committee, David Small and Murray Leys will provide an update on all the initiatives that are currently under way in Older People’s Services.

32.3. **How We Treat People – Our Strategic Approach.**

The Sub Committee received a presentation from Andy Jackson.

The presentation noted the imperative to define what core services are, to assess how these are going to be impacted and changed over the next 10 years and define the strategies that will be needed to support these services in a difficult financial climate.

The presentation noted

- The strategic framework over 5 – 10 years.
- Core business functions of the organisation.
- Key drivers – financial, demography, medical workforce, clinical development.
- The need to plan, coordinate and implement redesign of clinical services.
- What infrastructure might be needed to support services?

Andy Jackson outlined the time frames for defining the way forward noting that the Board of NHS Lothian would need to make key decisions in the course of the next 12 months or so.

The Clinical Director noted that he felt one of the key messages of the presentation was that there was not going to be enough money to sustain the current approach and services. If that is the case there needs to be an open approach that works through appropriate expectations with the public. Andy Jackson agreed that there is a need to make more effective use of the money that will be available.

The Clinical Director noted that he feels GPs have a very good overview of what works well and what does not, and they could very easily inform the Board about what services could be more effectively provided.

Ronnie Hill questioned what messages were being given to the public as there are clear tensions – e.g., trying to address health inequalities at the same time as reviewing services elsewhere. Ronnie Hill noted that he feels the best approach to be honest about what is proposed and in the consultation process give genuine choices.
Andy Jackson noted that a possible challenge will be the potential for politically unpopular proposals to come forward.

Tony Segal expressed concern that Carers issues did not appear to receive any prominence and questioned whether the wider public would be able to relate to what was being discussed in this debate. Andy Jackson offered to meet with Carer Groups if that would help.

Gill Colston noted that she felt worried about the length of time it would take to get through all the bits of the process described. Andy Jackson commented that some of the issues such as medical training are impacting now.

Lynne Hollis noted that a very recently published Audit Scotland report questioned the long term sustainability of services as they are currently designed.

Gill Colston commented that she feels there needs to be more emphasis on the services seeing and treating patients as real people and not components in a process.

It was agreed that the title of the Presentation was mis-leading as the content had not matched members expectations of what would be covered.

The General Manager noted the need for more structured but speedy debate with partners such as the Council, PPF and Carer organisations.

Decisions

It was agreed that Andy Jackson will return to a meeting of the CHP Sub Committee at some point over the next 6 – 8 months to provide an update on progress made.

33. Minutes of the Previous Meeting Held 29th June 2011

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

34. Matters Arising / Action Note

34.1 The Action Note will be updated and circulated with the minutes of the meeting.

34.2. (26.1.) Carers Forum

Lynne Hollis noted that a strategic decision had been made to allocate £230,000 of the carers’ information strategy allocation for Lothian wide projects.

34.3. (20.1) Care Homes

Murray Leys noted that it was not yet known if there was any interest
from other parties in acquiring the two care homes in East Lothian currently owned by Southern Cross. There has been a significant improvement within these establishments as a consequence of the implementation of the Improvement Plans which were developed following recent inspections.

35. **General Managers Report**

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

**Delayed Discharges**

In the July 2011 validated census East Lothian had 11 patients delayed with none over 6 weeks in post acute care and none over 2 days in acute care. It was reported that the August census has shown 7 patients delayed with none over 6 weeks in post acute care and none over 2 days in acute care.

The consistently good performance on delayed discharges was emphasised.

**Capital Projects**

The report provided updates in relation to the Gullane Medical Practice, Tranent Health Centre Extension and the re-provision of services from Edenhall Hospital.

The Gullane Business case was approved by the Finance and Performance Review Committee on 17th August.

The report noted that an Executive Group has met to set out the key milestones for the Older Peoples Strategy. The report noted that significant changes are under discussion for the provision of Older People’s Mental Health Services.

A draft template of performance measures for routine reporting was included as an appendix to the report. Tony Segall noted it would be helpful if some basic metrics on Carers activities could be included and offered to work with David Small and his team to develop these.

David Small will develop the Performance Report in detail and put forward a firm proposal on this and the frequency of reporting to a future meeting of the CHP Sub Committee. The reporting will encompass Council Managed services so that a full picture is created and will as far as possible be outcomes focused.

**Decisions**

The report was noted.
35.2. **Staff Governance Report** –

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

The staff turnover rate in the period from 1st May to 31st July 2011 was 1.7% - the annualised turnover rate is 6.99%.

The rate of sickness absence for July 2011 was 4.47% - the long term absence rate was 2.58% and the short term absence rate was 1.98%.

It was agreed that future reports should include an age distribution analysis of the workforce.

**Decisions**

The report was noted.

35.2. **Finance Report**

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

The CHP is reporting an overspend of £409,000 for the 4 months to 31st July 2011.

Core services were overspent by £74,000. Hosted Services were overspent by £51,000. Prescribing was overspent by £277,000. Core Pressures remain largely within Roodland’s Hospital costs.

The CHP is projecting an overachievement of the planned Local Reinvestment Programme (LRP).

The CHP has developed a recovery plan for HCH Budgets to bring the financial position back to a break-even position.

It was noted that the forecast outturn for the year on Prescribing across NHS Lothian is an overspend of £6 million. The CHPs have developed an action plan to identify savings and Lynne Hollis outlined the details of this work.

**Decisions**

The report was noted.
36.0. **Clinical Director’s Report**

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

The report noted that the new Junior Doctors rota at Roodlands Hospital started on 3rd August 2011. Initial indications are that this is working well.

The report highlighted that in relation to Herdmanflat Hospital an increasing number of patients (or their families) are appealing against decisions that they are no longer eligible for NHS Continuing Care. As second opinions need to be arranged within 14 days this could become a significant problem. The General Manager noted that a rota of consultants might need to be developed to address this issue.

Murray Leys noted that East Lothian Council is being financially impacted by the Continuing Care Criteria.

It was noted that the internal review part of the QOF process has been completed and external reviews will take place in October.

**Decisions**

The report was noted.

36.2. **Primary Care Joint Management Group – Contractual and Statutory Pro-forma evaluation**

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

The report provided details of the outcomes of the contractual and statutory pro-forma evaluation in 2010-2011. The report highlighted that there were no East Lothian Practices that were subject to the financial recovery process.

**Decisions**

The report was noted.

36.3. **Protecting Vulnerable Groups (P.V.G.)**

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

The report provided an update in relation to the P.V.G. scheme as it applies to independent contractors.

**Decisions**

The report was noted. The General Manager will liaise with East Lothian Council about the PVG Information sharing process.
37. **Chief Nurse Report**

37.1. 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**

The report noted that there were 52 children on the Child Protection Register as at 1st July 2011.

A working group has been set up to look at the impact of National Child Protection Guidance on East Lothian and Midlothian services and practice.

**Adult Protection**

Performance data is being developed and the Chief Nurse will provide an example of the reporting to a future meeting of the CHP Sub Committee.

**Community Nursing**

East Lothian has been conducting a Palliative Care in Care Homes pilot for about one year. The main focus of the project is to improve the standard of palliative and end of life care within the care home to reduce unnecessary hospital admission. The project is having a positive impact.

The report provided updates on the Leading Better Care and Releasing Time to Care initiatives.

**Community Hospitals**

The report advised that Endoscopy services at Roodlands had an inspection on 27th June 2011. The service was praised for many aspects of the care delivered. An action plan has been developed for those aspects identified as requiring improvement.

**HAI**

The Chief Nurse noted that the Healthcare Environment Inspectorate (HEI) are now also focusing on Mental Health and Older People’s Hospitals. Mock HEI audits have taken place at Roodlands, Belhaven and Edington and another will be conducted soon at Herdmanflat.

It was noted that issues in relation to hand hygiene, premises and environmental issues had been identified during the course of these audits. The Infection Control Nurse has expressed concerns in relation to Herdmanflat as that location is regarded as having most significant risks attached to it. The Infection Control Nurse is in talks with Estates to look at the areas of concern and to produce a costed improvement plan.

David Small noted the importance of the change of focus of the HEI audits to the hospital types mentioned. These visits could be un-announced.
Decisions

The report was noted.

Liz Cregan will prepare a paper for the October meeting of the CHP Sub Committee summarising the mock audit issues and detailing the costs of any remedial work.

37.2 Joint Inspection of Services to protect Children and Young People
East Lothian

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

The report noted the particular strengths that made a difference to children and families and referenced the examples of good practice.

Four aspects had been evaluated as ‘very good’
- Children are listened to and respected.
- Children are helped to keep safe.
- Response to immediate concerns.
- Meeting needs and reducing long term harm.

Two aspects were evaluated as good.
- Self-evaluation.
- Improvements in performance.

A multi-agency action plan has been developed to address the areas in which improvement is needed.

Decisions

The report was noted.

38. AHP Manager’s Report

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

The report noted that 65.1% of the Scottish population are either overweight or obese.

The report noted that a new Tiered model of care for the management of overweight and obese adults in NHS Lothian was introduced in April 2011. A new innovative telehealth programme using Weight Management Pods is being developed to help reduce waiting times. The suitable location for the pod in East Lothian has still to be identified.

The pod programme will reduce the number of face to face group sessions from 7 to 4 (once every 4 weeks). In between people will attend the weight management pod.

The report noted the risk register and people issues involved in the use of the pods.
Decisions

The report was noted.

Ann McCarthy suggested that an analysis of the current patients should be undertaken and then a possible venue for the pod should be identified in the area where most of these patients are based.

39. Hosted Services

39.1. There was no business raised under this item.

40. Carers Forum

40.1. A verbal update was provided to the meeting.

Tony Segal noted concerns in relation to the allocation of funding from the Carers Information Strategy.

In relation to the current year the report recommending the funding allocations had not been approved until late May and this had created significant issues for local groups. The Chief Nurse noted that a sub-group had been formed to consider the funding stream applications. There is £50k to be allocated. It was agreed that Liz Cregan and Tony Segal would meet to clarify understanding of the funding process.

In relation to the strategic decision to allocate funding to Lothian-wide actions Tony Segal noted that the amount appeared to have changed from £100k to £230k during the developments of the plans Tony Segal expressed concerns about the lack of involvement in this process.

David Small noted that he felt it would be helpful if the Lothian Wide Carers Board was re-constituted as that would have been an appropriate group to be consulted about the funding process, any Lothianwide allocation and the implications of that.

Tony Segal referenced the commitment of the Scottish Government to continue the funding of the Carers Information Strategy for the lifetime of the current parliament. It is essential that planning processes for the allocations in 2012 – 2013 start as early as possible and are not delayed until the final details of the overall allocation are known. The planning process should be more inclusive than it has been and include full and consultation with all appropriate Carer Groups.

Decisions

The update was noted and it was confirmed that David Small would pursue the re-constitution of the Lothian Wide Carers Board.

41. Public Partnership Forum (PPF)

41.1 The Sub Committee considered minutes of the PPF Meeting of 7th June 2011 which had been circulated in advance of the meeting.
It was confirmed that East Lothian will be looking at what a Polypharmacy trial would involve.

**Decisions**

The minutes were noted.

**42. Community Health Partnership Committee Appointments**

42.1. The appointment of Cllr Paul McLennan will need to be ratified.  

DS

**43. A.O.C.B.**

43.1. It was agreed that the option of having the meeting at alternative venues in East Lothian should be considered with the Council Chamber being a possible alternative.

**44. Date of next meeting**

It was agreed that the next meeting would take place on Thursday 27th October 2011 at 2.00pm. The Quay Complex Musselburgh
NHS LOTHIAN
EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB-COMMITTEE

Note of the meeting of the Edinburgh Community Health Partnership Sub-Committee (Public Session) held on Wednesday 5th October 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 Wadee, Optometrist
Jim Kendall, South Edinburgh Public Partnership Forum
Jim Brown, North Edinburgh Public Partnership Forum
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
David Jack, Head of Strategic Support, City of Edinburgh Council
Seb Fischer, VOCAL
Angela Lindsay, AHP Manager, Edinburgh CHP
Dr lan McKay, Clinical Director, Edinburgh CHP
Fiona McCready, Pharmacy Representative
Frances Fraser, North West Edinburgh LHP
Stuart McLauchlan, Staff Partnership Representative
William Hardie, North Edinburgh Public Partnership Forum
John Davidson, Dental Practitioner

In Attendance:  David White, Assistant General Manager Edinburgh CHP Minute Item 26.1.
Duncan Miller, General Manager PCCO, Minute Item 27.6.
Paul Currie, Strategic Programme Manager, Minute Item 27.6.
Drew McErlean, Acting Secretary

Apologies:  Dr Pete Shishodia, General Practitioner
Dr Ramon McDermott, General Practitioner

25.  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.

The Chair opened the meeting by advising that this would be the final meeting of the CHP Sub Committee attended by David Jack who is to retire from City of Edinburgh Council on 21st October. On behalf of the Sub Committee, the Chair expressed his appreciation of the very valuable contribution that David had made to the work of the CHP over the past few years and wished him well for his retirement.

Dr Margaret Douglas noted her appreciation of the support she had been given by David Jack in a number of very challenging areas and in particular the work done by David in pushing forward the debate on Health Inequalities.
25.1 Minutes of Previous Meeting held on 3rd August 2011

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

25.2 Matters Arising Not Covered on the Agenda

25.2.1. (19.3.1.) Finance Report

It was noted that instead of a paper on the Quarter 1 review being tabled at this meeting there would be a paper on the mid-year review tabled at the meeting on 7th December 2011.

26. Presentation

26.1. Willow Project

The sub committee received a presentation from David White, Assistant General Manager, Edinburgh CHP.

The presentation highlighted the background to the project which addresses repeat offending by female prisoners and tackling their health and wellbeing issues. David White emphasised that the project is dealing with some of the most deprived people in society who have multiple and complex needs.

The project is helping to support the policy of reducing the female prison population in Scotland over 10 years. To date 6 of the 13 women who attended the project have completed the programme.

The presentation noted that following the first phase of the project an evaluation was done in May 2010. A second phase of the project ran from 2010 to April 2011. Funding has been secured to continue the project to March 2013.

Outcomes from the project for some participants include reduced levels of offending, improved diet, reduced alcohol and drug abuse, improved relationships with their children and better employment prospects. There have also generally been improved mental health outcomes.

The cost effectiveness of the project against the costs of the criminal justice system and detention for prisoners was highlighted. A specific case was highlighted to demonstrate the outcomes experienced by that participant in the project.

The future direction of the project was referenced; noting that premises, long term follow up and coordination with partner organisations were amongst the issues being addressed.

In response to a question from Angela Lindsay it was confirmed that at the moment there is no formal follow up other than immediate evaluation but that some of the attendees were continuing to return to the project for support and advice due to the level of trust that had been created.

Dr Ian McKay asked if a similar approach could work for male prisoners. It was noted that projects with similar objectives for male prisoners had been started but these had experienced very high drop out rates.

The Chair asked when this would stop being a project and become a mainstream supported service. David White noted that after the current funding
ceases in March 2013 it is hoped there will be Change Fund support. The Chair noted that this is a good example of the sort of ‘preventative’ project which the Scottish Government has been keen to encourage.

Cllr Paul Edie noted this project was an excellent example of the importance of keeping minor offenders away from the prison environment. As there is strong evidences that this results in repeat offending and wider social issues.

Decisions

The presentation was noted and the slides will be circulated to the Sub Committee.

27. Items for Discussion / Information

27.1. Chairman’s Report

The Sub Committee received a verbal report on the activities undertaken by the Chair in relation to his role as Chair of the CHP.

- A very positive visit to the Family Nurse Partnership in Craigmillar.
- A visit to the Brain Injury Unit at the Robert Fergusson Unit
- The annual conference of the Scottish Federation of Housing Associations.
- The Chair hosted a table at the NHS Lothian Celebrating Success Annual awards.

Decisions

The update was noted.

27.2. General Manager’s Report

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

The report provided updates in relation to premises covering the Wester Hailes Healthy Living Centre, Firhill Community Centre, the re-provision of the West End Medical Practice and the new Chalmers Sexual Health Centre.

The report highlighted the modernisation and re-design work being undertaken at the Lanfine unit based at Liberton Hospital.

Other re-design projects are looking at, Orthotic Services, Amputee Rehabilitation, Sexual Health Services, Drugs and Alcohol Partnerships

The report noted a number of nominations for awards.

The report noted progress on trials taking place in relation to Telehealth.

Winter planning is progressing.

David Jack felt a number of the projects in the report were making very positive contributions to Health Inequality issues which should be highlighted in the report.

Decisions
The report was noted.

27.3. **Finance Report**

27.3.1. **Finance Report to 31st August 2011**

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

The CHP is reporting a net overspend of £1.749 million for the period to 31st August 2011. Of this total, £1.343 is attributable to Prescribing. Pricing issues are the principle factor in the Prescribing budget overspend.

The movement within the month is wholly attributable to Prescribing which is projecting a year end overspend of £6.1 million across Lothian. A Prescribing recovery plan has been developed.

The CHP has developed a recovery plan to manage the potential significant financial risk of an overspend in areas excluding Prescribing. This will be monitored very closely through to the year end.

**Decisions**

The report was noted.

27.4. **Health Inequalities**

27.4.1. **Health Inequalities Annual Report**

The Sub Committee received the 2010 annual report of the Edinburgh Health Inequalities Standing Group which had been circulated in advance of the meeting.

The report noted the key messages from the Chair of the Edinburgh Health Inequalities Standing Group with reference to the 6 Marmot objectives which have been adopted by the Group. The report gave a summary in the form of ‘A year at a Glance’ supported by some case studies. The Chair commented that the case studies in the report were very powerful.

There is £2.5 million allocated to supporting projects and David Jack noted that he felt the key areas have funded projects.

Jim Kendall noted that he had found the report to be very interesting and asked how difficult it would be to maintain current activity levels in the future. David Jack commented that Fairer Scotland funding is now part of the main council budget but that it has been reduced a bit. The bodies that are funded by grants have been briefed that to secure on-going funding it is essential that they set out clear measurable outcomes in their funding submissions.

Margaret Douglas hoped that via the Health Improvement Fund and CHP funding the current projects would continue to be supported.

It was noted that the report will be available via the Council website in due course but paper copies will not be published for the public.
27.4.2. Health Inequalities Framework Consultation

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

The report summarised the initial findings of the consultation exercise on a draft Health Inequalities Framework.

The report highlighted how the consultation exercise had operated.

Amongst the core themes from the consultation the following were highlighted:

- there was overwhelming support for the priority of reducing health inequalities in the city;
- there was majority support for using the Marmot Framework as the basis of a Health Inequalities Framework in the city; however, there were many detailed suggestions and caveats about its use and how it might be altered to suit an Edinburgh context – further discussions are planned.
- there was overwhelming agreement with the suggestion that the delivery of mainstream services needs to changed to have more of an impact on reducing health inequalities
- more than half of the respondents agreed that there should be a lead partnership or organisation for the Marmot objectives;

The importance of the partner organisations linking and working together was emphasised.

Margaret Douglas noted that she felt this work had brought out the tensions between the framework and the statutory focus of the HISG and there is ongoing debate about this.

Margaret Douglas noted that a Health Impact Assessment has been done in a number of key areas.

The Chair asked if there had been any surprises from the consultation process. Margaret Douglas noted the responses had largely been in line with expectations and were pleasing although there had been an element of surprise that some aspects of the Marmot objectives were felt to not be relevant.

The Chair noted that he was aware of feelings that some aspects of the Marmot objectives were not expressed in a Scottish or Edinburgh specific context. Margaret Douglas commented that some people felt the Equally Well objectives could have been used but Marmot is a strong proven framework with international recognition and credibility.

The Chair noted that the NHS should be noted as having a keen interest and responsibility in Objective 3 – ‘Create fair employment and good work for all’.

Decisions

The report was noted.
The Sub Committee agreed that the work should be progressed on the basis set out in the paper.

27.5. **Review of Edinburgh’s Intensive Home Treatment Teams (IHTT) and Mental Health Assessment Service (MHAS).**

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

The report noted the background of a shift in the balance of acute mental health care from hospital to the Community.

The report noted the key developments in 2010.

The development of IHTT and MHAS facilitated the planned reduction to the current level of 80 acute beds for Edinburgh – the lowest number per capita for Scotland.

A 32% decrease in average annual admissions to the Royal Edinburgh Hospital with the mean duration of stay falling by 6 days.

IHTT service user feedback is largely positive with 87% of respondents reporting clinical improvement and 43% feeling totally recovered at discharge. 96% felt safe during treatment.

The report detailed the number of referrals and assessments carried out.

The Chief Nurse noted that the teams are currently operating from 4 different bases but this will be rationalised to a single base to help improve the efficiency of working.

It was noted that the team has been nominated for a number of awards and this has been recognised as a very successful service re-design.

**Decisions**

The report was noted.

27.6. **Delivering Quality in Primary Care Action Plan**

The Sub Committee considered the NHS Lothian Delivering Quality in Primary Care Action plan which had been circulated in advance of the meeting. Duncan Miller and Paul Currie attended the meeting to note the key issues.

Duncan Miller noted the context within which this piece of work was being done.

In due course the plan will be submitted to the Scottish Government.

The process used to update and manage the plan was referenced. Good progress was reported for NHS Lothian with 12% of the plan complete and 56% on track to complete by the target date. This is being progressed within existing resources. Paul Currie noted that the range of
issues demonstrated how much work was being done by the CHP.

Jim Kendall noted that the paper identified several issues that would be impacted by patient or public involvement and asked how this involvement was coordinated. Paul Currie noted that Lead Clinicians were tasked with taking local decisions about the extent of patient/public involvement.

Bashir Wadee noted that he was pleased to see that funding had been made available to develop electronic links from optometry to other parts of the NHS. The Chair noted that this had been discussed at several meetings of the PPFs in Edinburgh and would be a very welcome development.

The Chair asked if a quality measures report from Primary Care would be developed for the NHS Lothian Board. Duncan Miller noted this is work in progress but that he expects to see the measures and reporting move forward over the course of the next 12 – 18 months.

Decisions

The paper was noted.

27.8. Prescribing

Robert Aitken noted that Prescribing is a very important issue given the overspend highlighted in the Finance report.

A detailed report on the issues and the work being done within the CHP will be tabled at the next meeting of the CHP Sub Committee on 7th December 2011. RA

The Clinical Director noted that a range of efficiency proposals are being progressed but noted the importance of the whole system working together to ensure that any changes can be implemented efficiently. The Clinical Director highlighted an example of where a recently recommended drug switch had become problematic due to the shortage in supply of the recommended drug.

The Clinical Director noted that work needed to be done in relation to repeat prescriptions for vulnerable elderly people. It is important that GPs are challenged on opportunities to remove drugs from a patient’s prescription to stop them from ‘stock piling’ medicines. Fiona McCready noted that Pharmacy Chronic Medications Team has also been considering this issue. Pharmacists will engage with GPs on this issue for patients but the most efficient means of doing so requires the resolution of an IT issue. RA/IM

This IT issue will be discussed at a meeting that the Acting General Manager and the Clinical Director have scheduled with the NHS Lothian Medical Director.

Decisions

It was agreed that for the foreseeable future, Prescribing should be retained as a standing item on the agenda for meetings of the CHP Sub Committee. DMcE
28. **Items for Decision Making**

28.1 **Firrhill Partnership Centre Initial Agreement Agreement**

The Sub Committee considered an Initial Agreement which had been circulated in advance of the meeting. This document is the start of the Governance process.

The proposal covers the development of a new facility in Firrhill which would bring together 3 GP Practices, and other services (Community Nursing, Podiatry and Child Health Services as well as a base for use by Community Mental Health, Learning Disabilities and Adult Health & Social Care).

The original proposal included Older Peoples Day Services but this will now be located elsewhere. Community Physiotherapy will no longer be included either.

Of the funding options described in the paper, Option 2 is being progressed – this is based on engaging Hubco to help develop the business case. Work on this will begin in late 2011.

Further discussions on the detailed proposals will continue with the South Edinburgh PPF.

Margaret Douglas noted that the proposal has been subject to a Health Inequalities Impact Assessment.

The document for the next phase of the project will have more explicit references to the Health Inequalities issues.

**Decisions**

The Initial Agreement was approved by the Sub Committee.

28.2. **Meeting Dates for 2012**

A schedule of proposed meeting dates for 2012 had been circulated in advance of the meeting.

**Decisions**

The schedule of meeting dates was agreed.

29. **Items for Review**

29.1. **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.
29.2 Minutes from other Groups

29.2.1. Edinburgh CHP Performance Management Sub-Group – 20th July and 17th August 2011 - Copies of the minutes were circulated to members and noted.

29.2.2. Edinburgh Alcohol and Drugs Partnership 29th June 2011 - A copy of the minutes was circulated to members and noted.

29.2.3. Edinburgh CHP Health and Safety Committee – 14th September 2011 – A copy of the minutes was circulated to members and noted.

29.2.4. Edinburgh CHP Health Inequalities Standing Group – 12th May and 28th July 2011. – A copy of the minutes was circulated to members and noted.

29.2.5. Carer Information Strategy – 23rd August 2011 - A copy of the minutes was circulated to members and noted.

29.2.6. Primary Care Joint Management Group 9th June and 11th August 2011 - A copy of the minutes was circulated to members and noted.

29.2.8. North Edinburgh PPF – 27th July 2011 - A copy of the minutes was circulated to members and noted.

29.2.9. South Edinburgh PPF – 28th July 2011. –A copy of the minutes was circulated to members and noted.

29.3. LHP Reports

There was no business raised under this item.

30. Questions from Members of the Public in Attendance

30.1. There were no questions.

31. Any Other Competent Business

31.1. There was no other business raised.

33. Date and Time of Next Meeting

33.1 The next meeting of the Edinburgh CHP Sub-Committee is scheduled for Wednesday 7th December 2011 at NHS Lothian, Waverley Gate, Edinburgh.
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<thead>
<tr>
<th>Topic</th>
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<tr>
<td><strong>25.2 Matters Arising Not Covered on the Agenda</strong></td>
<td>25.2.1. (19.3.1.) Finance Report</td>
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Apologies: Sue Edmond, PPF Representative  
Dr Hamish Reid, Acting Clinical Director Midlothian CHP  
Morag Barrow – AHP Manager

In Attendance: James Coghill (PPF Depute)  
Duncan Miller (General Manager PCCO) – Minute Item 28.1  
Paul Currie, (Strategic Programme Manager) - Minute Item 28.1  
Andy Jackson, (Assistant Director of Health) – Minute Item 28.3  
Tom Wood, Chair East and Midlothian Adult & Child Protection Committee) – Minute Item 28.4.  
Drew McErlean – Minutes

28. **Apologies and Welcome**

Apologies were noted as above.

Vivienne Baird (PPF Representative) and James Coghill (PPF Depute) were welcomed to their first meeting of the CHP Sub Committee.

28.1. **Delivering Quality in Primary Care – Feedback.**

The Sub Committee considered the NHS Lothian Delivering Quality in Primary Care Action plan which had been circulated in advance of the meeting.

The work being done by Leads to progress each of the actions was noted.

In due course the plan will be submitted to the Scottish Government.
The process used to update and manage the plan was referenced. Good progress was reported for NHS Lothian with 12% of the plan actions complete and 56% on track to complete by the target date. This is being progressed within existing resources. Some re-prioritisation of items may be required and Paul Currie noted that input from the CHP on what the local priorities are would be welcome.

George Wilson asked why only data for specific months had been provided in relation to the use of Ultrasound at Midlothian Community Hospital and A & E admissions. Paul Currie advised this data was illustrative only and confirmed that data for all months had been logged.

The Chair noted that the document proved that the challenges in the current fiscal environment would be very demanding and asked about facilities to undertake minor surgery in local Health Centres - e.g. minor eye ailments. Duncan Miller advised that discussions are taking place with the Eye Pavilion to identify how GPs can be authorised and funded to undertake local operations and prevent patients having to travel to the Eye Pavilion for relatively minor ailments to be treated.

Paul Currie advised that there are a number of areas in which the Scottish Government is looking to support investment in GP Practices to enable more local treatment for patients.

Eibhlin McHugh noted the importance of sharing Anticipatory Care Plans between Health and Social Care.

Questions provided in writing by Sue Edmond will be passed to Duncan Miller for a written response.

The Chair asked that he be kept fully informed of the progress made in national discussions in relation to any changes of hours for GP Practices.

Decisions

The report was noted.

28.2. Falls Pathway

The Sub-Committee considered a report which had been circulated in advance of the meeting. Sheena Wight attended the meeting. The report noted progress on the performance of NHS Lothian against the Delivery Framework for Adult Rehabilitation – Prevention of Falls in Older People.

The report noted that it has been agreed that Emergency Services should no longer provide a service for uninjured fallen patients and described how the Midlothian Emergency Care Service would operate and also detailed the Care Home Telecare Project.

Sheena Wight noted the work that has been and is being done in the area of falls prevention – both on a pro-active and re-active basis.

Change fund money will be used to target home safety checks as a means of reducing falls.

The work on the Care Home Telecare Falls Pilot within East Lothian and
Midlothian was highlighted. The pilot has been extended to cover 4 inpatient wards including the Midlothian Community Hospital. This will run for 4 months from 1st August 2011. Eibhlin McHugh noted that there had been very positive feedback from Care Homes in relation to this initiative. The Chair asked how members of the public would know which number to telephone in the event of a fall occurring. Eibhlin McHugh noted that a lot of work has been done to improve communication and coordination across services but agreed that more needs to be done to improve awareness of contact points. Sheena Wight undertook to follow up on this.

Decisions

The update was noted. It was agreed that a progress report would be brought to a CHP Sub Committee meeting in the first 6 months of 2012.

28.3 How we Treat People

The Sub Committee received a presentation from Andy Jackson.

The presentation noted the imperative to define what core services are, how these are going to be impacted and changed over the next 10 years and to define the strategies that will be needed to support these services in a difficult financial climate.

The presentation noted

- The strategic framework over 5 – 10 years.
- Core functions of the organisation.
- Key drivers – financial, demography, workforce, clinical development.
- The need to plan, coordinate and implement redesign of clinical services.
- What Infrastructure might be needed to support services.

The presentation noted the financial and demographic drivers that would influence change and highlighted the reduced number of medical personnel that are being trained currently and the downstream impact of this.

Andy Jackson outlined the time frames for defining the way forward noting that the Board of NHS Lothian would need to make key decisions in the course of the next 12 months or so.

The focus will be on core services and there is a clear need to work closely with partners including councils and the voluntary sector.

The next steps in the process leading to public consultation in 2012 were noted.

Sheena Wight noted that she felt the title of the presentation could be improved and might be seen as relating to individual patients. Andy Jackson agreed and advised that the title of this piece of work could change in due course.

Julie Gardner acknowledged the references to the vital work of unpaid carers. Andy Jackson will contact Julie Gardner to attend appropriate meetings of Carer Organisations to deliver the presentation.
Tom Welsh noted that he felt the report could be more explicit in its references to Shifting the Balance of Care.

The Chair commented that there needed to be more discussion with CHPs about dis-investment from services and where such decisions are made. There also needs to be work to look at the continued funding of treatments which have little clinical evidence of being effective.

The Chair also noted Public concerns over the continuing investment in PFI.

Decisions

It was agreed that Andy Jackson will return to a meeting of the CHP Sub Committee at some point over the next 6 – 8 months to provide an update on progress made.


The Sub Committee received a presentation from Tom Wood, Chair of the East and Mid Lothian Adult and Child Protection Committee.

The Biennial report had been circulated in advance of the meeting.

Tom Wood noted that recent Adult Protection legislation had implications for improvements in training and quality assurance – building on what had been in place informally prior to the legislation.

The new legislation had brought about specific challenges in relation to Care Homes, Mental Health issues and had most importantly highlighted the link between Adult Protection and other key issues such as Alcohol and Drugs and Child Protection. Tom Wood emphasised the key link between Violence Against Women, Alcohol and Drugs abuse and Child Protection.

It was emphasised that Midlothian has demonstrated a very robust approach across all areas to provide appropriate support and services.

In the past, services had been managed in individual silos but it was now recognised that this had been ineffective as some of the most challenging cases arise in situations where there are interlinks – and the services had failed to communicate and work together. This 'silo' approach therefore did not reflect real life.

It is critical that in the future early intervention is the key focus – and that is dependant upon Community and Neighbourhood involvement.

Tom Wood noted that in Midlothian the Support Services Lead Officers are now being co-located and trained together and this should be effective in improving joint working and early intervention.

It was noted that some top slicing of Scottish Government funding may provide opportunities to invest in Early Intervention initiatives.

The Chair noted that there is still a significant learning curve for Professionals and the General Public about what Adult Protection actually
means.

Decisions

The Chair thanked Tom Wood for attending the meeting and looked forward to receiving an update on progress in the future.

29. Minutes of the Previous Meeting held 28th July 2011

Marilyn Gill should read 'Marlene Gill'.

Sue Edmond had intimated apologies to the meeting.

Catherine Evans had not attended the meeting on behalf of Vivienne Baird.

Item 18.3. George Wilson noted that his comments in relation to the tone of the Audit Scotland report had been his own and had not been made on behalf of the PPF.

Item 18.3 – The Audit Scotland report had been made with reference to all CHPs.

Item 24 An unpaid carer is being sought to join the Sub Committee.

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

30. Matters Arising / Action Plan

30.1. Action Plan

The action plan will be updated and circulated.

19.3.1. Finance Report.

The Chair noted that NHS Lothian has now started work on the next phase of rationalising use of buildings.

George Wilson noted that this may provide some opportunities for voluntary organisations.

30.2. Older People’s Mental Health Services

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

The report outlined proposals for a new model of care for East and Midlothian Mental Health Services for older people.

The report outlined the key drivers for change and detailed the key aspects of the proposed service change in relation to Older Peoples Mental Health Admission / Assessment Wards at Herdmanflat Hospital and Midlothian Community Hospital, The Mental Health Continuing Care Ward at Herdmanflat Hospital and Older Peoples Day Services in East Lothian.
Key themes are the growing and ageing population and the increased demand for services. It is also important to address the issues from Shifting the Balance of Care with less emphasis on hospital admissions. Equity of access to services for older people is also an issue as there is a perception of discrimination once people reach the age of 65.

The proposed team structures for Older Peoples and Adult Community Mental Health Teams were noted.

The report proposed that Tantallon Ward at Herdmanflat should amalgamate with Rossbank Older Peoples Admissions / Assessment ward at Midlothian Community Hospital to ensure all patients were cared for in wards that maximised privacy and dignity and minimised health and safety and infection risks.

The report also detailed a number of significant re-investments in services that would be required as part of the overall proposal.

The report listed the benefits of the proposals.

Eibhlin McHugh noted that in principle Midlothian Council welcomes the reduction in beds and the move to support people in their own homes and looks forward to working closely with the NHS on the detailed aspects of the changes.

David Small noted that the paper has been discussed with Partnership who will be fully involved as the change process progresses.

The Chair noted the importance of seeing this as a 24/7 service issue. This is particularly important in the way that Day Centre provision and respite support are managed.

David Small noted that the strategic issues have involved all of the appropriate parties in East and Mid Lothian although it is recognised that earlier involvement of some of the bodies would have been helpful. The Joint Mental health Planning Group was also involved in the development of the proposals.

Jackie Aitchison and Eibhlin McHugh asked for detail on joint planning involvement in Midlothian. David Small accepted this had happened later and in less detail than he would have liked.

Decisions

The recommendations were supported. The paper should be updated as the process progresses and brought back to a future meeting of the CHP Sub Committee.

31. General Manager’s Report

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

Delayed Discharges
The report noted that the August census showed 6 delayed discharges with no patients in short stay beds and no patients over 6 weeks in post acute beds.

Capital Projects

Penicuik Health Centre extension was officially opened on 31st August 2011. The operational date for Dalkeith Health Centre was 26th September 2011.

The Chair noted concerns over the fact that an alarm system had not been fitted in a room where staff would be working alone with patients at the new Dalkeith Medical Centre. This should be a standard requirement in such a room. David Small will follow up on this.

Cllr Jackie Aitchison noted concerns over reported restrictions that were being applied to the use of a hall that was part of the new Dalkeith Medical Centre. David Small undertook to address this.

Investors In People

Work has been underway to improve staff engagement following the disappointing IIP Assessment in December 2010. Re-assessment will take place in November / December 2011.

Decisions

The report was noted.

31.2. Staff Governance Report

The staff turnover rate in the period 1st June – 31st August 2011 was 2.16% - an annualised rate of 8.59%.

The sickness absence rate for August 2011 was 4.32% - Long term absence being 2.82% and short term absence of 1.5%.

Decisions

The report was noted.

31.3. Finance Report to 31st August 2011

Midlothian CHP is reporting a net overspend of £494k for the 5 months to 31st August 2011. Prescribing accounts for £296k of this total.

There was £135k of unmet LRP in the 5 months to 31st August 2011.

As part of the quarter one review the CHP was forecasting a significant financial risk to the year end position and a recovery plan to ensure a break even out-turn has been prepared.

The key issues impacting Prescribing were emphasised – volume growth and pricing. It was noted that a Prescribing Recovery plan for NHS Lothian has been developed.
The Chair asked if CHPs would be tasked with finding additional savings if the overspend on Prescribing is not reversed. Lynne Hollis advised that the role of the CHPs is to achieve the LRP target and that it is acknowledged that the pricing issues are beyond the control of CHPs. Andrew Duffy advised that he was not aware of any evidence that minor ailment prescribing at Pharmacies has shown any significant increase since free prescriptions were introduced.

The Chair asked how ‘outliers’ were managed. David Small noted that extra Primary Care Pharmacy resource had been brought in to address this.

Cllr Jackie Aitchison noted discussions which had taken place at the NHS Lothian Board meeting on 27th September in relation to an alternative to methadone. The unit price of this drug was higher than methadone but that trials had shown that patients are able to come off this drug in a shorter timescale so overall costs may be lower in the longer term.

Jane Hopton reported that work is underway to look at the overall economics of this issue but it is very complex and there are differing views emerging about what the appropriate way forward is.

The Chair noted that this is not a new issue and is concerned that there is no definitive action plan.

**Decisions**

The report was noted.

### 32. Clinical Director Report

#### 32.1

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

The report provided an update on the Quality and Outcomes Framework Quality and Productivity Indicators (QOF- QP). This detailed the new indicators that had been introduced. A Protected Learning Time date has been set for 30th November to hold an external review meeting. Each practice has been asked to identify 2 members of staff to attend.

**Decisions**

The report was noted.

### 32.2. Prescribing Report

The Sub-Committee considered a report which had been circulated in advance of the meeting which detailed the Prescribing budget performance for the month of June 2011.

Midlothian had a significant overspend as noted in the finance report.

The report noted that Midlothian had received a lower budget allocation in 2011 – 2012 than it had in 2010 – 2011 this created a significant pressure. The Midlothian Prescribing LRP target for 2011 – 2102 was £412,000 and to date £198,683 (48.2%) has been achieved.
Decisions

The report was noted.

32.3. **East and Midlothian Prescribing Budget Plan 2011 - 2012**

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

The report set out the budget by CHP and GP Practices and detailed the LRP initiatives that are being undertaken in relation to Prescribing.

The Chair asked what investigations take place in relation to GP Practices that overspend. Lynne Hollis noted the process for budget setting and advised that it was an issue for CHPs as to how they dealt with ‘outliers’ where the prescribing pattern is not within the acceptable parameters.

The Chair emphasised that this is a very important issue as GP Practices are spending money that does not belong to them and accountability for any overspending has to be real and evidenced. There are contractual issues that arise and he was concerned that there was potential for double funding in payment for prescribing efficiencies.

David Small commented that practices were paid for the additional work involved e.g. in changing patient prescriptions.

Lynne Hollis noted the work being done by the PCCO to streamline the various funding lines for GP Practices which should help to simplify matters going forward.

**Decisions**

The report was noted and it was agreed that Hamish Reid should prepare a report for a future meeting of the CHP Sub Committee on the work that is being done to manage and deal with overspending Practices.

33. **Chief Nurse Report**

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

**Child Protection**

As of 1st September 2011 there were 176 children recorded on the child protection register. It was noted that the increased numbers are largely a consequence of early intervention work by practitioners.

The Midlothian HMIE Child Protection Inspection Report was also circulated in advance of the meeting. The Quality Assurance Sub Group is now working on a multi-agency action / improvement plan to address the areas that were identified as requiring improvement.

The Chair asked for clarification on the 22 Children logged on the Child Protection Register as ‘other risks – not specified’. The Chief Nurse will report on this at the meeting scheduled for 24th November 2011.
Adult Protection

A Violence Against Women symposium will be held on 14 October at the Scottish Mining Museum.

Community Nursing

The report noted that Health Visitor and Child Health Record components of TRAK has progressed within Midlothian with all sites live on the system during August.

Midlothian Anticipatory Care Service has been shortlisted for a Celebrating Success 2011 award.

Big lottery funding of £800k has been allocated to support a partnership programme led by the voluntary sector aimed at improving outcomes for children in Midlothian who are in families with multiple and complex needs.

The report also noted updates in relation to the Midlothian Change Fund, Midlothian Community Hospital and the Community Mental Health Teams.

A verbal update was provided in relation to the School Nursing Re-Design proposal on which staff consultation is continuing.

Cllr Aitchison suggested that Midlothian Council could provide resource to assist with the landscaping work at the Midlothian Community Hospital. This could be cost effective and a good example of partnership working.

Healthcare Associated Infections

The report provided an update on the various work including mock Healthcare Environment Inspectorate Audits. Work to address any issues identified is progressing.

In the period 1st June – 31st August 2011 there were no cases of Staphylococcus Aureus Bacteraemia or Clostridium Difficile in Midlothian community Hospital or Midlothian Community Services. There were also no outbreaks of Noro-Virus in Community Hospitals.

Decisions

The report was noted.

34. AHP Manager Report

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

The report provided an update on Dietetics and Falls.

In relation to Dietetics the report provided details of the new tiered model of care for the management of overweight and obese adults which was introduced in April 2011.

The solution involves the use of pods for self administered readings – 1 of these pods will be located in Midlothian.
The Chair queried whether this initiative was sustainable in the longer term and noted this was a new service being introduced at a time of financial constraint. Morag Barrow will report back on this at the meeting scheduled for 24th November 2011.

The report also referenced the work being done with Weight Loss and Weight Management Groups.

Decisions

The report was noted.

35. Hosted Services

35.1. Learning Disability Services

Jane Hopton noted that there was 1 Learning Disabilities Delayed Discharge case at the moment with another pending in a case where the patient is being returned to Lothian from a facility in England.

Jane Hopton referenced discussions at the previous meeting and noted the progress made in relation to the capital funding for the refurbishment of the Greenbank unit.

35.1.1. Learning Disabilities in-Patient Nursing Proposal

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

The report noted that LD Inpatient Services has the highest number of reported physical aggression incidents by patients towards other patients and staff in NHS Lothian.

The report noted concerns about the high level of reliance on bank staff in the service as they can have less experience of working directly with patients with a learning disability.

In 2010 an action plan was agreed to address the staffing gap to reduce dependency on bank staff. A further review was undertaken in June 2011.

From this review it is recommended that the service requires an uplift of 39 wte to provide a safe level of service. The average monthly use of nurse bank was 34 wte. There is a further 5 wte equivalent used in excess hours. This means that the current financial outlay in bank spend and excess hours directly maps with the safe staffing levels required.

Jane Hopton reviewed the resourcing and recruitment implications.

Decisions

It was agreed that Jane Hopton and Lynne Hollis would meet to look at what can be done within current budgets to address the financial issues which the Sub Committee agreed were of a significant concern.

The Chair noted the concerns over the number of physical aggression incidents and undertook to discuss this with the Senior Management Team.
35.1.2. **LD Clinical Governance and Risk Management Issues**

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

The report noted that the Mental Welfare Commission visit in August 2011 had praised the highly developed and individualised care plans across all LD services and the range of services offered. Positive feedback was also received in relation to staff engagement with patients who can present challenging behaviours.

Areas of improvement were identified in relation to building maintenance and redecoration. Opportunities to address these areas for improvement are being progressed.

**Decisions**

The report was noted.

35.2. **Health Promotion Service**

The Sub Committee received a verbal report.

The attainment of the Healthy Working Lives Silver Award was noted. Mhairi Simpson will progress appropriate publicity for this achievement.

**Decisions**

The update was noted.

36. **Carers Forum**

The Sub Committee received a verbal update.

A meeting of the Midlothian Carers Strategic Planning Group took place on 8th September and good progress was made albeit it was noted that Health had not been represented at the meeting.

Progress has been made on identifying Carer Representatives to attend the meetings of the CHP Sub Committee. Julie Gardner will liaise with David Small on practical issues that need to be resolved.

**Decisions**

The update was noted.

37. **Public Partnership Forum**

The minutes of the meeting held on 21st July 2011 had been circulated in advance of the meeting and were considered by the Sub Committee.
DRAFT

Decisions

The update was noted.

38. **A.O.C.B.**

There was no other business raised.

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

Thursday 24th November 2011 @ 14.00 in the Council Chambers, Buccleuch Street, Dalkeith
Minutes of the West Lothian Sub Committee
1st September 2011 2 – 4pm
Room 1 Fauldhouse Partnership Centre, Fauldhouse

Present
Ellen Glass (EG) Councillor West Lothian Council
Sally Westwick (SW) AHP Manager, West Lothian CHCP
Jennifer Scott (JS) Interim Head of Social Policy, WLC
Jane Kellock (JK) Manager, C&F/Health Improvement
Caroline Wells (CW) Community Pharmacist, SJH
John Richardson (JR) Public Involvement Representative
James McCallum (JMc) Clinical Director
Jim Forrest (JF) Director, West Lothian CHCP
Marion Christie (MC) Head of Health
Gill Cottrell (GC) Chief Nurse
Julie Cassidy (JC) Public Involvement Coordinator
Jane Houston (JH) Partnership Rep, West Lothian CHCP
George Mackie (GM) GP East Calder
Drew Elliot (DE) Lothian and Border Police Representative
Ann Gee (AG) Head of Housing and Building
Alan Bell (AB) Senior Manager, Communities & Information
Karen Cawte (KC) Community Planning Manager, WLC
Lorraine Gillies (LG) Life Stages Manager
Stewart Murdoch (SM) Scottish Ambulance Service
Phyllis Carr (PC)

Apologies
Theresa Douglas (TD) Chair, West Lothian CHCP
Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
Jim Gallagher (JG) Chief Executive VSGWL
Lindsay Seywright (LS) Assistant Principal West Lothian College
Claire Kenwood (CK) Lead for Mental Health
Sandra Mair (SM)
Moira Niven (MN)

In Attendance
Marjory Simpson (MS) Administrative Manager
Dick Fitzpatrick (DF) Project Manager REH
Aileen Muir (AM) Consultant in Pharmaceutical Public Health
Ann Marie Keast (AK) Deputy Manager Carers of West Lothian
Duncan Miller (DM) General Manager, PCCO

1 APOLOGIES FOR ABSENCE
As above

2 ORDER OF BUSINESS INCLUDING NOTICE OF URGENT BUSINESS
No urgent business notified
3. **ANY OTHER BUSINESS FOR TODAY**

4. **DECLARATION OF INTEREST**

There were no declarations of interest.

5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**

The minutes of the meeting held on the 9th June were approved as an accurate record. EG requested the initials were added to the list of attendees to correspond with the initial in the body of the minutes.

6. **CONFIRMATION OF ACTION POINTS**

A copy of the action points were circulated to all members of the committee.

7. **MATTERS ARISING FROM PREVIOUS MINUTES**

There were no matters arising from previous minutes.

8. **MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING**

The PPFHC minutes 26/05/11 were noted.

9. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**

The PCJMG minutes 12/05/11 and 09/06/11 were considered.

10. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP**

The CFMG minutes 18/04/11 and 16/06/11 were noted.

11. **MINUTES OF CHCP COMMUNICATION GROUP**

The minutes of the communication group meeting 26/05/11 were noted.

12. **SECTION 17C/2C A & E ATTENDANCES PROJECT 2010/11**

DM talked to a presentation on the Section 17C/2C A & E Attendances Project 2010/11. He gave the background to the different types of contracts with GP practices. 17C practice based contract and 17J General Medical Services contract.

The project was based around the HEAT target T10 to aim to reduce attendances at A & E Departments. 26 17C practices took part with 2 based in West Lothian.

The key findings highlighted that 13% of all A & E attendances were judged by GP’s to be potentially avoidable. In the majority of these cases could have resulted in more appropriate health care provision. Recommendations are...
patients need to be more aware of the range of services available at different locations of care; in particular improved awareness of alternatives to A & E. Signposting through a variety of different methods and mediums is required.

Discussions were held regarding closer working on unscheduled care involving GP’s and options available to A & E departments to redirect patients. QOF peer reviews and anticipatory care plans were discussed. AG suggested sharing information with relevant partnership.

The project was supported by the Sub Committee to promote a whole system approach.

13. INITIAL AGREEMENT (IA) FOR THE REDEVELOPMENT OF THE ROYAL EDINBURGH HOSPITAL (REH) CAMPUS

The project manager, Dick Fitzpatrick talked to the report to seek support of the statement of strategic intent, as described in the redevelopment of the REH Campus initial agreement, for a high level plan to develop the REH campus incrementally over a number of years.

The redevelopment is being proposed to be carried out over 5 phases. Phase 1 involves Mental Health – Acute and Intensive Psychiatric Care Inpatient services with a completion date of 2014.

Indicative costs range from £60m option 1, £142m option 3 through to £181m option 2 for 100% new build. Option 2 and 3 are based on delivering 400 beds on a phased basis.

The project will be revenue funded and HUBCO has been identified as procurement. The timescale will be 10 years over 5 separate phases, releasing hospital sites. Outline business cases will be produced at each phase.

Concerns were raised regarding the financial assumptions re the selling of sites. Assurance was given by DF regarding safety loops described in each business case. JH highlighted that partnership were totally opposed to Private Partnership Funding.

EG asked for assurance that all services currently available in St John’s hospital would not be transferred. DF gave the assurance that St John’s hospital was not part of the scoping exercise.

The Sub Committee look forward to further updates

14. PHARMACEUTICAL CARE SERVICES PLAN

Aileen Muir consultant in pharmaceutical public health talked to the paper recommending the Sub Committee accept the update on the current work plan to develop a pharmaceutical care services plan for NHS Lothian.

The NHS (Pharmaceutical Services) (Scotland) Amendments Regulations 2011 introduced an annual requirement for Boards to produce an annual Pharmaceutical Care Services Plan from April 2010. Due to the tight timescale agreement was made for 2011/12 Boards to publish extended Pharmaceutical
lists detailing full range of services and fuller PCSPs for April 2012 and a short life working group would produce some additional guidance for this.

The overarching aim is to assess local needs and identify where there is a mismatch with current provision in order to inform service development. The plan is an opportunity to provide an NHS Lothian view of the need for Pharmaceutical care services but will break some of the information down by CHP/CHCP which will contribute to CHP/CHCP planning of services.

Discussions took place regarding the services provided by the pharmacy and how they are advertised to the public. It was felt there is a need to update what additional services are provided over and above the core services on an annual basis.

JR asked for documentation to be provided for the PPF to distribute to the public that they would fully understand. AM is happy to send question direct to the PPF to consult with the public.

Emergency contraception available to 13 year olds and above was questioned whether this was generally known to the public. JS discussed a paper that had been produced detailing this services and will send to EG for information.

JH questioned the delivery of palliative care services provided by West Lothian pharmacies. Out of 23 pharmacies in West Lothian 5 deliver palliative care services. JH asked how the public would be aware of the pharmacies providing this service. In general it would be NHS staff accessing these services for the public and they are aware of the pharmacies to access.

The plan will try to maximise resources to cover the majority of the population using a certain amount of pharmacies.

GMc highlighted in West Lothian per head of population there are fewer pharmacies benchmarked across East of Scotland, giving a disproportionate access to pharmacy services.

15. PRIMARY CARE (GENERAL PRACTICE) WORKPLAN 2011/12

JMc talked to the Primary Care Workplan 2011/12 which has been developed to meet the requirements of Delivering Quality in Primary Care and the Clinical and Staff Governance Standards for General Practice.

This is a new concept giving strategic direction within primary care. The plan has been developed from output from Practice Managers Development event and comments from other stakeholders to help work towards a corporate direction, to develop ways of working to improve patient care, patient safety and look after staff.

The CHCP is responsible for the planning, development and delivery of health and social care services. Effective partnership working is essential to ensure patients have access to integrated services coordinated for their pathway of care. West Lothian has historically done well integrating with secondary care, but the workplan will hopefully develop integration further.
A question was raised on how this would influence the Primary Care community Forum (PCCF). JMc commented the workplan would be the engine room and will create the agenda of the PCCF.

MC commented on the good practice and West Lothian are the first to take this concept forward in Lothian.

Certain items on the workplan were discussed and JF commented that this was an excellent step forward.

LG stated the language regarding outcomes and activities would require to match other documents within the CHCP for consistency. LG to contact Carol Bebbington.

The Sub Committee look forward to further updates and the workplan will be taken to the Board.

16. PUT YOUR WEST FOOT FORWARD

JK informed the Sub Committee that there has been a revised report produced that will be circulated to the members following the meeting, but would be happy to talk to the report circulated highlighting the changes.

The purpose of the report is to provide the Sub Committee with the Annual Report on the Put Your West Forward walking project from the period April 2010 to June 2011. The Sub Committee is recommended to accept this paper and support the key themes emerging from the full annual Report.

The project is funded by West Lothian on the Move costing £15K per annum. A half time buddy walker will be employed from 2012 to encourage vulnerable participants. Referral can be made through self-referral, exercise referral, keep well project, annual walking group. Consultation with the disabled access group is also carried out. In general the population of the walkers is older adults.

JK highlighted physical activity positively contributes to the prevention and management of over 20 chronic diseases and conditions including coronary heart disease, diabetes, cancer and obesity.

JMc commented following an award service, that the group represented fantastic cohesive working.

17. GETTING IT RIGHT FOR EVERYCHILD SOUTH EAST REGION

JS talked to the paper to recommend that the Sub Committee is informed of the role of the South East Region Getting It Right For Every Child group coordinating the implementation of the GIRFEC agenda across the Lothian & Borders region.

The group consists of representation from 5 local authorities, 2 health boards and Lothian and Borders police who meet on a monthly basis, to ensure there is no duplication of work, to learn from others and to achieve consistent results.
The Scottish Government has allocated funds to support the sharing of practice across the region. It is proposed this funding will fund a coordinator to take forward the work and report directly to the south East Region Group.

A stakeholder’s event took place on the 24th June to share practice and learning and to explore difficulties and find solutions from across the south East region.

18. **EARLY YEARS HEALTH IMPROVEMENT FUND RECOMMENDATIONS**

JK talked to the paper to update the Sub Committee on the use of the Early Years allocation from the Health Improvement Fund in West Lothian to the committee future allocations.

Evaluation reports of the projects have been taken to the Children and Families Management group for ratification.

JK highlighted the reduction in available funding from £62,000 per year to £52,870.

Recommendations are being made for funding not to be made a priority for the provision of the Fauldhouse ante/post natal programme as this was not well attended due to the provision of a similar programme through Surestart. The Infant Feeding Advisor programme and the Stay Safe should continue to be funded with increased funding to develop the programme further and cover the increase of costs of equipment. All additional funding will go towards equipment and not staffing increases.

19. **CARER INFORMATION STRATEGY FUNDING**

GC talked to the paper recommending the Sub Committee approve the West Lothian CHCP action plan to address the implementation of the national strategies Caring Together and Getting it Right for Young People strategies launched in July 2010.

The key focus of both strategies is that of carers being empowered to have the confidence and emotional and physical wellbeing to enable them to manage in their caring role.

The year 4 funding for West Lothian CHCP is £95000 (20.2%) of the total monies allocated to NHS Lothian.

This work will focus on 50 young carers who will have timely access to support as requited to promote their health, wellbeing and safety and their ability to fulfil their potential. Continued work with Minority Ethnic Carers of Older People Project (MECOP) to follow on with the actions identified through the scoping work carried out in 2010/11.

The Sub Committee is happy to support the action plan.
20. SCHEDULE OF DATES FOR SUB COMMITTEE MEETINGS 2012

A paper reporting the proposed meeting dates for 2012 taking into consideration an attempt to maintain 2 – 3 weeks interval between the Board and Sub Committee and the requirement to meet at least 6 times a year was discussed and no objections were received.

21. ANY OTHER COMPETENT BUSINESS

No other business was discussed.

22. DATES AND VENUES OF FUTURE MEETINGS 2011

Meeting dates for 2011

13th October 2011
24th November 2011

The meeting closed at 3.50pm
1. **MINUTE OF MEETING OF THE BOARD - 28TH JUNE 2011**

   The Board approved the Minute of its Meeting held on 28th June 2011 as a correct record.

   In relation to Item 2(c) on page 551 of the Minute, it was agreed that Board Members should be provided with the dates of expiry of the remaining premium rate telephone contracts.

   In relation to decision 2 of Item 14 on page 556 of the Minute, it was noted that Board Members had not received an early alert in relation to the financial problems of Choices Care Limited, and it was agreed that arrangements should be put in place to ensure that early notification should be made to Board Members in similar circumstances in future.

   In relation to decision 2 of Item 9 on page 553 of the Minute, it was noted that the information remained outstanding, and that the CHCP Director would ensure that it was provided to Board Members.

2. **RUNNING ACTION NOTE**

   The Board considered the Running Action Note (which had been circulated).

   **Decisions**

   1. To note that Items 1 and 2 were still in progress.

   2. To agree that Item 3 was completed and should be deleted.

   3. To agree that the Running Action Note should be updated accordingly.

3. **MINUTE OF MEETING OF THE PRIMARY AND COMMUNITY PARTNERSHIP COMMITTEE OF NHS LOTHIAN BOARD - 13TH JULY 2011**

   The Board noted the Minute of the Meeting of the Primary and Community Partnership Committee of NHS Lothian Board held on 13th July 2011.
It further noted that the Primary and Community Partnership Committee had now ceased to exist, and that its remit had been divided between the Service Redesign Committee and the Finance and Performance Review Committee.

In relation to Item 37.1.3, it was noted that there was work underway at a national level to assess costs and liabilities.

4. **MINUTE OF MEETING OF THE WEST LOTHIAN COMMUNICATIONS GROUP - 26TH MAY 2011 -**

The Board noted the Minute of the West Lothian Communications Group Meeting held on 26th May 2011.

5. **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 her meeting with the Chief Executive of West Lothian Council, the business of and NHS Lothian representation on the St John’s Hospital Stakeholders Group, and the visit carried out to the Sexual Health Clinic at Howden on 5th August.

**Decision -**

To note the contents of the report.

6. **SCHEDULE OF DATES FOR FUTURE CHCP BOARD MEETINGS -**

The Board considered a report (which had been circulated) by the CHCP Director proposing a schedule of meetings for the Board for the calendar year 2012. The Clerk advised that there was a potential overlap of business with council committee meetings on 10th January, but that otherwise the dates did not coincide with scheduled meetings of council committees or other bodies.

The Chair advised the Board that after the meeting proposed to be scheduled for 10th April 2012 she would be stepping down from the Board, since at that date the position of Chair would pass to a nominee of the council.

**Decision -**

To agree the proposed schedule of meetings for 2012.

7. **RESPONSE TO REVIEW OF COMMUNITY HEALTH PARTNERSHIPS BY AUDIT SCOTLAND -**

The Board considered a report (which had been circulated) by the CHCP Director proposing a response to be sent in the name of the Board to Audit Scotland in response to its review of community health partnerships which had been published in June 2011. It was recommended that the proposed
response by approved by the Board for inclusion in a Lothian-wide response.

The report set out the background to the review by Audit Scotland, and it listed the key messages and recommendations, with the proposed response to be sent on behalf of the CHCP Board. The CHCP Director advised that it was not felt that the recommendations and conclusions of the review reflected the good practice and close working relationships which were present in the West Lothian CHCP.

A completed self-assessment form designed to record and improve joint working between health and social care services was attached as an appendix to the report.

Decision -

To approve and support the CHCP response to the Audit Scotland Review, for inclusion in a Lothian-wide response.

8. WEST LOTHIAN HEALTH AND WELLBEING PROFILE -

The Board considered a report by the Clinical Director (which had been circulated) providing an update on the Health and Wellbeing Profile of the population of West Lothian, and highlighting the good work being carried out to address health inequalities.

The report provided some background to the overall aim of the CHCP, the areas on which the CHCP actions were focussed and the challenges to improving health in West Lothian. The report explained those challenges, and the role played by the Life Stages Outcomes Planning Model in delivering quality of life improvements and tackling health inequalities.

The Health and Wellbeing Profile as at June 2011 was attached as an appendix to the report.

The Board was invited to comment on the content and format of the report, and to remit it with recommendations to the CHCP Sub-Committee for actions to be incorporated into the CHCP workplan.

Decisions -

1. To note the report and the good work being carried out to address health inequalities.

2. To agree that a report in this format should be published annually.

3. To note that the Chair and the CHCP Director would consider what information would be useful to provide to West Lothian Licensing Board to inform its policy and decision making.

9. INCIDENCE AND TREND DATA FOR BREAST CANCER IN WEST LOTHIAN -

The Board considered a report by the Consultant in Public Health
Medicine (which had been circulated) summarising data in relation to the incidence of breast cancer in West Lothian, Lothian and in Scotland and the uptake of breast screening services.

The table containing detailed information in relation to those matters was produced in the appendix to the report. The report advised that the numbers of cancers documented in West Lothian for any individual year were relatively small and fluctuated, which would influence the reliability of conclusions to be drawn from the data. The report went on to summarise the data, and to draw comparisons between West Lothian, Lothian and national figures.

Decisions -

1. To note the report and the findings in the appendix.

2. To agree that a further report should be brought to the Board in relation to the variance between uptake of breast screening in West Lothian and elsewhere, and with additional information about breast cancer in the male population.

3. To note that the Chair and the CHCP Director would consider inviting MacMillan Cancer Support to make a presentation to a future meeting of the Board.

10. JOINT COMMISSIONING PLANS -

The Board considered a report by the CHCP Director (which had been circulated) advising the Board of the development of an over-arching strategy for the joint commissioning of health and care services in West Lothian, outlining the approach to be taken in subsequent development of a series of care group commissioning plans, and the intention to engage with all key stakeholders, including service users, carers and service providers, in drafting and developing those plans.

The report explained the definition of "commissioning", the elements of that definition and provided an outline of the commissioning process as a fundamental component in the effect of delivery of health and social care services. It explained the long term view taken by the Joint Commissioning approach, and referred to the national guidance available from the Social Work Inspection Agency and Joint Improvement Team.

The report went on to set out the West Lothian perspective, the need for close partnership working and the joint approach between the council and NHS Lothian, and the way in which it was proposed to develop that existing partnership working towards a Commissioning Strategy, its regular revision, and the development through the strategy of joint commissioning plans.

The draft Joint Health and Social Care Commissioning Strategy 2011-2021 was produced in appendix 1 to the report, and the proposed template for Care Group Joint Commissioning Plans was produced in appendix 2.
The Board was asked to approve the over-arching commissioning strategy, and the subsequent development of care group commissioning plans.

Decisions -

1. To note the draft over-arching commissioning strategy and proposals for the development of care group commissioning plans.

2. To note the advice from the Clerk that if the proposals represented a change to an existing council policy then that would require approval through the council's PDSP arrangements and at Council Executive.

3. To agree to support the approach to joint commissioning in principle.

4. To agree that consideration of the report would be continued to the next meeting of the Board to allow the CHCP Director to consider whether alternative reporting and authorisation paths should be following in the respective partner organisations.

5. To agree that in the meantime members of the Board with reservations about the report and its terminology should pass comments to the CHCP Director with any suggestions for alternative wording.

11. RESHAPING CARE FOR OLDER PEOPLE - UPDATE -

The Board considered a report by the CHCP Director (which had been circulated) informing the Board of the progress of West Lothian's Change Fund Plan, Reshaping Care for Older People.

The report explained the provision of the Change Fund by the Scottish Government, and the allocation made to West Lothian, and went on to explain the development and submission of Change Plans by local partnerships. The West Lothian Change Plan was produced in appendix 1 to the report, built around individual projects on integrated universal care at home re-ablement service, integrated patient pathways for long term conditions, out of hours crisis response and care management service, technology, and community capacity building.

The report advised that the Scottish Government had approved the West Lothian Change Plan, and that a programme board had been set up to provide leadership and governance in its implementation. It went on to explain that three of the five projects had been formulated through appropriate project management documentation, and that the remaining two projects would be completed in that way within the near future. The report concluded by explaining the monitoring and performance measurement arrangements which had been put in place and the way in which finance for the programme was being held and applied.

Decision -

To approve the contents of the report.
12. **SOUTHERN CROSS CARE HOMES** -

The Board considered a report (which had been circulated) by the Acting Head of Council Services providing an update on the current position in West Lothian in relation to Southern Cross Health Care, Care Homes, the contingency planning arrangements to support continuity of care of service users, and the reassessment process in place to support a transition to new service providers.

The report summarised the financial difficulties experienced by South Cross Health Care, its apparent insolvency, and the plans for transfer of the care homes operated by the company in West Lothian to new service providers. It explained that the council had developed a comprehensive contingency plan to ensure that satisfactory arrangements were in place to safeguard the interests and welfare of the care home residents and to ensure continuity of care. The up to date provision in relation to the three care homes in West Lothian was summarised. The report concluded by explaining that a re-assessment was being arranged for every resident to ensure that the new service provider was clear about the service required of them, and that advocacy and support was being provided to service users and their families during the transition process.

**Decision** -

To note the contents of the report.

13. **BEST VALUE REVISED GUIDANCE** -

The Board considered a report by the CHCP Director (which had been circulated) informing Board Members of the revised guidance on "Best Value" issued by the Scottish Government on 6th April 2011. The report summarised the best value regime and the guidance with which public bodies in Scotland were expected to comply.

The best value assurance statement by NHS Lothian Audit Committee dated 21st June 2011 was included in appendix 1 to the report, the statement of the current position against best value characteristic was produced in appendix 2, and the revised guidance was attached as appendix 3.

**Decisions** -

1. To note the new guidance on Best Value.

2. To agree that members of the Board should pass any questions on the terms of the guidance to the Chair who would forward them to the Corporate Governance and Value for Money Manager for NHS Lothian for a response.
14. **CLINICAL GOVERNANCE - QUALITY AND OUTCOMES FRAMEWORK**

The Board considered a report (which had been circulated) providing an update on the government arrangements in General Practice for the Quality Outcomes Framework (QOF).

The report set out the background to the QOF, the purpose of the programme and the rewards available for those practices who chose to participate on a voluntary basis. The indicators used in the framework would explain, and detail was provided of the measure of "prevalence", with comparisons between West Lothian and the national position.

The report concluded by summarising the changes in the QOF for 2011/12.

**Decisions -**

1. To note the terms of the report.

2. To agree that a report should be brought to the Board in relation to the CHCP QOF data which was presently subject to embargo, and in relation to proposed CHCP QOF performance indicators.

15. **CARE GOVERNANCE - CARE AT HOME SERVICES - QUALITY ASSURANCE**

The Board considered a report by the Acting Head of Council Services (which had been circulated) to advise the Board of the inspection framework undertaken by Social Care and Social Work Improvement Service (SCSWIS) in relation to care at home provision.

The report set out the way in which the new agency operated its registration and inspection processes and the grading system applied at the end of those inspections.

The report concluded by advising that the quality of care at home services for West Lothian clients was high, with 80% of all grades obtained being either "very good" or "good".

**Decisions -**

1. To note the report and the proposal that an annual summary report on SCSWIS inspection reports in presented to the Board.

2. To agree that the proposed summary report should be brought to the Board on the bi-annual basis.

16. **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 the council, information was provided on mandatory training in social policy, and in relation to health services, on Electronic Knowledge and Skills framework and the NHS Lothian internal audit report on lone working arrangements.

Decision -

To note the contents of the report.

17. 2011/2012 REVENUE BUDGET MONITORING REPORT AS AT 30 JUNE 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 30 June 2011.

The report advised that the anticipated draft outturn for the CHCP was a breakeven position.

In relation to the overall Social Policy budget, the forecast was for breakeven.

The report outlined the reasons for the outturn position, and the main pressure areas for the council budget.

The report indicated that the forecast for NHS Lothian's share of the CHCP budget was for break even to the end of March 2012.

The report went on to explain the pressure areas for the council and NHS Lothian elements of the CHCP budget.

Decision -

To note the draft 2011/12 outturn position for the CHCP budget.

18. 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 Board meeting.

The Board was advised of work carried out in relation to the CHCP website, a revision of report templates for committees, the official opening of Pathways at Quigley House, a forthcoming ministerial visit and the receipt of a draft reports form SCSWIS following its recent inspection. The CHCP Director advised that the draft report raised no areas of significant concern, and that a more detailed report would be available for the next Board meeting.

Decision -

To note the contents of the report.
CHAIRMAN’S REPORT TO LOTHIAN NHS BOARD

1. Internal

1.1 Celebrating Success - On 29 September I joined other Non-Executive Board members in hosting a table at the Celebrating Success staff awards. It was good to see continuing staff enthusiasm for this event, and to welcome the sponsors who are funding a growing proportion of the costs.

1.2 Visits - My visit destinations in this period included Edinburgh CHP and St John’s Hospital.

1.3 Mid Year Reviews - Mid-term reviews were carried out in this period for the Chief Executive and almost all Non-Executive Board members.

1.4 MSP Briefing - The Board’s quarterly MSP briefing took place on 18 November.

2. External

2.1 Annual Review - This year NHS Lothian was one of the Health Boards asked to conduct its Annual Review without attendance by the Cabinet Secretary. Feedback from attendees at our resulting Review on 27 October was positive, with a general view that the Board was being held to account in an effective manner by the public we serve.

2.2 Consort Board - On 3 October I attended the NHS Lothian/Consort joint Board. The Board has oversight of the joint working at the Royal Infirmary site.

2.3 Sustainable Cities - On 29 September, at the invitation of the City of Edinburgh Council (CEC), I joined NHS Lothian Public Health staff at a Sustainable Cities meeting. This examined the potential for sustainable local food provision to public bodies. NHS Lothian now has an invitation to participate in a pilot with CEC and the University of Edinburgh to assess the nutritional, economic, and environmental value of local food provision to locally hosted test sites. Meetings with management will shortly review the proposal.
2.4 Relaunch of Organ Donation Programme - On 25 October the Cabinet Secretary for Health and Wellbeing relaunched the National Organ Donation Programme at the Royal Infirmary. The media event was attended by clinicians and patients.

2.5 Wester Hailes - A turf cutting ceremony by the Cabinet Secretary took place on 14 November at the site of the Hub-funded Wester Hailes centre. This will house community services, including a GP practice.

2.6 Edinburgh Garrison Commander – At his request, on 17 November the new Edinburgh Garrison Commander, Colonel Bates, visited me to introduce himself and discuss issues of mutual interest.

2.7 Code of Practice - I attended a workshop on the new code of practice for Ministerial Appointments to Public Bodies on 8 November, hosted by the Commissioner for Scottish Public Appointments. The new code requires more consistency of process.

2.8 Chairs Group - Colleagues may wish to note that I have been asked by fellow Chairs to take over the role of ‘Chair of Chairs’ from January 2012 for up to two years. The holder of the role is expected to act as a conduit for views from Boards to the Scottish Government, liaising with the Chair of the Chief Executive’s group. I will also help co-ordinate Board representation on national committees/groups and chair the monthly meetings of national Chairs.

Charles Winstanley
Chairman
10 November 2011
CHIEF EXECUTIVE’S REPORT

1. Local Initiatives

1.1 Celebrating Success Awards – Along with many Board colleagues, I was delighted to attend the annual Lothian Celebrating Success Awards on September 30. The Chairman and I presented awards in ten different categories and, as always, the quality of the shortlist from which winners were drawn was extremely high. The evening benefitted from a wide range of sponsors including University of Edinburgh, College of Medicine and Veterinary Medicine, NHS National Education for Scotland, Unison Lothian Health Branch, Edinburgh Napier University, the Royal College of Midwives, Ernst and Young and Munro Consulting. The evening was once again a great success and has been followed by very positive feedback from staff and those present on the evening.

1.2 Achievements of NHS Staff – Board members will wish to note that staff across NHS Lothian continue to win national awards. NHS Lothian’s IT Team was awarded IT Service Delivery Team of the Year award at the National eHealth awards in London. The PET/CT Team at the Royal Infirmary of Edinburgh was awarded Team of the Year for Scotland by the Society of Radiographers and will collect their Certificate at a ceremony at the House of Commons in November. Anne-Marie Nisbet, who works in the Imaging department at the Royal Infirmary of Edinburgh was awarded the title of Radiographer of the Year for Scotland 2011. Morag Barrow and the Tele-Pulmonary Rehabilitation Team for NHS Lothian have won a national British Lung Foundation award for their work. Libby Tait and our Lean team won the Best Poster award at the Institute of Health Management Conference held on October 4. A medical team from NHS Lothian have been honoured in the Military and Civilian Health Partnership Awards being recognised twice for their innovative work in providing healthcare for the Armed Forces, their families and veterans. They received two awards - one in mental health care and one for the care of veterans for the Veterans First Point (V1P) services, based in Edinburgh. NHS Lothian staff have also been shortlisted in the Innovation in Mental Health category for the Health Services Journal Award.

Finally at the Daily Record Scottish Health Awards on 10 November, NHS Lothian staff were successful in the following categories:

Care at Home Award – Intensive Home Treatment Team, NHS Lothian
Doctors Award – Dr Thanos Tsirikos, spinal surgeon, Royal Hospital for Sick Children, NHS Lothian

Nurses Award – Sharon McMenemy, charge nurse, Mother and Baby Unit, St John’s Hospital, NHS Lothian

Quality Improvement Award - Dr Nicholas L Mills, Royal Infirmary of Edinburgh, NHS Lothian

We were also shortlisted in the following categories.

Care for Mental Health Award – CAMHS Intensive Treatment Service, NHS Lothian.

Doctors Award - Dr Enrique Garrido, spinal surgeon, Royal Hospital for Sick Children, NHS Lothian.

Quality Improvement Award – The Women’s Clinic, Spittal Street Centre, NHS Lothian

1.3 Visit to Royal Infirmary of Edinburgh and Clinical Research Imaging Centre - In the company of Jackie Sansbury, Chief Operating Officer, I visited the Royal Infirmary of Edinburgh Renal services on September 30. I met colleagues from the Renal ward and those active in outpatient dialysis, as well as a number of patients. Of particular interest is our work in counselling elderly patients who may be faced with the need to undergo dialysis. I also toured the Clinical Research Imaging Centre with University colleagues, including Professor David Newby and Professor Edwin van Beek, who is the University Chair of Radiology. The Centre offers unrivalled imaging capability including a magnetic resonance scanner, a high specification computer tomography scanner and positron emission tomography. This is complemented by an on-site cyclotron and on-site radiopharmacy. The Centre is at the cutting edge of clinical research using state-of-art equipment, which benefits patients both diagnostically and in respect of future applications of the service.

2. Regional Initiatives

2.1 Healthy Working Lives – I was delighted to be invited to present Health Working Lives awards to representatives of some thirty-four organisations on November 8. These are very important awards since they demonstrate how employers across the Lothian area are securing better health outcomes for staff through actively promoting health and well-being in the workplace. I am delighted that NHS Lothian secured Gold awards for St John’s Hospital and for Waverley Gate, Silver awards for the East and Midlothian CHP, the Royal Edinburgh Hospital and West Lothian CHCP and Bronze awards for the Lauriston Building, the Princess Alexandra Eye Pavilion and for the Western General Hospital.

James Barbour
Chief Executive
15 November 2011
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents clinical effectiveness measures to assess the quality of stroke and surgical care in NHS Lothian as set out in the timetable previously agreed by the Board in September 2011. As scheduled, the core quality measures will be reported to the Board along with cancer clinical effectiveness measures in January 2012.

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

2 Recommendations

The Board is asked to:

2.1 Review the quality measures presented.

3 Discussion of Key Issues

3.1 Over the course of the year it has been agreed that a priority area will be considered at each board meeting (diabetes, stroke, CHD, 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.

3.2 For the November report, stroke and surgical profiles are considered.

3.3 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.

3.4 Stroke Effectiveness Measures

The stroke effectiveness measures show that Lothian has a lower mortality rate from stroke than Scotland and a similar level for premature mortality. With the exception of thrombolysis of acute ischaemic stroke, Lothian does not meet the
NHS Health Improvement Scotland (HIS) standards, which is similar to the position across Scotland as a whole.

The measures presented for stroke include mortality and measures from the NHS HIS standards which are evidence-based interventions to improve outcomes:

1. Age and sex standardised mortality rate per 100,000 population;
2. Age and sex standardised premature mortality rate per 100,000 population;
3. Percentage of patients admitted to an Acute Stroke Unit (ASU) on the day of or day following presentation at hospital;
4. Percentage of patients who have a swallow screen on day of admission;
5. Percentage of patients who have a brain scan on the day of admission;
6. Percentage of patients who receive aspirin on the day of admission or the day following admission;
7. Percentage of patients who are seen at stroke/TIA clinic within 7 days of receipt of referral;
8. Percentage of patients who receive a bolus of thrombolytic therapy within one hour of arrival at hospital;
9. Rate of patients per 100,000 population who receive thrombolysis.

Figure 1 shows that Lothian has a lower mortality rate from stroke than Scotland overall when these data are adjusted for age and sex. The rate has reduced since 2000. Figure 2 shows a similar trend for premature mortality from stroke.

**Figure 1: Age and sex Standardised Mortality Rate per 100,000 population for cerebrovascular disease for Lothian and Scotland (both sexes) (2000-2009)**

Source: ISD Scotland. Available at: http://www.isdscotland.org/Health-Topics/Stroke/Topic-Areas/Mortality/
Figure 2: European Age Standardised Mortality Rates per 100,000 Population for those under 75 years for cerebrovascular disease Lothian and trend towards target* (1995-2009)

Cerebrovascular Disease; Ages Under 75; European Age Standardised Mortality Rates per 100,000 Population

0.0 5.0 10.0 15.0 20.0 25.0 30.0 35.0 40.0
Rate per 100,000 Population

Both Sexes European Age Standardised Rate of Mortality — Both Sexes Trend to Target

Source: ISD Scotland. Available at: http://www.isdscotland.org/Health-Topics/Stroke/Topic-Areas/Mortality/

* Targets for reductions in deaths from cerebrovascular disease were set out in the 1999 'White Paper Towards a Healthier Scotland'.

Tables 1 and 2 show that, with the exception of the rate of patients receiving thrombolysis of acute ischaemic stroke, Lothian does not meet the HIS standards for stroke care, which is similar to the position across Scotland as a whole.

Table 1: Key measures for effectiveness of stroke care for Lothian and Scotland (2009 and 2010)

<table>
<thead>
<tr>
<th>Measure</th>
<th>HIS Standard (%)</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of stroke unit admissions on the day of presentation at hospital</td>
<td>60</td>
<td>29</td>
<td>37</td>
</tr>
<tr>
<td>Percentage of stroke unit admissions on the day of admission, or the day following presentation at hospital</td>
<td>90</td>
<td>54</td>
<td>61</td>
</tr>
<tr>
<td>Percentage of swallow screens on day of admission</td>
<td>100</td>
<td>61</td>
<td>62</td>
</tr>
<tr>
<td>Percentage of brain scans on day of admission</td>
<td>80</td>
<td>67</td>
<td>49</td>
</tr>
<tr>
<td>Percentage of patients receiving aspirin treatment on the day of admission or the following day</td>
<td>100</td>
<td>82</td>
<td>63</td>
</tr>
<tr>
<td>Percentage of new patients seen within 7 days at TIA clinic</td>
<td>80</td>
<td>89</td>
<td>81</td>
</tr>
<tr>
<td>Percentage of patients who receive a bolus of thrombolytic therapy within one hour of arrival at hospital</td>
<td>80</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

3.4.1 A substantial programme of work has been underway in 2010 and 2011 to address this. This has included a 5x5x5 project and a major Lean work stream as part of the older people’s pathways work. Examples of improvement actions are as follows:

- A trial of direct admissions to stroke units and agreement to manage acute stroke unit beds across the three acute hospital sites;
- Daily “staff huddles” to ensure patients are moved on without delay and to allow stroke unit beds to become available each day;
- Implementation of a ‘stroke checklist’ to prompt personnel at the front door to contact the stroke team, request scans earlier and deliver appropriate urgent care;
- Training nursing staff at the ‘front door’ to undertake and record swallow assessments;
- Establishment of a system to ensure that results of brain scans are available immediately;
- Splitting the single outpatient clinic day for SJH (with two consultants) onto two days and offering patients an appointment at the WGH clinic if they can’t be seen within seven days at SJH;
- A ‘FAST’\(^1\) public awareness campaign, establishment of a pre-hospital thrombolysis protocol agreed with the Scottish Ambulance Service and production of a thrombolysis awareness package for the web;
- The establishment of a 24/7 telestroke consultant rota enables GPs, Scottish Ambulance Service and front door clinicians immediate access to expert advice. This service ensures inappropriate referrals are reduced and those with stroke can be dealt with urgently;
- The Stroke Pathway Management Team (SPMT) has proposals on how job plans can be developed to ensure appropriate input to stroke from the constituent clinical groups and this will be led by Tim Montgomery with Directors of Operations for the other services involved.

3.4.2 The latest unpublished data indicate that there is an improvement in Lothian’s performance across the HIS standards. The standard in relation to stroke unit admissions on the day of admission, or the day following presentation at hospital has now become a HEAT target. There is confidence within the SPMT that not only will this target be met but that outcomes for patients will be improved and their recovery will be speedier. This is as a result of improvements in the operation of ward services which will be further improved with integrated units.

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\(^1\) Face - can they smile? Does one side droop? Arm - can they lift both arms? Is one weak? Speech - is their speech slurred or muddled? Time to call 999. See: [www.chss.org.uk/about_us/campaigns/fast.php](http://www.chss.org.uk/about_us/campaigns/fast.php)
From January to June the outpatient clinic data has been above 85%. The latest 12 month mean (August 2010 – July 2011) for all the standards (except aspirin within 1 day) has been above the 2010 figure.

3.5 **Surgical Effectiveness Measures**

The HCGRM committee received a summary of data on the quality of surgical care in Lothian at its October meeting. This followed the publication by Information Services Division/Healthcare Improvement Scotland of so-called ‘surgical profiles’ for each NHS Board in Scotland.

3.5.1 Overall these data demonstrate a high quality of surgical care in NHS Lothian. Nonetheless, in areas where Lothian’s hospitals appear to be doing less well, plans to investigate this further have been developed and submitted, as requested, to HIS. These plans were also reviewed by the HCGRM committee.

The full surgical profile contains tens of graphs; those reported below are some of the most ‘high level’ and show mortality rates, rates of major complications or other poor outcomes.

For the following measures NHS Lothian is within 2 standard deviations of the Scottish mean or, if outwith these limits, is below the mean, indicating a favourable performance. The hospitals for which the data are provided are indicated in brackets. All data are standardised and relate to patients admitted between 1st July 2009 and 30th June 2010.

- All specialties - Mortality within 30 days for non-elective patients (SJHL, WGH, RIE)
- Trauma and Orthopaedic Surgery - Mortality within 30 days for non-elective patients (RIE)
- Trauma and Orthopaedic Surgery - Rate of DVT/PE within 90 days (RIE)
- Trauma and Orthopaedic Surgery - Mortality rate within 30 days following hip fracture (RIE)

3.5.2 The following graphs show areas where NHS Lothian is an outlier in both ‘positive’ and ‘negative’ directions. All data are shown on ‘control charts’ where the horizontal line represents the Scottish mean and the curved lines represent 2 (inner set) and 3 (outer set) standard deviations from the mean.

3.5.2.1 **All specialties**

For all surgical specialties, the mortality rate for elective patients is below the Scottish mean for all three Lothian hospitals (Figure 1).
3.5.2.2 General Surgery

For elective general surgery the mortality rate in Lothian is better than across Scotland as a whole; at both WGH and RIE the rates are 3 standard deviations away from the Scottish mean (i.e. below or on the lower ‘control limit’) (Figure 2). For emergency general surgery, the rate at WGH is also 3 standard deviations away from the Scottish mean; the RIE’s mortality rate remains with control limits (Figure 3).

The rate of DVT/PE for general surgical patients is higher than the Scottish mean for WGH and RIE; the WGH is 2 standard deviations away and the RIE is 3 standard deviations away (Figure 4). This indicates the requirement for further investigation of these data. This is ongoing and includes analysis of data in relation to imaging for DVT/PE in order to exclude the possibility that Lothian diagnoses these conditions at a higher rate than other Boards. A review of the SIGN guideline in relation to prevention of DVT/PE is also being undertaken.

The rate of emergency re-admission to any specialty within 28 days is within control limits for SJHL and WGH (Figure 5). The rate for RIE is out with the upper control limit, again indicating the requirement for further investigation. The rate for re-admission to surgery (rather than any specialty) is lower (data not shown), suggesting that some of these patients may be assessed and discharged without the requirement for further emergency surgical intervention. Further work on this includes an audit of some of the highest volume pathways to better understand who is re-attending.
The rate at which permanent stomas are created during surgery for rectal cancer (a poor outcome of care) is below the Scottish mean for WGH (where the majority of these procedures are performed) and similar to the Scottish mean for RIE (Figure 6). The high volume of these procedures carried out at WGH compared to other centres should be noted here.

Figure 2: General Surgery Standardised Mortality Ratio within 30 days of admission by hospital for elective patients admitted between 1st July 2009 and 30th June 2010. Shaded circles indicate (from left to right) WGH and RIE.

Figure 3: General Surgery Standardised Mortality Ratio within 30 days of admission by hospital for non-elective patients admitted between 1st July 2009 and 30th June 2010. Shaded circles indicate (from left to right) WGH and RIE.
Figure 4: General Surgery Indirectly Standardised rate of Deep Vein Thrombosis/Pulmonary Embolism within 90 days by hospital for patients admitted between 1st July 2009 and 30th June 2010. Shaded circles indicate (from left to right) SJHL, WGH, RIE.

Figure 5: General Surgery Indirectly Standardised rate of emergency readmission within 28 days to any medical specialty by hospital for patients admitted between 1st July 2009 and 30th June 2010. Shaded circles indicate (from left to right) SJHL, WGH, RIE.
4 Key Risks

4.1 Not achieving the Healthcare Improvement Scotland stroke standards.

5 Risk Register

5.1 Ensuring timely patient access to a stroke unit is on the Medicine of the Elderly Clinical Management Team’s Risk Register.

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 The 5x5x5 report on stroke which includes actions to improve compliance against the HIS standards was subject to an impact assessment.

8 Involving People

8.1 The Stroke Managed Clinical Network has active patient involvement in a range of workstreams which are relevant to the compliance with HIS standards.
9 Resource Implications

9.1 There are no resource implications associated with this report.
NHS LOTHIAN: REPORT ON THE 2010/11 AUDIT

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with the external auditors’ report on NHS Lothian for 2010/11, completed by Audit Scotland.

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

2 Recommendation

2.1 The Board is requested to:

Note the report, the business risks identified within the document and the response and action deadlines contained within Appendix A to the report.

3 Key Issues

3.1 The work of the external auditors is primarily concerned with arriving at an opinion on the annual financial statements, however Audit Scotland’s responsibilities and remit also extends to providing a view on overall organisational performance, regularity and use of resources. This is done with the aim of supporting improvement in performance and accountability.

3.2 The Audit Committee received the report at its meeting of 11 October 2011.

3.3 The key messages from the report are:

- The external auditors have provided an unqualified audit opinion on the 2010/11 accounts, and have drawn attention to the Board’s position with respect to equal pay claims.
- The Board met its financial targets. The report summarises the key issues that have been, and require to be managed, in order to maintain this. The report also sets out the continuing and increasingly challenging financial climate that all of the public sector must respond to in terms of prioritisation of resources for delivery of key targets.
The Board’s high level corporate governance and control systems operated satisfactorily during the year. The auditors have commented that at operational level there are issues with compliance on general and financial operating procedures upon which action is being progressed.

The report from the auditors highlights the Board’s commitment to and arrangements for securing Best Value in its use of resources.

The Board has key risks that need to be managed, and these are summarised in the Action Plan on pages 36-40 of the report. Management’s response to these issues is also summarised in the Action Plan.

4 Key Risks

4.1 The report highlights risks that populate the Board’s corporate and Finance directorate risk register and the management responses in the report addresses how these risks are to be managed.

5 Impact on Health Inequalities, Equality and Diversity

5.1 The report itself has no impact on inequalities, although the activities of the Board do. The report acknowledges that the Board’s corporate objectives include addressing health inequalities, as well as the progress made in achieving these targets, e.g. smoking cessation, alcohol interventions. It also highlights the Mutuality and Equality Governance role within the overall framework of governance in managing the board’s responsibilities in this area.

6 Involving People

6.1 The report has already been circulated in draft form within the Finance directorate and the final report was reviewed by Audit Committee at its meeting on 11 October 2011.

7 Resource Implications

7.1 The report summarises key issues of financial governance for the Board as at July 2011 that are replicated on the Corporate Risk Register.

Susan Goldsmith
Director of Finance
15 November 2011

List of Appendices

Appendix 1: Annual Report on the 2010/11 Audit
Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Government and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.
Key Messages

2010/11

In 2010/11 we looked at the key strategic and financial risks being faced by NHS Lothian. We audited the financial statements and we also reviewed the use of resources and aspects of performance management and governance. This report sets out our key findings.

Financial statements

We have given an unqualified opinion on the financial statements of NHS Lothian for 2010/11. We have also concluded that in all material respects, the expenditure and receipts shown in the financial statements were incurred or applied in accordance with applicable enactments and relevant guidance, issued by Scottish Ministers.

Financial position and use of resources

The board carried forward a surplus of £0.146 million. This together with the surplus achieved during 2010/11 of £0.152 has resulted in a cumulative surplus of £0.298 million relative to a Revenue Resource Limit (RRL) of £1.192 billion. The outturn position against the RRL has been achieved through the delivery of a cash efficiency savings programme including, workforce reductions, slippage of developments, a reassessment of provisions and slippage on new allocations.

NHS Lothian’s 2010/11 financial plan included a £37.2 million efficiency savings target. At the year end, all planned savings were achieved. However, of the total savings achieved, some £4.1 million were non-recurrent savings and will have to be re-provided in the 2011/12 financial plan.

Capital expenditure during the year amounted to £90.5 million which equalled the capital resource limit. Key areas of the programme included the completion and bringing into operation the new Public Private Partnership funded Midlothian Community Hospital in September 2010 (£18 million) and the re-provision of the Royal Victoria Hospital (£11.2 million).

Scotland’s economy continues to be adversely affected by the economic downturn. The pressure on the public sector has intensified as a result of the measures announced in the UK Comprehensive Spending Review in October 2010 and the Scottish Government’s budget in February 2011. In the current economic climate difficult decisions will have to be made across the public sector to determine priorities. There will be significant challenges to prioritise spending, identify efficiencies and review commitments to ensure delivery of key targets and objectives and manage financial pressure.
Performance and best value

Sound processes and systems are in place for monitoring against the Local Delivery Plan targets and internal standards. The board achieved many of its HEAT targets and internal standards. However, there remains a continued issue around maintaining targets over the course of each year. We noted that action continues to be taken to address problem areas and the board considers it is well placed to meet targets in due course.

During 2010/11 the Lean in Lothian programme has focused on the delivery of improved patient pathways in older people’s services. To date, management have estimated that the Lean in Lothian programme has supported achievement of £6.5 million in increased productivity/cost avoidance/cost savings. The programme continues to provide significant positive impact on efficiency and the patient experience without the need for significant funding.

Governance and accountability

Corporate Governance is concerned with the structures and process for decision making, accountability, control and behaviour at the upper levels of an organisation. Overall, the high level corporate governance and control arrangements for NHS Lothian operated satisfactorily during the year, as reflected in the Statement on Internal Control.

We examined the key financial systems underpinning the organisation’s control environment. We concluded that financial systems and procedures operated sufficiently well to enable us to place reliance on them.

Outlook

The position going forward is becoming even more challenging than previous years with limited increases in funding, increasing cost pressures and challenging savings targets. For 2011/12 the board is depending on achieving savings of £50.1 million, which is the fourth year in succession that the board has been required to make efficiency savings in order to maintain its financial position. This is particularly challenging given cost pressures arising from the effects of pay growth, increasing prescribing costs and volatile energy costs. In addition there continues to be a difference between actual funding levels and the recommendations from the National Resource Allocation Committee (NRAC) report (currently estimated to be circa £55 million).

The significant financial challenges that the board will face in 2011/12 and beyond will require the board to prioritise its use of resources. This will make maintaining or improving on the performance targets set by the Scottish Government even more challenging.

The achievement of the board’s 2011/12 cost savings plan will require a further reduction in staff numbers of approximately 734 Whole Time Equivalents (WTEs). It is important that this process is well managed and aligned with business and financial plans. In particular, the board should ensure appropriate knowledge and experience is retained among key officers to maintain the board’s capacity to deliver its services.
From April 2013 endowment funds may require to be consolidated within NHS Scotland boards’ financial statements. This means that the board may need to ensure that audited endowment fund figures are available for inclusion in the 2013/14 financial statements, with comparatives required for 2012/13.
Introduction

1. This report is the summary of our findings arising from the 2010/11 audit of NHS Lothian. The purpose of the annual audit report is to set out concisely the scope, nature and extent of the audit, and to summarise the auditor’s opinions (i.e. on the financial statements) and conclusions and any significant issues arising. The report is divided into sections which reflect our public sector audit model.

2. A number of reports have been issued in the course of the year in which we make recommendations for improvements (Appendix A). We do not repeat all of the findings in this report, but instead we focus on the financial statements and any significant findings from our wider review of NHS Lothian.

3. Appendix B is an action plan setting out the high level risks we have identified from the audit. Officers have considered the issues and agreed to take the specific steps in the column headed “planned management action”. We do not expect all risks to be eliminated or even minimised. What we expect is that NHS Lothian understands its risks and has arrangements in place to manage these risks. The board and Accountable Officer should ensure that they are satisfied with the proposed management action and have a mechanism in place to assess progress.

4. This report is addressed to the board and the Auditor General for Scotland and should form a key part of discussions with the audit committee, either prior to or as soon as possible after the formal completion of the audit of the financial statements. Reports should be made available to stakeholders and the public as audit is an essential element of accountability and public reporting.

5. This report will be published on our website after consideration by the board. The information in this report may be used for the Auditor General’s annual overview of the NHS in Scotland’s performance later this year. The overview report is published and presented to the Public Audit Committee of the Scottish Parliament.

6. The management of the board is responsible for preparing financial statements that show a true and fair view and for implementing appropriate internal control systems. Weaknesses or risks identified by auditors are only those which have come to our attention during our normal audit work, and may not be all that exist. Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.
Financial Statements

7. Audited bodies’ financial statements are an essential part of accounting for their stewardship of the resources made available to them and their performance in the use of those resources.

8. Auditors are required to audit financial statements in accordance with the timescales set by Audit Scotland, which may be shorter than statutory requirements, and give an opinion on:
   - whether they give a true and fair view of the financial position of audited bodies and their expenditure and income
   - whether they have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements
   - the regularity of the expenditure and income.

9. Auditors review and report on, as appropriate, other information published with the financial statements, including the Director's Report, statement on internal control and the remuneration report. This section summarises the results of our audit of the financial statements.

Audit opinion

10. We have given an unqualified opinion that the financial statements of NHS Lothian for 2010/11 give a true and fair view of the state of the body's affairs and of its net operating cost for the year.

11. NHS Lothian is required to follow the 2010/11 Government Financial Reporting Manual (the FReM) and we confirm that financial statements have been properly prepared in accordance with the FReM.

12. We have also reviewed the board's statement on internal control and concluded that it complies with Scottish Government guidance.

Regularity

13. The Public Finance and Accountability (Scotland) Act 2000 imposes a responsibility on auditors that requires us to certify that, in all material respects, the expenditure and receipts shown in the accounts were incurred or applied in accordance with applicable enactments and guidance issued by Scottish Ministers. We have been able to address the requirements of the regularity assertion through a range of procedures, including written assurances from the Accountable Officer as to his view on adherence to enactments and guidance. No significant issues were identified for disclosure.
Accounting Issues

14. A full set of accounts was due to be presented for audit on 9 May 2011. While a set of draft template accounts were provided for audit on 11 May, these contained some outstanding issues. A full version of the draft accounts was presented on 16 May. There were some challenges for the board in providing a complete and balanced set of accounts; this was partly due to the requirement to complete the review of asset lives. As a consequence, some working papers were not always available for audit review when required. This led to delays in the audit process. However, the standard of the supporting papers was generally satisfactory and responses from NHS Lothian staff allowed us to conclude our audit within the agreed timetable and provide our opinion to the audit committee on 21 June 2011 as outlined in our Annual Audit Plan.

15. Several items were identified during the audit, where if adjustments were made these would decrease the net operating costs and increase the saving against the Core Revenue Resource Limit by £2.131 million. The net impact on the balance sheet would be that net assets would increase by £2.131 million. While our preference would have been for these items to be adjusted for, it was agreed with management and the audit committee that no amendment would be processed in the financial statements.

16. As required by auditing standards we reported to the audit committee on 21 June 2011 the main issues arising from our audit of the financial statements. The key issues reported were as follows.

Trade Payables

17. During 2010/11 NHS Lothian received funding from the Scottish Government Health Directorate (SGHD) for specific projects which would largely require working with partners. Due to the nature of those projects the funding had not been spent by the year end. NHS Lothian has returned £1.9 million to the SGHD and has accrued expenditure to match the remaining income (£2.1 million) as a commitment to spend on specific projects in 2011/12. We considered this to be an over-accrual and included this amount within the summary of unadjusted differences.

18. Since 2008 an accrual of £167k has been rolled forward which relates to a building works legal dispute. There is a possibility that this accrual is no longer required and could be released for application to NHS Lothian services. In the absence of further information we are satisfied that NHS Lothian has adopted a prudent approach, retaining the accrual. We recommend however that management consider further during 2011/12 as to whether this accrual should be retained.

Trade Receivables

19. After many years of pursuit, in conjunction with the Practitioner Services Division (PSD), Central Legal Office and NHS Counter Fraud Service, NHS Lothian has received settlement of £450k for reimbursement of payments from an orthodontist practitioner. Dental payments fall into the category: Non Cash Limited and do not relate to the Revenue Resource Limit of NHS
Lothian. Management have advised us that previous overpayments have been retained by the relevant NHS board, in view of the efforts that an NHS board has to make to recover the monies. Management have provided assurances in their letter of representation that they can retain the £450k.

20. A number of receivables from NHS bodies are in dispute. These total £1.365 million, the most significant of which are NHS Fife £0.308 million, NHS Borders £0.490 million, NHS Ayrshire and Arran £0.308 million and NHS Lanarkshire £0.135 million. In view of the disputes there is a risk of non-recovery. We are advised that this relates to the phased implementation of the ‘East Coast Costing Model’ and discussions are continuing with board Directors of Finance to resolve any outstanding matters. There is a risk that trade receivables and income are overstated. Management have provided assurances on this matter.

21. There is an aggregate debt of £385k from GP practices, of which £115k is older than two years. The dispute relates to assigning responsibility for old VAT invoices. In 2009/10 a provision of £135k was considered to be appropriate by management. No provision for bad debt has been made in 2010/11. We consider this to be an under provision for bad debts and have therefore included this amount within the summary of unadjusted differences.

22. There are a number of trade receivables due from Consort, the PFI partner. One of these (£1.3 million) relates to car park and retail unit income. In 2009/10 there was a matching creditor as the debt was considered irrecoverable. However, there is no matching creditor in 2010/11 and management advise that agreement has been reached with Consort for £1.3 million to be paid over to NHS Lothian. Management have provided assurance in their letter of representation that the £1.3 million will be recovered.

Pay and Conditions Accrual

23. This was formerly known as the Agenda for Change accrual. The liability figure included in NHS Lothian’s financial statements at the year end is £12.5 million. There have been a number of significant movements in the accrual in 2010/11 and the overall impact is a net reduction of £9.1 million. The most significant movement, £10.9 million, relates to the reversal of accruals for Leavers’ Arrears and Review Arrears which the board has had in place for a number of years. Management has advised that additional pay costs have been borne in 2010/11 as a result of settling a number of cases. So whilst it is difficult to match the detail of the movement in the provision to additional pay spend in 2010/11, management are satisfied that the overall movement is in line with expectations. Management have provided assurances in their letter of representation to the completeness and robustness of the estimated accrual at 31 March 2011.

Inventories

24. Stockholdings of £14.3 million are recorded in the accounts. We reported in 2008/09 and 2009/10 that two stock areas (£0.9 million) were included in the accounts where validity test checks had not been undertaken in order to provide assurance as to their value. In 2010/11 no test counts were carried out of pharmacy stock (£450k) at the year end and management
decided to omit the figures from the balance sheet, and consequently recognise them fully through revenue. Other stock, for example, HSDU (which is subject to similar test count processes) continues to be recognised in the balance sheet. Management’s treatment of the pharmacy stock is inconsistent relative to previous years and not in line with expectations, relative to the board’s accounting policy in this area. We recommend management ensure processes are put in place to comply with the accounting policy for this area.

Cash Target

25. NHS Lothian achieved its cash target at 31 March 2011. However it was only achieved due to a number of late actions that had to be undertaken, including the acceleration of two payment runs, and return of a substantial figure of cash (not income) to the SGHD. The issue arose due to different interpretations of the monthly monitoring return (MMR) between the SGHD and NHS Lothian. We note that management have already taken steps to ensure consistent interpretation of the MMR.

Workforce reduction plan

26. We noted that NHS Lothian’s workforce reduction plan took effect in 2010/11, with a 762 WTE reduction. 48 members of staff have accepted voluntary severance at a cost of £1.9 million, of which £1 million was included as a provision in the financial statements.

Equal pay claims

27. NHS Trusts in England have settled equal pay claims for employees in traditionally female roles and similar claims have been received by boards in Scotland. NHS bodies should evaluate the financial impact of any potential equal pay claims and make appropriate disclosure. By the end of March 2011, there were 1,665 grievances registered against NHS Lothian. Discussions have been held between Audit Scotland, the SGHD and the Central Legal Office (CLO). Due to the lack of movement in any cases, there is no additional information which would enable NHS Scotland to estimate the probability and value of the liability associated with these claims. Consequently these claims continue to be disclosed as an unquantifiable contingent liability in the notes to the accounts of NHS Lothian.

28. We continue to strongly encourage NHS Lothian, working with the SGHD, the CLO and other NHS boards to form a view of the potential liabilities as soon as possible taking into account the progress of cases in Scotland and England. As with other boards, NHS Lothian is unable to quantify the extent of its liability for equal pay claims. There is a risk that these liabilities could have an impact on the board’s financial position.

Risk Area 1

FHS income / expenditure

29. FHS income and expenditure accruals were compared to the outturn figures reported to NHS Lothian by NHS NSS after the statement of accounts had closed. The net impact on cash
limited and non cash limited expenditure was an under accrual of expenditure of £283k and £53k respectively, both of which were taken to the summary of unadjusted differences.

**Related party transactions**

30. In line with the NHS Manual, related party transactions must be disclosed in the accounts. At the time the draft accounts were passed to external audit the Register of Interests was not up to date and therefore there was no assurance over the completeness of the related party transaction note. The Register was updated on 10 June 2011 and following management review, the financial statements were amended to take account of disclosures made by officers.

**Prior year adjustments - cost of capital**

31. The 2010/11 FreM removed the requirement for boards to charge a notional cost of capital in their accounts. This was a change in accounting policy which was reflected in the financial statements of NHS Lothian with appropriate amendments made to prior year statements and to the 2010/11 funding allocation. As a consequence, £12.8 million cost of capital expenditure was no longer chargeable to the 2009/10 Revenue Resource Limit.

**Change in estimation of asset lives**

32. As a consequence of SGHD direction, the board conducted a review of the methodology for determining the useful life of assets. The exercise was carried out with the assistance of consultants appointed by the SGHD (PricewaterhouseCoopers LLP). The revised methodology takes account of patterns of consumption and maintenance and preservation spending. This approach aligns the lives of the less significant elements with the overall life of the building so that they can be depreciated over that period. As a result, the annual depreciation charge should reflect the pattern of consumption of the asset.

33. As noted in paragraph 14 above, the late notification from the SGHD to change the methodology led to a delay in completing the financial statements. NHS Lothian finance staff faced a significant challenge in commissioning, reviewing and accounting for the revised valuations. (The valuations were supplied by an independent valuer). The revised methodology resulted in a reduction in the board’s annual depreciation charge of £2.1 million. However, a further consequence of this change was that expenditure amounting to £3.4 million which had previously been capitalised as refurbishment or enhancement expenditure had to be reclassified as revenue expenditure because, in accounting terms, the acceptability of increased asset lives had to be accompanied by an increase in revenue maintenance costs.

34. Therefore, the net effect for NHS Lothian of asset re-lifing was an increase in revenue costs of £1.3 million. While we are satisfied as to the process followed by NHS Lothian working with the independent valuers, we note the impact on revenue costs and its potential impact on future expenditure. (Most other boards are reporting an overall decrease in costs). We have been advised by management that among the relevant factors are the condition of the estate and the nature of NHS Lothian’s capital refurbishment programme prior to the asset re-lifing.
exercise. We have therefore recommended that NHS Lothian continue to keep this area under review until accounting on this new basis becomes embedded in the ongoing capital accounting arrangements. While it has been agreed with the SGHD that these increased revenue costs will be funded from a transfer from capital resources in 2011/12, going forward, it will be a challenge for NHS Lothian to absorb these increased revenue costs.

PFI/PPP schemes

35. NHS Lothian has a number of PFI commitments which are disclosed in Note 23 in the accounts. Seven contracts are now reported on balance sheet including the Midlothian Community Hospital PFI project which was completed in September 2010 at a value of £18.170 million. The largest PFI scheme is the Royal Infirmary of Edinburgh (RIE) which has a capital value of £173 million with the remaining five projects (units for frail elderly and dementia patients and a primary care centre) ranging in capital value from £2.3 million to £3.6 million. The associated recurrent revenue cost of these schemes is £51 million with a total future commitment recorded in the balance sheet of £205 million.

Other issues

36. Our review of the Remuneration Report included within the financial statements highlighted one instance where the Remuneration Committee, which is responsible for reviewing the pay arrangements for senior managers within NHS Lothian, was provided late information on one matter.

Risk Area 2

37. We have raised in previous years with officers the need to improve the process for providing external audit with the accounts for certification. This year the board meeting to approve the financial statements was held on 22 June but the accounts were not passed to us for final audit review until 29 June; we are required to undertake a number of checks on these accounts prior to being certified by no later than 30 June. Due to errors being identified as part of this checking process, the financial statements were not actually certified until after 4pm on 30 June. This places unnecessary pressure on all parties.

Risk Area 3

Outlook

Endowments

38. As a result of an agreed derogation from the FReM NHS Scotland boards were not required to consolidate endowment funds within their 2010/11 financial statements. It is likely however, that from 2013/14, this derogation will no longer apply. If this is the case the board will require to have audited endowment fund figures available for inclusion in their financial statements.

Risk Area 4
Heritage assets

39. A heritage asset is a tangible asset with historical, artistic, scientific, technological, geophysical or environmental qualities that is held and maintained principally for its contribution to knowledge and culture. We are aware that the board has a number of potentially valuable art works which may be classified as heritage assets. From 2011/12 the board will be required to separately disclose such heritage assets. The board should conduct a review to identify and value any such assets.

Risk Area 5

Audit appointment for 2011/12

40. Audit appointments are made by the Auditor General, either to Audit Scotland staff or to private firms of accountants for a five year term. 2010/11 is the last year of the current audit appointment. The procurement process for the next five years was completed in May 2011. From next year (2011/12) the auditor for NHS Lothian will be Audit Scotland. As Audit Scotland has again been appointed as the auditor for NHS Lothian, we look forward to continuing the good working relationship that exists and thank officers and members of the board and committees for their assistance during the last five years.
Financial position

41. Audited bodies are responsible for conducting their affairs and for putting in place proper arrangements to ensure that their financial position is soundly based.

42. Auditors consider whether audited bodies have established adequate arrangements and examine:

- financial performance in the period under audit
- compliance with any statutory financial requirements and financial targets
- ability to meet known or contingent, statutory and other financial obligations
- responses to developments which may have an impact on the financial position
- financial plans for future periods.

43. These are key areas in the current economic circumstances. This section summarises the financial position and outlook for the organisation.

The board’s financial position as at 31 March 2011

44. NHS Lothian is required to work within the resource limits and cash requirement set by the SGHD. In 2010/11, the SGHD required NHS boards to differentiate between core and non-core expenditure for both revenue and capital.

45. The board achieved all of its financial targets in 2010/11 as outlined in Table 1 below.

Table 1: 2010/11 Financial Targets Performance £'000

<table>
<thead>
<tr>
<th>Financial Target</th>
<th>Target</th>
<th>Actual</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Resource</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core</td>
<td>1,099,302</td>
<td>1,099,003</td>
<td>299</td>
<td>0.03</td>
</tr>
<tr>
<td>Non-Core</td>
<td>91,895</td>
<td>91,896</td>
<td>(1)</td>
<td>0</td>
</tr>
<tr>
<td>Capital Resource</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Capital Resource Limit</td>
<td>72,328</td>
<td>72,328</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Non-core Capital Resource Limit</td>
<td>18,170</td>
<td>18,170</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Cash Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Requirement</td>
<td>1,330,000</td>
<td>1,327,302</td>
<td>2,698</td>
<td>0.20</td>
</tr>
</tbody>
</table>

46. The board has achieved a cumulative surplus of £0.298 million. Historically, boards have relied upon a measure of non-recurring funding to achieve financial targets. However, with the tighter financial settlement compared to the past and reduced flexibility within expenditure...
financial position

budgets, there is less scope for reliance on non recurring income to achieve financial balance as NHS boards seek to rationalise their cost base.

47. In 2010/11 the board recorded an underlying recurring deficit of £4.1 million which was met by a non-recurring surplus. However the challenge will be to ensure that in 2011/12 recurring expenditure is met through recurring funding.

48. NHS Lothian’s 2010/11 financial plan included a £37.2 million savings target to achieve financial balance. By the end of 2010/11, all required savings were achieved. However, of the total efficiency savings achieved, as noted above, £4.1 million represented non-recurrent savings and this has been re-provided in the 2011/12 financial plan.

49. The board’s plans to significantly reduce staff numbers, primarily through natural wastage, took effect in 2010/11 with a 762 WTE reduction. 48 members of staff accepted voluntary severance at a cost of £1.9m. The following workforce efficiencies were achieved during 2010/11:

- in-post workforce reduction of 762 WTE against a target of 734 WTE (1,000 headcount)
- an overtime reduction of £1m, the lowest figure since NHS Lothian became a single system
- a supplementary staffing cost reduction of £4m
- achievement of nearly half of the Scottish Government five year target in relation to the 25% reduction in Senior Managers, a 20 WTE reduction against the 43 WTE target.

50. Capital expenditure during the year amounted to £90.5 million which equalled the capital resource limit. Key areas of the programme included the completion and bringing into operation the new Public Private Partnership funded Midlothian Community Hospital in September 2010 at a fair value of £18 million. Other significant completed capital projects in 2010/11 include the Elective Short Stay Surgical Centre at St Johns Hospital (£4.5 million), the refurbished sexual health centre at Chalmers Hospital (£5.6 million) and expenditure of £2.8 million fitting out administrative accommodation at Waverley Gate and Pentland House thereby releasing clinical accommodation.

51. Expenditure was also incurred on a number of continuing capital projects including the re-provision of the Royal Victoria Hospital (£11.2 million) the new Primary Care Centre in Musselburgh (£4.8 million) and medical equipment (£15 million).

52. Some progress was made on the new Royal Hospital for Sick Children/Department of Clinical Neurosciences joint build which, following on from the decision taken by the Scottish Government, is now to be funded through the revenue funded ‘non profit distributing’ model. Development costs of £10 million which included enabling works, land purchase and design costs were incurred during 2010/11.

53. The change in the arrangements for the management of NHS Scotland capital resources is having an impact on NHS Lothian’s planned capital programme. The 5 year capital plan (2011/12 - 2015/16) anticipates expenditure of £380 million. However a number of projects,
over the delegated limit but not yet approved, totalling £56 million, are at particular risk and alternative funding routes may have to be explored.

Financial sustainability and the 2011/12 budget

54. Uplifts in financial settlements have been reducing in recent years. In 2009/10 there was a general uplift of 3.15%, in 2010/11 the corresponding figure was 2.55% (inclusive of a supplementary uplift of 0.4%) while the general funding uplift for 2011/12 is 2.1%. After taking account of earmarked recurring funding and an element of National Resource Allocation Committee (NRAC) funding, NHS Lothian has received an above average settlement of 4.2% for 2011/12. SGHD have advised that an element of the additional funding is to be used for the ongoing development costs of the Royal Hospital for Sick Children and Department of Clinical Neurosciences (RHSC/DCN).

55. Following advice from the SGHD, NHS Lothian’s five year financial plan (2011/12 - 2015/16) assumes that additional funding will be received in order to bring the board closer to its NRAC calculated level. The plan assumes that some £10 million will be received in each of the four years (2012/13 - 2015/16) in addition to the agreed £13.85 million to be received in 2011/12. However, it is unclear as to whether this additional funding will actually be received going forwards. This will have a significant impact on the board’s ability to meet its current and projected level of service and achievement of its HEAT targets.

56. The board’s 2011/12 local reinvestment plan (LRP) is crucial to the board achieving financial balance. There is currently a funding shortfall of some £50.1 million (including the 2010/11 carry forward) which will require to be met through the achievement of efficiency savings. This is a major challenge to NHS Lothian which has been delivering efficiencies for several years in order to achieve a balanced position. This is against the background of significant cuts in public sector spending and its continued shortfall against its assessed NRAC allocation share.

57. The board plans to break even in 2011/12 although it is facing significant cost pressures with projected expenditure growth of £77.2 million. These cost pressures include:

- **Growth in prescribing costs.** For 2011/12 prescribing growth and inflation costs increases are likely to be in the order of £12.8 million. The board expects to achieve costs savings of £5.9 million in 2011/12 through a wide range of initiatives thereby containing net overall prescribing expenditure growth within £6.9 million. The scale of the cost savings and the initiatives which require to be successfully implemented present a high level of risk for the board.

- **Pay growth.** The board anticipates that pay growth in 2011/12 will be £4.9 million as a result of the provision for a living wage, incremental pay progression, changes to National Insurance Contribution thresholds and Agenda for Change (AFC) low pay bands.

- **Supplies inflation and VAT increase.** This reflects the increased impact of inflation on supplies and payments to Consort, NHS Lothian’s partner on the RIE (£9.6 million).

- **Impact of capital investments.** Management have estimated that the revenue implications for projects recently completed and the ongoing costs to support the RHSC/DCN reprovision are likely to be in the region of £4.8 million.
Other costs. The board considers that certain costs are unavoidable. These include clinical supplies (£5.1 million), rates (£4.4 million) clinical negligence and other risks (£3 million) and waiting time costs (£4 million).

Nurse staffing review. Additional costs have been identified following a review of the nurse staffing budget. This is as a consequence of incremental drift which has been exacerbated by a decrease in turnover in higher graded posts and Agenda for Change enhancements. The financial plan recognises that £11 million is required on a recurring basis to fund these costs.

58. The cost challenges facing the board are significant and there is an element of uncertainty about further potential increases in costs. The board plans to maintain close monitoring and scrutiny of costs in order to take remedial action through supplementary cost savings schemes. In this context, it is essential that the board has robust management accounting information.

Workforce planning

59. Staff costs account for over 60% of board expenditure and therefore any significant cost savings are likely to have some staffing impact.

60. The board is looking to further reduce the workforce by 734 WTE during 2011/12 and once again it anticipates the majority of manpower savings will be achieved through natural wastage and redeployment. However as part of the financial planning and review process, the mid-year review may indicate that these measures alone may not be sufficient to generate sufficient savings and a provision may be required to cover the cost of voluntary retirement.

Financial Overview of the NHS in Scotland 2009/10

61. This Audit Scotland National Report considers the current financial health of the NHS and also considers the challenges for the NHS in a tighter financial challenge and was presented to the board’s audit committee in February 2011.

62. The key messages were that despite the slowdown of funding increases, the NHS continues to face growing demand for its services. Budgets will come under pressure as costs associated with pay, energy, prescribing and demographic changes rise at a faster rate than funding increases. This leaves NHS bodies with a major challenge to find significant savings so that they can continue to provide the same level and quality of services within their available budgets.

Outlook

Financial forecasts beyond 2011/12

63. The board’s financial plan provides indicative figures for the level of cost savings needed over the 4 year period (2012/13 - 2015/16) in order to achieve financial balance. The plan notes that cost savings, on a recurring basis, of £40 million per annum will be required in order to
fund planned services. This level of savings will be extremely challenging because in the previous four years many of the readily achievable savings initiatives will have been identified.

64. Furthermore the financial plan assumes that future funding uplifts will be of the order of 1%. This combined with growing cost pressures and the risk involved by building in an assumption that the SGHD will provide an £10 million NRAC funding over each of the years, will make the delivery of cost savings even more important.

**Risk Area 6**

65. Following the advice of the Scottish Government, Note 24: Pension Costs reflects a net liability of £370 million for the NHS Superannuation Scheme arising from the most recent actuarial valuation. Note 1 of the accounts, Accounting Policies, states that the most recent actuarial valuation was for the year 31 March 2004. Given that the Scheme ought to be subject to a full actuarial valuation every four years, a more up to date valuation would have been expected to have been reflected in the 2010/11 accounts.

66. While there was a more recent actuarial valuation carried out at 31 March 2008, the publication of this valuation has been placed on hold by HM Treasury pending the outcome of public sector pension reforms. Given periodic actuarial valuations are key to determining the adequacy of employer and employee contributions to the Scheme, publication of the latest actuarial valuation will bring clarity as to their adequacy of current contributions to meet the future commitments of the Scheme.

67. The net liability figure for the Scheme, as disclosed in Note 24 is therefore out of date. There is a risk that, as the level of contributions from employers and employees have not been recently reviewed there is uncertainty as to their adequacy to meet the future commitments of the Scheme.

**Risk Area 7**
Governance and Accountability

68. The three fundamental principles of corporate governance – openness, integrity and accountability – apply to all audited bodies, whether their members are elected or appointed, or whether they comprise groups of people or an individual accountable officer.

69. Through its chief executive or accountable officer, each body is responsible for establishing arrangements for ensuring the proper conduct of its affairs including the legality of activities and transactions, and for monitoring the adequacy and effectiveness of these arrangements. Audited bodies usually involve those charged with governance (including audit committees or similar groups) in monitoring these arrangements.

70. Consistent with the wider scope of public audit, auditors have a responsibility to review and report on audited bodies’ corporate governance arrangements as they relate to:
   - corporate governance and systems of internal control
   - the prevention and detection of fraud and irregularity
   - standards of conduct and arrangements for the prevention and detection of corruption.

71. In this part of the report we comment on key areas of governance.

Corporate governance

Processes and committees

72. The corporate governance framework within NHS Lothian is centred on the board which is supported by a number of standing committees that are accountable to it. These standing committees include:

   - Audit
   - Healthcare Governance and Risk Management (HGRM)
   - Finance and Performance Review (FPR)
   - Ethics
   - Remuneration
   - Staff Governance
   - Service Redesign
   - Primary and Community Partnership
   - Mutuality and Equality Governance
   - Joint Board of Governance

73. The following paragraphs provide a brief comment on some of the main standing committees of the board, including their roles and responsibilities.

   - **Audit Committee.** Its purpose is to assist the board to deliver its responsibilities for the conduct of its business, including the stewardship of funds under its control. In particular,
the Committee provides assurance to the board that an appropriate system of internal control has been in place throughout the year. The Committee is supported by an Operational Audit Sub-Committee. Both committees are attended by both internal and external audit and senior officials are invited to attend to respond to auditors’ reports.

- **HGRM Committee.** It assists the board in delivering its statutory responsibility for the provision of quality healthcare and provides assurance to the board that the quality of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard. In particular, the Committee seeks to ensure that clinical governance mechanisms are effective; that appropriate principles and standards are applied to health improvement activities; and it oversees the delivery of healthcare to the local population.

- **Staff Governance Committee.** Its role is to provide assurance to the board that NHS Lothian meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard. In particular, the Committee seeks to ensure that workforce policies are consistent and that there is equity of treatment of staff in relation to remuneration.

- **FPR committee.** The FPR committee informs board decisions through the detailed consideration and discussion of financial and performance targets, the achievement of value for money, and the detailed review of business cases.

74. Our overall conclusion is that the high level governance arrangements within NHS Lothian at board and committee level are satisfactory and have operated throughout 2010/11. We have however noted that at an operational level there were instances where arrangements were not as effective. Internal Audit noted that, for example, staff awareness of policies and procedures and associated training was not sound and we noted that financial operating procedures were not always being followed by staff. This has been recognised by the board and action is being progressed.

**Risk Area 8**

75. We have also noted instances where management have been unable to commit to agreed external audit reviews within a pre-determined timescale. For example, we advised the audit committee in our annual audit plan (February 2011) of a follow up review of external consultants. Despite requesting and obtaining contact details, this exercise has not been progressed by NHS Lothian. In addition, areas of work are submitted for audit review without consideration of our role, for example, we were given less than one week to conclude on the review of salaries in excess of £100k and the financial statements were not submitted for the final review until the day before certification (refer to paragraph 37).

**Risk Area 9**

Patient safety and clinical governance

76. Following on from the launch of the NHS Scotland Quality Strategy in May 2010, NHS Lothian approved the NHS Lothian Quality Improvement Strategy 2011 - 2014. The aim of the strategy is to improve patients’ experiences and outcome of care while systematically identifying and eliminating waste. A comprehensive measurement plan supports the monitoring of the above
outcomes and will be progressed through current management structures and reported to the HGRM Committee at the board.

77. The Scottish Patient Safety Programme (SPSP) was launched in 2007 by the Scottish Patient Safety Alliance which brings together the Scottish Government, NHS Quality Improvement Scotland (NHSQIS) (now Healthcare Improvement Scotland) and NHS boards. NHS Lothian is making progress in implementing the tools and techniques of the SPSP to ensure the risk of harm to patients in hospital settings is reduced. NHS Lothian is continuing to roll out the SPSP across all sites including primary care. It aims to reduce adverse events by 30% and mortality by 15% by the end of December 2011. In order to achieve these targets the board has set up 5 key workstreams which have clearly defined measurement plans and improvement goals in place. This should ensure the systematic improvement in the safety and reliability of hospital care.

78. NHS QIS has lead responsibility for reviewing boards’ performance in relation to patient safety, and for working with boards to improve patient safety. During 2010/11 the board has worked towards achieving the highest level, level 4 (reviewing), in each standard and has internally assessed compliance and introduced action plans where appropriate.

79. The Healthcare Environment Inspectorate (HEI) carried out a number of planned and unplanned inspections to several hospital sites during 2010/11. The inspections found evidence that NHS Lothian is complying with the majority of Healthcare Associated Infection (HAI) standards to protect patients, staff and visitors from the risk of acquiring an infection, with the overall standard of cleanliness in departments and wards noted as being satisfactory.

80. The Local HEI Action Group/Site Group Meeting are responsible for ensuring that all actions are completed and that follow up updates are returned to the HEI. This group in turn reports to the NHS Lothian’s HEI Steering Group which meets bi-monthly.

81. NHS Lothian continues to manage and reduce HAI through the implementation of its MRSA screening programme; continued communication to staff, patients and the public about the importance of hand hygiene; and increased compliance with best practice. The Staphylococcal Bacteraemia target was 254 instances or less in 2010/11; the actual number recorded was 316. Although performance is below target it continues to improve and is a reduction on the figure for 2009/10 (360 instances). The Clostridium Difficile target was 557 or less. This target has been exceeded with 358 incidences recorded in the year, again a further reduction on the previous year.

82. Patients’ records are not held centrally by NHS Lothian with specialties continuing to hold separate electronic and paper records. In a report to the HGRM Committee, it was highlighted that inadequate clinical documentation has been implicated in complaints, critical incidents and fatal accident inquiries. It is of paramount importance therefore that a patient’s full medical history is readily available and complete in order that no errors may be made in the patient’s treatment. NHS Lothian undertook a clinical documentation re-audit during the year following the launch in June 2010 of the Clinical Documentation Standards. The result of the re-audit indicated improvements in the overall condition of the clinical documents. A number of
improvement actions have been identified to develop further compliance with the standards. Plans to locate patients' records centrally remain under development.

83. During 2009/10 we noted that the use of the DATIX system to manage quarterly incident reporting required to be further developed in order that improvements to patient care and safety could be made. A report to the HGRM Committee in February 2011 provided detail of the type and volume of incidents recorded on DATIX. The committee noted that the board was continuing to see a rising trend in the number of incidents being reported and this was due to improvements in the incident reporting system and an increasing awareness of safety culture.

Partnership working

84. Partnership working in the NHS covers a number of areas, including partnerships with staff groups, local authorities, the voluntary sector, private healthcare providers and regional planning with other NHS boards. The board has an established Community Health Care Partnership (with West Lothian Council) and Community Health Partnerships with Edinburgh, East Lothian and Midlothian Councils. These partnerships provide care and public health services in a local setting to meet the needs of the local population. NHS Lothian is committed to the delivery of shared outcomes with its community planning partners. Public Partnership Forums are established in each CH(C)P area with relevant committees meeting during the year. These ensure that service users are involved in service developments, and links are established with other local governance structures, for example, community planning committees, to co-ordinate services which meet the needs of local areas.

85. The Audit Scotland Review of Community Health Partnerships issued in June 2011, identified that the Scottish Government, NHS and councils need to show stronger shared leadership and support for community health partnerships to improve people’s health and move more services into the community. Our local review of partnership working arrangements, which is currently being finalised, indicates that NHS Lothian demonstrates a commitment to effective partnership working.

86. During the financial year 2010/11 the board acquired 11.11% of the share capital of Hub South East Scotland Limited (hubCo) and holds its shares together with 9 public and private sector partners including the Scottish Futures Trust. Funding will be made available to the hubCo to develop a number of community infrastructure facilities. These include Gullane Surgery, a joint development between NHS Lothian and East Lothian Council, and Wester Hailes Healthy Living Centre.

87. NHS Lothian continues to be a key partner in the South East and Tayside (SEAT) regional planning group which works to implement services across NHS boundaries. NHS Lothian promotes this partnership to the benefit of patients across Scotland. Recent agreement has been reached to develop 5 workstreams where a shared service approach across the region is expected to bring quality and efficiency/productivity benefits.
Internal control

88. While auditors concentrate on significant systems and key controls in support of the opinion on the financial statements, their wider responsibilities require them to consider the financial systems and controls of audited bodies as a whole. The extent of this work should also be informed by their assessment of risk and the activities of internal audit.

89. Key controls within systems should operate effectively and efficiently to accurately record financial transactions and prevent and detect fraud or error. This supports a robust internal control environment and the effective production of financial statements. In their annual report for 2010/11 NHS Lothian Internal Audit provided their opinion that, based on the internal audit work undertaken during the year, adequate and effective internal controls have been in place throughout the year. During the year no reports were issued with an ‘unsatisfactory’ rating, although, 8 audit reports (40%) were concluded as requiring improvement. We noted that 4 critical related issues were raised in 2 reports and these have been highlighted within the Statement of Internal Control.

90. As part of our audit we reviewed the high level controls in a number of NHS Lothian systems that impact on the financial statements. This audit work covered a number of areas including payroll, accounts payable and receivable, fixed assets, general ledger, family health services, stores and procurement. We also reviewed the register of interests and the register of gifts and hospitality. We identified a number of areas where controls could be strengthened and agreed an action plan with management. We were however able to conclude that there were no material weaknesses in the accounting and internal control systems and that the key controls were operating effectively.

91. With the development of shared services in NHS Scotland, there are a number of systems where NHS Lothian is dependent on another NHS body for provision of services. NHS National Services Scotland (NSS) provides the following services:
   - practitioner services
   - national procurement
   - logistics
   - national IM&T
   - shared services consortium: financial ledger services.

92. In accordance with Statement on Auditing Standard No 70, NHS NSS has commissioned service auditors to provide independent assurance that the key controls and processes operate satisfactorily to support defined key objectives. All opinions from service auditors were unqualified for the year 2010/11.

Internal Audit

93. A key element of our work on internal controls is the extent of reliance that we can place on the work of internal audit in terms of International Standard on Auditing 610 (Considering the Work of Internal Audit). We carried out a review of the internal audit function in November
2010 and concluded that the internal audit service operates generally in accordance with Government Internal Audit Standards and has sound documentation standards and reporting procedures in place. We are pleased to record that we were able to rely on the work undertaken by internal audit, as planned.

Statement on internal control

94. The Statement on Internal Control (SIC) provided by NHS Lothian’s Accountable Officer reflected the main findings from both external and internal audit work. The SIC records management’s responsibility for maintaining a sound system of internal control and summarises the process by which the Accountable Officer obtains assurances on the contents of the SIC.

95. The SIC highlighted issues identified by Internal Audit as requiring to be addressed during 2011/12. These were capacity planning and staff awareness in relation to policies and procedures. Action plans have been developed with management to address the identified weaknesses.

96. The SIC also drew attention to a follow up audit undertaken by the Information Commissioner’s Office (ICO) which is discussed further at paragraphs 100 and 101 below.

Review of staff earning over £100,000 per annum

97. The Cabinet Secretary asked NHS boards for assurance that earnings paid to those staff earning over £100,000 complied with relevant national pay policies and guidance. Auditors were also requested to sample check earnings over £100,000 to give additional assurance on the validity of the figures. We reported our findings to the chairman of the board, in two letters (dated 1 April and 21 April 2011). We did not identify any matters that in principle indicated that the board had been in breach of relevant national policies and guidance relating to pay matters. However, we referred to work undertaken by the Associate Director, Pay and Workforce Modernisation who drew our attention to one payroll error (£26,000) that was identified as part of the review: one clinician has been in receipt of a 5% availability supplement to which they were not entitled. We have been advised that recovery proceedings have been instigated.

eHealth Service Delivery

98. eHealth is a key service within NHS Lothian. The information and communications technology (ICT) based systems provided and supported by the eHealth department underpin all aspects of healthcare delivery throughout Lothian. Over recent years the department has grown in line with the range of supported systems and the increasing reliance that healthcare staff place on these systems to ensure that required service levels are achieved. However the financial pressures currently facing all public sector organisations are reversing this trend.

99. The main focus of this review was to assess how the eHealth department continues to provide the expected level of ICT service to its users, against this background of reducing budgets.
Our findings have been reported in draft and a response and completed action plan is expected from management in due course.

100. We noted the following:

- Provision of a customer-focused, responsive eHealth Service Desk is recognised as a key departmental objective within the eHealth Strategy.

- Service performance is regularly reviewed by eHealth management; however routine review of the eHealth performance indicators by NHS Lothian’s operational management teams has been discontinued.

- Investment in staff training is recognised as important and ensures that staff are able to support new systems and technologies as they are implemented; however, a department-wide training needs analysis has not been performed and no central record of eHealth staff training is maintained.

- Individual system disaster recovery plans are tested on a regular basis to verify that they are correct; however these plans do not address specific resource requirements (e.g. specialised knowledge).

- There is no over-arching service continuity plan that considers the potential staff resourcing and accommodation issues following a major incident (e.g. simultaneous loss of many systems).

ICT data handling and security

101. Following on from a formal investigation by the Information Commissioner's Office (ICO), arising from a data loss incident in 2008, it was agreed that the ICO should conduct a full Data Protection Act (DPA) audit during 2009. Their report, published in April 2010, could only provide ‘limited assurance’ regarding procedures in place to assure DPA compliance.

102. In their follow-up report, published in December 2010, the ICO reviewed NHS Lothian’s progress towards implementing the agreed actions from their original report, concluding that the arrangements in place now provided a ‘reasonable assurance’ regarding the procedures to assure DPA compliance. ICO noted specifically the introduction of the new senior role of Information Governance Manager, and the implementation of the FairWarning audit tool as key factors in this improved rating. The SIC records that a set of agreed follow up actions will be reviewed by the HGRM Committee in August 2011.

Data management – progress update

103. As part of our 2010/11 audit we have reviewed progress taken towards reducing the risks identified on our 2009/10 data management report. As an aspect of this work we took assurance from the audit action tracking system used to inform audit committees of progress. Overall we found that good progress has been made with most actions now fully addressed. However, the greatest challenge identified in this report was the requirement to implement a detailed Information Asset Register (IAR). We note that although progress continues towards this goal, there is still some way to go before a fully implemented IAR is in place.
Prevention and detection of fraud and irregularities

104. Audited bodies are responsible for establishing arrangements to prevent and detect fraud and other irregularity. Auditors review and report on these arrangements.

105. NHS Lothian has in place a number of measures to prevent and detect fraud, including Standing Financial Instructions, Standing Orders and supporting policies and procedures. The board has also entered into a formal partnership agreement with NHSScotland Counter Fraud Services (CFS).

106. The board has a formal programme of internal audit work, which, although not designed to detect fraud, does provide assurance on the operation of the control systems which are designed to prevent fraud. The board also has in place a formal protocol covering a programme of regular payment verification checks with the Practitioner Services Division of NHS National Services Scotland. In 2010/11 these checks included verification against patient records, requesting patients to confirm treatment, visits to practices and examination of patients.

NFI in Scotland

107. In 2010/11 NHS Lothian took part in the National Fraud Initiative (NFI) in Scotland. It uses computerised techniques to compare information held by different public bodies, and on different financial systems, to identify circumstances (matches) that might suggest the existence of fraud or error. The SGHD and NHS Counter Fraud Services have strongly supported the involvement of health bodies in the exercise, which is undertaken as part of the audits of the participating bodies.

108. NFI allows public bodies to investigate these matches and, if fraud or error has taken place, to stop payments and attempt to recover the amounts involved. It also allows auditors to assess the arrangements that the bodies have put in place to prevent and detect fraud, including how they approach the NFI exercise itself.

109. As part of our local audit work we carried out a high level assessment of NHS Lothian’s approach to the NFI and monitored the board’s clearance of cases. We are pleased to note the commitment shown by NHS Lothian to the 2010/11 NFI process. The Audit Scotland report ‘The National Fraud Initiative in Scotland; making an impact’ (May 2010) included a self-appraisal checklist which informed NHS Lothian’s approach to this work. Internal audit are working with payroll, HR and finance staff to review the data matches and regular updates are being provided to the audit committee.

110. 125 recommended matches were identified of which 115 have already been fully investigated. In consultation with CFS the thresholds were adjusted in specific areas and further cases identified for investigation; this work is being progressed. The overall position currently is that 46 cases have been found with errors and 31 of these are potential recoveries worth £36,000.
111. The Audit Scotland report mentioned above highlighted that much of the information used in the last NFI round was collected before the recession really took hold. An economic downturn is commonly linked to a heightened risk of fraud, and public bodies need to remain vigilant.

112. The current NFI round is being carried out under new powers approved by the Scottish Parliament in terms of the Public Finance and Accountability (Scotland) Act (as amended) and which came into force from 20 December 2010. These provide for more collaboration with other UK agencies to detect ‘cross border’ fraud, extend the range of public sector bodies involved, and allow data matching to be used to detect other crime as well as fraud.

Standards of conduct and arrangements for the prevention / detection of corruption

113. Audited bodies are responsible for ensuring that their affairs are managed in accordance with proper standards of conduct and have proper arrangements in place for implementing and monitoring compliance with standards and codes of conduct, standing orders and financial instructions. Auditors consider whether bodies have adequate arrangements in place. We have concluded that the arrangements in NHS Lothian are satisfactory and we are not aware of any specific issues that we need to identify in this report. We did however advise officers of the need to regularly update and review the register of interests. We are also aware that the register of gifts and hospitality requires updating to take account of recent acceptances of gifts hospitality.

Risk Area 10

Outlook

114. The Scottish Government is aiming to improve the efficiency and effectiveness of infrastructure investment by promoting partnership working with public bodies and the private sector with the aim of achieving better value for money. We note that the new government intends to release a new manifesto on policy regarding primary and community care. A key challenge moving forward will be more integrated working and working more efficiently with local authorities. We are aware that early discussions have been held with a number of neighbouring Councils on shared services.

115. In terms of progressing the Royal Hospital for Sick Children and Department of Clinical Neurosciences Reprovision project, NHS Lothian requires to obtain Consort’s agreement to all key requirements in order to satisfy Scottish Futures Trust / Scottish Government Health Directorates Outline Business Case criteria. This is fundamental to the project’s development and will allow the public procurement process to move forward. Good working relationships are essential as any delays in this process may impact on the completion of the project.
Best value, use of resources and performance

116. Accountable officers have a specific responsibility to ensure that arrangements have been made to secure best value.

117. The Auditor General may require that auditors consider whether accountable officers have put in place appropriate arrangements to satisfy their corresponding duty of best value. Where no requirements are specified for auditors in a period they may, in conjunction with their audited bodies, agree to undertake local work in this area.

118. As part of their statutory responsibilities, the Auditor General and the Accounts Commission may procure, through Audit Scotland, examinations of the use of resources by audited bodies and publish reports or guidance. Auditors may be requested from time to time to participate in:
   - a performance audit which may result in the publication of a national report
   - an examination of the implications of a particular topic or performance audit for an audited body at local level
   - a review of a body’s response to national recommendations.

119. Auditors may also consider the use of resources in services or functions, where the need for this is identified through local audit risk assessments. Audit Scotland has prepared a series of best value toolkits to facilitate its reviews in these areas.

120. During the course of their audit appointment auditors should also consider and report on progress made by audited bodies in implementing the recommendations arising from reviews in earlier years.

121. This section includes a commentary on the best value / performance management arrangements within NHS Lothian. We also note any headline performance outcomes / measures used by NHS Lothian and any comment on any relevant national reports and the board’s response to these.

Management arrangements

Best value

122. In March 2011, the Scottish Government issued new guidance for accountable officers on best value in Public Services. The new guidance, in essence, required public bodies to take a systematic approach to self-evaluation and continuous improvement.

123. The guidance identifies the themes which an organisation needs to focus on in order to deliver the duty of best value, but notes that implementation should be appropriate and proportionate to the priorities, operating environment, scale and nature of the body’s business.
The five themes and two cross-cutting themes (some of which we have commented on earlier in this report) are:

- vision and leadership
- effective partnership
- governance and accountability
- use of resources
- performance management
- equality (cross-cutting)
- sustainability (cross-cutting).

NHS Lothian is committed to best value and has arrangements in place to help ensure continuing performance improvement. The audit committee receives an annual report which confirms that the board has arrangements in place to deliver the duty of best value. The Best Value Assurance Statement sets out each of the 7 themes of best value and summarises for each one the sources of assurance that NHS Lothian has received. These assurances include audit opinions and a summary of key developments within each theme. These demonstrate NHS Lothian's commitment to continuous improvement.

The board also has arrangements in place to develop systems in response to relevant reviews and developments, including consideration of Audit Scotland national reports. We have however noted that there is no process in place to apply the findings from our reviews using Audit Scotland's best value toolkits nor are actions identified for follow-up by management. The use of these toolkits could further assist NHS Lothian to demonstrate good practice and deliver best value.

Risk area 11

Managing risk

The board has put in place robust systems for the identification and management of risk. These corporate risk arrangements are supported by local departmental risk registers. An annual risk management report is presented to the audit committee which provides assurances that adequate and effective risk management procedures are in place for the year. The audit committee reviews the risk register on a quarterly basis. During 2010/11 the quarterly reports have been subject to review and revision to ensure there is more clarity around the reporting of risk.

As reported by Internal Audit in November 2010 the board’s updated Quality Improvement Strategy did not cover risk management responsibilities, risk registers and risk reporting. In the absence of an overarching strategy it is not clear if risk management is owned at a corporate level. An NHS Lothian Risk Management Policy to expand on existing risk management guidance is now being developed to comply with the NHS Quality Strategy.

The Risk Register module on the DATIX system has now been fully developed. There is an agreed process in place for monitoring risks in the divisions, and during 2010/11
improvements have been made to the risk register review process at a corporate level. Corporate risk registers have been mapped, areas of omission identified and risk registers put in place as required. Risk register workshops have been held at an operational level to further imbed the process and a revision to the board’s risk management key performance indicators has also been carried out.

Service Development

130. NHS Lothian continues its commitment to developing a sustainable health service through its Improving Care, Investing in Change (ICIC) programme. This includes significant capital investment, for example the Royal Victoria Hospital (£44 million), and the Musselburgh Primary Care Centre (£21 million). These major projects are now underway. As noted above the Royal Hospital for Sick Children and the Department of Clinical Neurosciences is to proceed on the basis of a combined build and will be taken forward under the revenue funded not for profit distributing model. The new capital funding regime is likely to impact on the overall programme of work and the current economic climate continues to impact on the capital plan in terms of realisation of receipts from assets sales. The challenge for NHS Lothian continues to be to ensure it has sufficient resources and capacity to deliver the projects in line with plans.

131. As at 31 March 2011, 42 projects from the original ICIC programme have been delivered and the reports to the Service Redesign Committee indicate that action plans are in place to progress the remaining 22. However, of the remaining projects, 13 are likely to be subject to delay; these include the Forensic Service Redesign, two Care of the Elderly projects and the RHSC/DCN.

132. NHS Lothian is making good progress towards the 18 week referral to treatment time target, although the board has highlighted that it will be a significant challenge to meet this target. Further service development/redesign together with appropriate funding may be necessary in order to deliver the projects and attain national targets.

133. Demographic forecasts for the Lothians predict a rise at 3 times the rate of elsewhere in Scotland with a 53% rise in the elderly population between 2009 and 2028. This highlights the potential for a corresponding rise in the demand for services which are already nearing a capacity. This issue presents a continuing challenge to NHS Lothian to ensure that its long term service provision will meet the needs of Lothian’s population.

Performance Management

134. NHS Lothian has a sound performance management framework in place which provides the information required to effectively manage and monitor the local health system. The main elements of this framework included:

- A consistent approach to monitoring performance across the organisation.
- Bi-monthly reporting to the FPRC.
- Monthly reports to the board on waiting times and access targets.
Performance is linked into individual performance appraisal of directors and senior managers.

135. The Lean in Lothian Programme was established in 2006 with the support of GE Healthcare. The programme offered a proven set of tools and techniques to support process improvement and involve and engage front line staff to identify waste within their current working processes and agree, and then implement service improvements. The Lean in Lothian programme over the 5 year period has supported services to deliver £6.5 million of efficiency and productivity benefits.

136. Projects undertaken during 2010/11 included support to implement improved patient pathways in older people’s services. This was agreed as a key redesign priority by NHS Lothian. The Lean in Lothian programme continues to evolve and in 2010/11 has used the skills of a wide group of staff trained in lean improvement to benefit patients and support delivery of NHS Lothian’s vision for the future.

137. NHS Lothian is subject to an annual review which is chaired by the Cabinet Secretary for Health and Wellbeing. The annual review highlights good performance and identifies areas where specific action would be required to improve health and treatment

People management

138. Plans to reduce and restructure the workforce further during 2010/12 by 734 WTE staff will place added demands on medical and other staff. Without well thought-out plans there is a risk to clinical care and patient safety. Furthermore, uncertainty can be detrimental to staff morale. However it is also important that the board retains the right staff with the right skills and effective succession planning arrangements in place to maintain its capacity to deliver.  

Risk area 12

139. NHS Lothian continues to face a challenge in working to achieve the sickness absence target of 4% set for all Scottish Health Boards. The sickness absence rate for the board has fluctuated during the year but at 31 March 2011 was at 4.19%. This was a significant achievement in relation to other major Scottish Boards. An intensive review of cases continues in NHS Lothian to reduce the occurrence of short term absence.

140. The board achieved the assimilation of all key staff under Agenda for Change by December 2008 and during 2009/10 the majority of employees received payment of the arrears. A review process during 2009/10 and 2010/11 ensured a significant reduction in the number of cases requiring to be settled. The review process is now largely complete.

141. The Knowledge and Skills Framework (KSF) identifies the knowledge and skills that individuals need to apply in their post. NHS Lothian aims to achieve at least 80% of staff covered by Agenda for Change to have their annual KSF development reviews completed and recorded on electronic-KSF by March 2011. As at 31 March 2011 NHS Lothian recorded 69% of staff receiving e-KSF annual reviews against an interim target of 80%, a significant improvement on previous years; however this is the lowest figure recorded by a Scottish board.
Improving public sector purchasing – follow-up audit

142. A follow-up audit was carried out in 2010/11 to assess whether local procurement arrangements in NHS Lothian were consistent with good practice and addressed the key issues identified in Audit Scotland’s national performance report ‘Improving public sector purchasing (July 2009)’.

143. In carrying out the study we used a checklist based on the key issues identified in the national report. We have prepared an early draft report but this has yet to be issued to management. We noted that the board’s Performance Capacity Assessment (PCA) rose from 66% to 82% (superior practice) and that the board is committed to sustainable procurement. We have identified a small number of areas for improvement which will be subject to agreement with management.

Overview of performance in 2010/11

144. As noted above, the board receives regular reports on progress towards achieving the key performance targets set by the Scottish Government (HEAT targets and standards).

145. Of the 50 HEAT measures against which standards/targets were set; 28 standards or milestones are being or have been met, 10 measures were behind the milestone but the standards were yet to apply and 12 measures were short of the standard/milestone. The board was successful in achieving a number of challenging targets by the end of March 2011. These included a number of the health improvement targets, day patient/outpatient waiting times targets, 48 hour access to GPs and a reduction in energy consumption.

146. Waiting times have been falling over recent years in an effort to meet the Government’s targets and by March 2011 a number of targets had been successfully met or bettered. These included the target from referral to treatment for those with suspicion of cancer and the time to operation following hip fracture. The SGHD has introduced a new standard that patients will wait no longer than 18 weeks from referral to treatment. The target of 90% will come into force in December 2011 and a number of milestones have been set to make sure boards are on track to achieve it. NHS Lothian is reporting achievement at 84% as at March 2011.

147. However, severe weather from November through to January affected waiting time performance and it was acknowledged that it would take time to bring performance back to normal levels. Specific areas where performance requires improvement includes waiting time for diagnostic testing, Accident & Emergency waits and audiology.

148. Significant other areas where targets have been difficult to achieve are Healthcare Associated Infection (see paragraph 80 above) and delayed discharge. Through close working between hospital, community and social work staff the average length of stay continues to reduce, however, with the exception of April 2010, the Lothian Partnership has not managed to achieve the National Standard of having no delays over 6 weeks. Other areas where targets have been missed are smoking cessation numbers, Did Not Attend (DNA) numbers, % of staff covered by AfC with e-KSF reviews in place and rate of attendance at A&E.
149. There continues to be a challenge to maintain the 6 week delayed discharge standard throughout the course of the year. For example delayed discharges fluctuated from a high of 118 in May 2010 to a low of 63 in January 2011 with the figure at 85 in March 2011. We are aware that Lothian partnerships remain committed to reducing the number of individuals delayed in hospital and the board considers it is well placed to meet targets in due course.

Risk area 13

National performance reports

150. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland. The findings and key messages of these studies are published in national reports.

151. All Audit Scotland reports are considered for their applicability to NHS Lothian by the Corporate Governance team. Those national reports which are considered to be of specific interest to NHS Lothian are considered in detail by officers, with action to be taken discussed at the board’s Operational Audit Sub-Committee (OASC). Relevant senior managers are invited to attend to outline the impact of the findings and the board's response and progress in addressing recommendations locally. In respect of other national reports which have been considered to be non-applicable or more over-arching in nature, a record of decisions taken by officers following review are then presented to the OASC for approval. NHS Lothian has a robust system for reviewing Audit Scotland’s national reports and implementing improvement actions, as appropriate.

152. National reports issued during the year include:

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<th>Table 2: A selection of National performance reports issued 2010/11</th>
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<tr>
<td>• Using locum doctors in hospitals (June 2010)</td>
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<tr>
<td>• Emergency departments (Aug 2010)</td>
</tr>
<tr>
<td>• Financial overview of the NHS in Scotland 2009/10 (Dec 2010)</td>
</tr>
<tr>
<td>• Getting it right for children in residential care (September 2010)</td>
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Using locum doctors in hospitals

153. Scottish health boards spent around £47 million a year on locum doctors in hospitals in 2008/09. This spending has doubled in the past decade but, in many cases, health boards are not always clear about why locum doctors are being hired and how long they are using them for. The NHS in Scotland could save almost 15% of the money it spends on locum doctors in hospitals, or about £6m a year, through better planning and procurement.
154. The report also says the NHS needs to improve at managing the potential risks to patient safety of using locum doctors. This is particularly important for locum doctors who are hired through private agencies as they may be unknown to the board and unfamiliar with the hospital in which they are working. Health boards across Scotland need to be consistent in the way they screen and induct locum doctors and the way they manage their performance. There are no formal systems for sharing information about individual locum doctors between boards.

155. The report was presented to the OASC in November 2010. A number of recommendations were considered for action and are to be resourced through the Local Reinvestment Plan.

Emergency departments

156. Patient satisfaction with emergency care services is high. However there is widespread variation in the services provided at hospital emergency departments and a lack of clarity about where best to treat different patients. Attendances, costs and workforce pressures are rising, and the NHS in Scotland can do more to manage these services more efficiently. The report highlights that attempts to reduce attendances at emergency departments are not underpinned by an assessment of what works or how much it would cost to have people treated in another setting, such as a minor injuries clinic, where this is appropriate. Closer working across the whole health and social care system is needed to make further improvements.

157. The report was presented to the OASC in September 2010. NHS Lothian developed an action plan to take forward the report’s recommendations. Officers highlighted to the committee that many of the recommendations in the report linked to work currently underway through the Emergency Access Support Team (EAST) and a review of the workforce model in relation to Modernising Medical Careers.

Getting it right for children in residential care

158. The report examined how effectively councils use their resources on residential placements for looked after children and identified areas for improvement. It is important that this vulnerable group of children can have the best possible start in life along with improved life opportunities. This can be achieved through effective joint working but also ensuring value for money in the residential child care services that are being provided.

159. The report was primarily aimed towards local authorities for them to improve their joint management of services to help children in residential care realise their potential. However a number of recommendations were identified as being relevant to NHS boards. These included working in partnership with councils to develop and use formal contracts for commissioning residential child care services and also implement with councils joint budgeting in order to develop an approach that avoids negotiating residential school placements on an individual case by case basis. A number of actions from this report are being progressed by the NHS Lothian Child Commissioner.
The role of boards

160. The report examines the role of boards in the Scottish public sector. The key issues highlighted in the report included the need for boards to demonstrate strong leadership in order to make difficult decisions about their funding, the requirement for roles of Chairs and Chief Executives to be clear, the need for the appointment process for non executives to be further developed and the lack of consistency in providing scrutiny.

161. The recommendations in the report have been considered against what is in place in NHS Lothian. Two broad areas were highlighted for further action. These were the appointment of board members and addressing the financial challenge.

Improving energy efficiency - follow-up

162. Scotland’s public bodies need to cut their energy use to minimise the impact of predicted price rises and to reduce carbon emissions. The public sector faces significant financial pressures over the next few years and needs to reduce its spending. Reducing energy use will be an important element of this. The report considered the change in energy use and CO$_2$ emissions between 2006/07 and 2008/09, provided an assessment of progress made in implementation of the recommendations in the 2008 report and examined the CRC Energy Efficiency Scheme and how prepared the public bodies are for the scheme.

163. NHS Lothian has responded positively to the report and has an action plan in place to meet the requirements of Government legislation highlighted in the report. The Sustainable Development Management Group will take the actions forward for further consideration.

Outlook

Performance

164. Over recent years the board has invested substantial resources in order to achieve challenging performance targets set by the Scottish Government. The board’s 2011/12 Financial Plan assumes that it will require to allocate £4 million to meet the national access targets. The significant financial challenges that will be faced in 2011/12 and beyond may force the board to prioritise its resources. This will make maintaining or improving performance even more challenging.
# Appendix A: audit reports

## External audit reports and audit opinions issued for 2010/11

<table>
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<tr>
<th>Title of report or opinion</th>
<th>Date of issue</th>
<th>Date presented to Audit Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Audit Reliance Letter</td>
<td>29 November 2010</td>
<td>6 December 2010</td>
</tr>
<tr>
<td>Annual Audit Plan</td>
<td>4 February 2011</td>
<td>8 February 2011</td>
</tr>
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<td></td>
<td>4 March 2011</td>
<td>12 April 2011</td>
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<tr>
<td>Review of staff earning over £100,000</td>
<td>1 April 2011</td>
<td>12 April 2011</td>
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<td></td>
<td>21 April 2011</td>
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<tr>
<td>Internal Controls Management Letter</td>
<td>17 June 2011</td>
<td>21 June 2011</td>
</tr>
<tr>
<td>ICT review of service delivery</td>
<td>July 2011 (draft)</td>
<td>11 October 2011 (proposed)</td>
</tr>
<tr>
<td>Report to Audit Committee in terms of ISA 260</td>
<td>17 June 2011</td>
<td>21 June 2011</td>
</tr>
<tr>
<td>Independent auditor’s report on the financial statements</td>
<td>17 June 2011</td>
<td>21 June 2011</td>
</tr>
<tr>
<td>Improving Public Sector Purchasing – Follow-up audit</td>
<td>July 2011 (draft)</td>
<td>11 October 2011 (proposed)</td>
</tr>
<tr>
<td>Annual report to members and AGS</td>
<td>29 July 2011</td>
<td>11 October 2011 (proposed)</td>
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</table>
## Appendix B: action plan

### Key Risk Areas and Planned Management Action

<table>
<thead>
<tr>
<th>Action Point</th>
<th>Refer para no</th>
<th>Risk Identified</th>
<th>Planned Management Action</th>
<th>Responsible Officer</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>28</td>
<td>NHS Lothian as with other boards has not been able to quantify the extent of its liability for Equal Pay claims. There is a risk that these liabilities will have a significant impact on the board’s financial position.</td>
<td>The board continues to work with HR and the Central Legal Office in managing this risk. Any liabilities subsequently identifiable as having to be provided for will be initially classified as Annually Managed Expenditure and subsequent calls on the board's Revenue Resource Limit will be discussed in full on a national basis with the SGHD.</td>
<td>Director of Finance</td>
<td>Ongoing</td>
</tr>
<tr>
<td>2.</td>
<td>36</td>
<td>There is a risk that if the Remuneration Committee and chief officers are not provided with the necessary information on a timely basis, they are unable to carry out an effective review of pay arrangements including consideration of the impact on budgets.</td>
<td>Chief Officers of the board handled this matter in accordance with individual contractual terms and normal procedures in that no individual received anything to which they were not entitled to. This was reported and accepted by the Remuneration Committee of the board, and as such no further action is required.</td>
<td>Director of HR</td>
<td>N/A</td>
</tr>
<tr>
<td>Action Point</td>
<td>Refer para no</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
<td>Target Date</td>
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<td>3.</td>
<td>37</td>
<td>A process should be introduced to ensure that certification of the accounts is addressed according to pre-determined timings. This will ensure that undue pressure is avoided.</td>
<td>The board's certification process will be reviewed and agreed timings developed as part of accounts planning for 2011/12.</td>
<td>Director of Finance</td>
<td>February 2012</td>
</tr>
<tr>
<td>4.</td>
<td>38</td>
<td>Audited endowments accounts may be required to be consolidated into the NHS Lothian's financial statements.</td>
<td>The board are aware that consolidation requires to be planned for in the event that the governance arrangements for Endowment funds remain as they are. The commencement date for consolidation is 1 April 2013 and comparative data for 2012/13 will be required. The process is being initially reviewed by TAG during 2011/12 as it raises technical and governance issues in relation to capital scheme management.</td>
<td>Director of Finance</td>
<td>Autumn 2012</td>
</tr>
<tr>
<td>5.</td>
<td>39</td>
<td>NHS Lothian will be required to identify whether any heritage assets exist and, if so, they will require to be valued and separately disclosed.</td>
<td>Management have already undertaken a cataloguing exercise on art and heritage collection and a small number of potentially valuable items have been identified in the inventory. These items are not deemed material to the accounts of the board but the</td>
<td>Director of Finance</td>
<td>September 2011</td>
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<tr>
<td>Action Point</td>
<td>Refer para no</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
<td>Target Date</td>
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<td>overall disclosure requirements will be discussed with both internal and external audit, and (as required) with the Trustees of the Edinburgh &amp; Lothians Health Foundations.</td>
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<tr>
<td>6.</td>
<td>63/64</td>
<td>The longer term financial plan remains at risk of not being affordable due to the wide range of financial challenges and pressures being faced by the board. Savings targets may not be achieved.</td>
<td>The board's formal quarterly and mid year financial review process is an important element of the risk management approach to this financial challenge. The Efficiency and Productivity group reviews proposals and progress with savings schemes; this is reported to the EMT and the board through the Financial and Performance Review Committee.</td>
<td>Director of Finance</td>
<td>Ongoing</td>
</tr>
<tr>
<td>7.</td>
<td>67</td>
<td>There is a risk that, as the 2008 actuarial valuation has not been completed, the current level of contributions from employers and employees will not meet the future commitments of the Scheme. NHS Lothian should work with the SGHD to ensure that the Scheme is subject to timely evaluation in compliance with the requirements of the Scheme, and that the adequacy of the employer and employee contributions has been reviewed.</td>
<td>This a national issue. The scheme contributions are set in accordance with the recommendations of the actuary and costs to the boards and from employees advised through communications from the SGHD.</td>
<td>Director of Finance</td>
<td>Ongoing</td>
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<tr>
<td>Action Point</td>
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<tr>
<td>8.</td>
<td>73</td>
<td>NHS Lothian should review its processes for ensuring that staff comply with agreed policies and procedures.</td>
<td>A comprehensive action plan is in place to address the subject of policy compliance. The Audit Committee and Staff Governance Committee have received this action plan, and the Healthcare Governance &amp; Risk Management Committee will receive it on 2 August. Progress has already been made on the action plan.</td>
<td>Director of Human Resources</td>
<td>December 2011</td>
</tr>
<tr>
<td>9.</td>
<td>74</td>
<td>There is a risk that the external auditors are unable to complete their agreed audit plan leading to additional input and cost.</td>
<td>As part of accounts planning for 2011/12, all aspects of timing and communications will be discussed and agreed, with clarity on expectations of both parties. This will include information to and from the External Audit team.</td>
<td>Director of Finance</td>
<td>February 2012</td>
</tr>
<tr>
<td>10.</td>
<td>112</td>
<td>The register of interests should be updated regularly and reviewed by management to ensure no conflict of interests exists. In addition the register of gifts and hospitality should be kept up to date.</td>
<td>The register is updated at least annually through the offices of the secretariat.</td>
<td>Board Secretary</td>
<td>Ongoing</td>
</tr>
<tr>
<td>11.</td>
<td>125</td>
<td>The board should review the Audit Scotland best value toolkits and any associated reports to identify areas where practice can be improved and best value delivered</td>
<td>Where Best Value toolkits have been used as part of the external audit programme, the outcome shall be</td>
<td>Director of Finance</td>
<td>Immediate</td>
</tr>
<tr>
<td>Action Point</td>
<td>Refer para no</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
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<td>treated in the same way as the existing process for Audit Scotland national performance reports. The Operational Audit Sub-Committee shall receive the report, along with a paper from management to highlight what (if any action) is going to be taken. The Sub-Committee will receive periodic high level updates on how any agreed actions are progressing.</td>
<td></td>
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</tr>
<tr>
<td>12. 137</td>
<td>As the board reduces its workforce, effective succession planning needs to be in place to ensure the right skills are in the right job.</td>
<td></td>
<td>The Workforce Modernisation Team / Group, work in partnership across NHS Lothian, to ensure reductions to staff take account of key issues and risks to service provision and staffing levels. The Group meet fortnightly.</td>
<td>Director of Human Resources</td>
<td>Ongoing</td>
</tr>
<tr>
<td>13. 148</td>
<td>There is a risk that in a climate of reducing funding, performance targets are not achieved or maintained.</td>
<td></td>
<td>Performance targets are subject of regular review and monitoring through the Finance &amp; Performance Review Committee of the board.</td>
<td>Director of Planning/EMT</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
NHS LOTHIAN FALLS PREVENTION & BONE HEALTH STRATEGY

1 Purpose of the Report

The purpose of this report is to invite the Board to approve the NHS Lothian Falls Prevention and Bone Health Strategy (2011-2016).

Any member wishing additional information (including a copy of the full strategy document) should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is invited to:

2.1 Approve the Falls Prevention and Bone Health Strategy (2011-2016)

3 Discussion of Key Issues

3.1 The primary aim of the Falls Prevention and Bone Health Strategy recommendations (Appendix 1.0) is to reduce the number and harm arising from falls across Lothian by 30% per annum from 2014 following implementation, and improve bone health in our population. The strategy sets out the vision for NHS Lothian (2011-2016) for service provision to those individuals who are at risk of falling or bone fragility fractures, and or have had a fall.

3.2 The Scope of the strategy includes:

- Population approaches Health Promotion/Improvement
- Bone Health & Osteoporosis
- Individuals at risk of falling, at home, in care homes and in hospitals.

3.3 HDL (2007)13-Delivery Framework for Adult Rehabilitation-prevention of falls in older people, sets out a clear recommendation that all NHS Boards develop and implement a Falls Prevention & Bone Health Strategy. This strategy has been written in partnership and with the assistance of a multidisciplinary group of experts in the area of falls and bone health.
3.4 Within the UK there are over 11 million people aged over 65 years, 28,000 women over the age of 90. The estimated national costs associated with fractures are £1.8 billion per annum.

3.5 NHS Lothian Demographic data outlined in figure 1.0, demonstrates projected increase in the older population over next 21 years. The potential ongoing economic impact Falls and fractures will have in Lothian is therefore substantial. There is an estimated increase of 63% in those living in Lothian over the age of 65, greatest projected increases in West Lothian (102%) and East Lothian (72%).

Figure 1.0 65+ population projections for Local authority areas in Lothian to 2031.

3.6 The Current data on emergency admission to hospital as a result of a fall across Lothian is illustrated in Figures 2.0, there are increasing trends due to increase in number of older people and better recording of falls as a reason for admission. In financial year 2009/10 there were 505 discharges in patients aged 65+ following an emergency admission to hospital due to a fractured neck of femur. These admissions utilised 20,635 bed days across the acute and rehabilitation sectors in NHS Lothian and patients had a median stay of 21 days. (Source: SMR01 inpatient records).

Figure 2.0 Emergency Admissions to Hospital due to a fall in Lothian
3.7 The outlined strategy has been aligned to:

- Reshaping Care for Older People
- Rehabilitation Framework
- Healthcare Quality Strategy
- Whole Systems older peoples model of care
- Scottish Patient Safety Programme

This approach will ensure that the implementation of the strategy is aligned as a core element of the above workstreams.

3.8 The ethos of this strategy is to provide integration, connectivity and creativity to existing pockets of excellence in this area and translate it to whole systems working. The strategy promotes the following tiered approach:

- Self management and population based health promotion
- Identify those at Risk
- Assess those at most risk and intervene
- Co-ordinate the management of existing specialist services

This model will be implemented through an integrated prevention and management of falls and trauma fractures pathway that transcends health, social and community care. Developing a generic as opposed to specialist model of care highlights the potential of all those that interface with target groups in the community and in acute settings to identify risk and signpost for more detailed assessments. Some Health Boards have pursued a specialist model with a few highly trained staff running a discrete specialist falls service. In line with other workstreams in Lothian, the development of a more generic approach was consciously taken in the writing of this strategy to ensure the implementation was cost effective and maximised the skills and competencies of our existing workforce.

3.9 Evidence and economic impact: Targeted evidence based interventions will reduce falls incidence and fracture rate up to 30% in the community. Ferraz-Nunes (2005) highlights the great potential for reducing costs and achieving significant health benefits within older populations through prevention programmes in the community. (Ferraz-Nunes J (2005) Cost effective prevention of hip fractures, International Advances in Economic research, 11(1), 49-67)

3.10 There is emerging data from Patient Safety Programme and also improvement methodology across the UK that demonstrates a reduction in both harm and incidence of falls for targeted inpatient areas. Within NHS Lothian a falls bundle has been developed and is being implemented as part of this strategy across inpatient sites. The improvement target in 2011/12 is a 20% reduction in major or moderate harm from falls across inpatient sites. In month 6 we are on target with regard to the implementation plan and have seen a reduction in falls causing harm in the wards that have completed implementation. Currently this has been rolled out to 18 wards on four hospital sites based on those with highest incidence of harm across Lothian.
3.11 Nationally a public and patient involvement study was conducted in 2008 by the Royal College of Physicians in collaboration with Help the Aged to ascertain older people’s experiences of falls and bone health services on behalf of the Department of Health. Key findings from this were translated and tested in a local public focus group in Lothian to inform the writing of this strategy. Key messages from both the local event and the national findings have been incorporated into the strategy. Work being conducted in partnership with the local councils across Lothian has also fed into the strategy through the community Falls co-ordinators and operational groups.

3.12 A plain English version of the strategy and a key messages paper were prepared for the public consultation which ran from May 7th –August 1st 2011. The papers were distributed through public partnership forums across Lothian, standing committees within the University Hospitals Division and CH(C)P’s and internal stakeholder groups across Lothian. Furthermore the strategy consultation was formally presented to NHS Lothian Service Redesign committee and Healthcare Governance and Risk Management. A short survey about the strategy asking key questions was also devised. The draft strategy and the survey were also placed on the NHS Lothian website. The findings of the consultation were collated and reviewed by an expert group independent of the writing group, and this expert group agreed final changes to be made to the strategy document.

3.13 The recommendations have been streamlined to reflect the comments obtained from the consultation process and thought given to the metrics which will be used to measure the impact of the strategy annually.

4 Key Risks

4.1 The strategy has been constructed to promote integration single system pathway working for those individuals at risk of falling and/or fragility fractures. This approach has been taken to reduce the need for resource allocation for specialist services and to promote the ethos that falls remains a highly prevalent cause of fracture, hospital admission and accidents for people across Lothian. Consequently it is an area that many different healthcare professionals, sectors and carers require knowledge about and empowered to act to ensure those most at risk receive the correct advice and preventative help to minimise harm, hospital admission and risk associated with falling.

4.2 The key risks associated with this strategy are failure to adequately communicate the ethos behind its intent and a reluctance of staff and population to own the preventative aspects of the strategy. To mitigate against this risk, a communication strategy to support its launch and assessment of educational needs of staff and target client group will be undertaken as part of the implementation plan.

5 Risk Register

5.1 There are no new identified risks for the NHS Lothian Risk Register. This is incorporated on the Risk Register under Standards of Clinical Care.
6 Impact on Health Inequalities

6.1 A Rapid Impact Assessment was carried out on the Falls Prevention & Bone Health Strategy on 27 September 2011. This revised and updated the earlier impact assessment carried out on the previous strategy, and identified a wide range of positive impacts on health inequalities and equality & diversity for patients, carers and those at risk of falling. Actions arising from the impact assessment are incorporated into the Strategy.

7 Impact on Inequalities

7.1 See section 6.1 above.

8 Involving People

8.1 The involvement process in the development of the strategy with staff, patients and members of the community has been summarised in paragraphs 3.11 and 3.12.

9 Resource Implications

9.1 The resource implications are outlined within the strategy. A number of programmes in the community are currently funded through short term funding. The full economic benefit of this strategy will require implementation of the prevention programme. NHS Lothian have been successful in securing Quality & Efficiency funds from the Scottish Government to assist in the implementation of this strategy. The year on year cost benefit is anticipated to be £467K per annum, through 20% reduction in harm with inpatient falls and a 30% reduction in harm from community falls. It is recommended that we utilise existing workforce to drive forward the implementation of this strategy, link with patient safety programme and the continuous improvement agenda within older peoples workstreams to fully realise the benefits of this strategy.

Lynne Douglas
AHP Director
15 November 2011
Lynne.douglas@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Falls Prevention & Bone Health Strategy Key recommendations
NHS Lothian Falls Prevention & Bone Health Strategy- revised recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Lead Responsibility</th>
<th>Working With</th>
<th>Timescale</th>
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</thead>
<tbody>
<tr>
<td>1. NHS Lothian Falls Prevention and Bone Health Strategy will fit with local and national guidelines with regard to the care of older people.</td>
<td>NHS Lothian Falls Group/Prevention Strategy Group/ UHD – Health and Social Voluntary Bone Health</td>
<td>CH(C)P Operational Falls Group/ UHD/ Local Authority and Voluntary Organisations</td>
<td>Oct 2011 - 16</td>
</tr>
<tr>
<td>2. Data to be collated uniformly across all services about individuals presenting to services with falls and fractures with the purpose of screening, intervention and measuring improvement and with Quality Improvement Teams having responsibility for reviewing this.</td>
<td>UHD A&amp;E Clinical Lead</td>
<td>UHD SMT/ Informatics</td>
<td>Apr 2012</td>
</tr>
<tr>
<td>3. Care pathways are developed to identify people at risk of falling to ensure that they are screened and signposted to appropriate services to prevent/manage risk of future falls.</td>
<td>CH(C)P Operational Falls Group CH(C)P Falls Lead</td>
<td>Falls Co-ordinators</td>
<td>Apr 2012</td>
</tr>
<tr>
<td>4. CHP’s / CHCP collate a Directory of Services across Health / Social Authorities / Voluntary Sector to signpost older people and carers to services and organisations that can support health and self management improvement. Individuals who fall or fracture and their families/carers should be offered written advice about prevention and self management of their falls risk and bone health.</td>
<td>CH(C)P Operational Falls Group</td>
<td>Falls Co-ordinators/ Long term conditions Leads/ Public Health Local Authorities</td>
<td>December 2011</td>
</tr>
<tr>
<td>5. A corporate falls and bone health lead with appropriate experience in falls prevention and bone health should be appointed to oversee the implementation of the operational policy. This lead will require administrative and secretarial support and should be accountable to the board.</td>
<td>Corporate Falls Lead</td>
<td>CH(C)P’s</td>
<td>April 2012</td>
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<td>Recommendation</td>
<td>Lead Responsibility</td>
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<td>6. CHP/CHCP Falls Leads agree appropriate evidence based tools for falls screening for both community and hospital environments.</td>
<td>Falls Lead AHP Leads</td>
<td>Divisional Falls Leads</td>
<td>June 2012</td>
</tr>
<tr>
<td>7. All healthcare professionals should be aware of how to access the pathways of care and these pathways of care should be easily accessible to the social care and voluntary sector e.g. Single point of access to services for the fallen uninjured person.</td>
<td>CH(C)P’s/ LUHD Operational Falls Group</td>
<td>Falls Leads Local Authorities</td>
<td>April 2012</td>
</tr>
<tr>
<td>8. Agreement about best practice exercise interventions relevant to particular conditions is established with outcome measures so that these programmes may be delivered across all settings including community, hospital and leisure centres.</td>
<td>CH(C)P Operational Falls Group</td>
<td>Fracture Services AHP’s/Falls MOE Consultants</td>
<td>April 2012</td>
</tr>
<tr>
<td>9. Falls Co-ordinators/Leads within CH(C)P’s should work in collaboration with local authorities and private care providers to identify training needs in their locality and NHS Lothian Falls Co-ordinators will work collaboratively to provide a single system training package for falls.</td>
<td>CH(C)P Operational Falls Group</td>
<td>Falls Co-ordinators/Leads</td>
<td>April 2012</td>
</tr>
<tr>
<td>10. Care home residents should have an assessment to determine falls and bone health risk and individual intervention care plans documented to help minimise risk of fracture and falls.</td>
<td>CH(C)P Operational Falls Group</td>
<td>Falls Co-ordinators Care Home providers</td>
<td>April 2012</td>
</tr>
<tr>
<td>11. NHS Lothian implements falls care bundles across inpatient sites to reduce harm from hospital based falls</td>
<td>Quality Improvement Teams</td>
<td>Divisional Falls groups</td>
<td>April 2012</td>
</tr>
<tr>
<td>12. Falls data (eg DATIX) is actively used by the quality improvement teams to ensure a culture of continuous improvement and consolidated learning from falls incidents and a reduce patient harm.</td>
<td>Divisional Senior Management Teams</td>
<td>Quality improvement teams</td>
<td>October 2012</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Lead Responsibility</td>
<td>Working With</td>
<td>Timescale</td>
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<tr>
<td>13. Hospital Falls Leads work in collaboration with Fracture Liaison Nurses and Community Falls Co-ordinators or Leads to ensure single system Falls pathway development in Lothian (particularly when patients deemed to be at risk in hospital environment are transferred into primary or community care).</td>
<td>Divisional Operational Falls Groups</td>
<td>Fracture/ Bone Health</td>
<td>April 2012</td>
</tr>
<tr>
<td>14. Dexa scanning should be offered to individuals who meet the criteria for osteoporosis risk and those individuals should receive both bone health and falls prevention interventions.</td>
<td>Bone Health &amp; Osteoporosis Steering Group</td>
<td>Falls Co-ordinators/ Leads</td>
<td>April 2012</td>
</tr>
<tr>
<td>15. All divisions in NHS Lothian work collaboratively to define, implement and monitor an evidenced based Bone Health pathway as a component of the NHS Lothian Integrated Falls Pathway.</td>
<td>Bone Health &amp; Osteoporosis Steering Group</td>
<td>Falls Co-ordinators</td>
<td>July 2012</td>
</tr>
<tr>
<td>16. NHS Lothian risk assess capacity and demand of existing DXA services and impact of SIGN 71, Nice 87 and the Scottish Hip Fracture Audit and changing demography.</td>
<td>Bone Health &amp; Osteoporosis Steering Group</td>
<td>NHS Lothian Planning</td>
<td>April 2013</td>
</tr>
<tr>
<td>17. All healthcare professionals should be aware of how to access the pathways of care and these pathways of care should be easily accessible to the social care and voluntary sector e.g. Single point of access to services for the fallen uninjured person.</td>
<td>NHS Lothian Falls Group</td>
<td>Public Health Comm. Team</td>
<td>April 2012</td>
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REFRESHING THE HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT STRATEGY

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approves the attached paper as a formal policy of the Board.

2 Recommendations

The Board is invited to

2.1 Note the position achieved in respect of the extant Human Resources Strategy – November 2008 to November 2011.

2.2 Approve the content of the attached paper (see appendix 2) and in doing so endorse the Human Resources and Organisational Development strategy framework for the period December 2011 to March 2014 (39 months rather than 36 to bring the arrangements back into line with the normal performance management cycle).

3 Discussion of Key Issues

3.1 In November 2008 the Board approved its Human Resources and Organisational Development Strategy for a three year period to November 2011. During this period two annual reviews of performance and three interim performance reports have been made to the Board in respect of the actions set out in this strategy.

This paper to the Board constitutes the final annual report in respect of the full year period to November 2011 (see appendix 1).

3.2 The extant strategy was based on three fundamental principles:

3.2.1 Living Values

- Doing what we say we will do
- Making explicit the behaviours and attitudes expected from all staff
• Providing leadership which is visible, accessible and involved
• Enhanced Health and Safety performance

3.2.2 Engaging Leadership

• Ensuring appropriate training is provided
• Growing internal capacity to modernise roles and ways of working to deliver 21st century services to patients
• Developing and delivering coaching plan

3.2.3 Delivering Quality

• Improving our processes to deliver better health and care
• Develop our workforce to deliver person centred and compassionate care
• Develop best value plans with key strategic partners in ‘Public Scotland’

A point that emerged as part of the consultation on our future direction of travel (in respect of our Human Resources and Organisational Development Strategy) was that these principles had served us well as an anchor point from which to base our subsequent actions, and had acted as the glue which held our current strategy together. Given this, the fundamental of principles have been retained to enable a consistent overall approach to how we manage people.

Also I have a view that whilst the extant strategy was ambitious, stretching and appropriate, perhaps as a strategy it could have been more focused on a smaller number of higher level actions. Certainly the extant strategy was written in 2008 when the world was a different place. It is perhaps a testimony to its design that it remains largely relevant today. Much of the original direction of travel, whilst remaining relevant, needs to be updated to take account of the global economic environment in which the Board must now operate. Rather than abandon the extant strategy and move in an entirely different direction, the attached paper is a modernisation and refreshed approach to managing our greatest asset; our people.

In writing our refreshed approach a number of matters were taken into account. The single most important strategy for the Board to consider is the Clinical Strategy. As the Boards Director of Human Resources and Organisational Development, it is a privilege to work with my executive colleagues on the design of our Clinical Strategy, for whom the lead executive is Dr David Farquharson, Medical Director. Whilst every care has been taken to ensure that our refreshed Human Resources and Organisational Development Strategy fully supports the delivery of the Clinical Strategy, given that work on the Clinical Strategy is work in progress, it will be appropriate to revisit the approach after the Board has approved its Clinical Strategy in 2012.

In addition, all of what we achieve will be better achieved in partnership with the trades unions and professional organisations. Partnership working will remain the cornerstone of our approach to employee relations. Working in partnership with the trades unions and professional organisations gives us the best possible platform from which to achieve our stated ambition to be at the level of Scotlands best and in the top 25 large healthcare providers in the world.
Finally, we have an absolute responsibility to ensure that as a public body we live within the resources made available to us, and on every occasion achieve our key financial objectives. Our new strategy is designed to ensure the people management contribution to our financial security will a) be delivered year on year and b) be delivered against a challenging future given relative available resources and a growing demand for our services in a manner that is person centred, safe and effective, and which continues to improve the quality of the services provided to patients.

3.3 To do this the focus for our refreshed approach is on six key areas from which specific work programmes will be developed, delivered and or refreshed. Each specific work programme will be considered by the Lothian Partnership Forum and the Finance and Performance Review Committee of the Board prior to implementation. Subsequent governance arrangements will be considered by the Staff Governance Committee, Healthcare Governance Committee, Service Redesign Committee, Mutuality and Equality Governance Committee and of course twice a year by the full Board. These six key areas are as follows:

3.3.1 Employability and Social Responsibility

3.3.2 Promoting Organisational Values and An Aspirational Culture that Enhances Staff Engagement, and Ensures that our people have the opportunity to reach their maximum potential to drive organisational performance.

3.3.3 Best Practice in Leadership, Staff Governance, Performance Management Compliance

3.3.4 Managing Change, Organisational Design, Development, Implementation and Sustainability

3.3.5 Workforce Planning, Redesign, Modernisation and Productivity

3.3.6 Provision of Core and Expert Human Resources and Organisational Development Services and Systems.

3.4 A key feature for us will also be in customer care and service quality. Our approach will dovetail with our ‘Delivering Better Care’ Framework that is being developed by the Nurse Director. Through the psychological contract work and through our policies and training programmes every member of staff will be aware of the standards that are required when dealing with patients, relatives, carers or partner agencies. There can be no place in NHS Lothian for anything other than the highest standards of communication and service to the public.

3.5 Our HR/OD Framework continues the fundamental principles expoused in Living Values, Engaging Leadership and Delivering Quality. Doing what we say we will do, making explicit the standards we expect of our people, providing leadership based on an evidence base, ensuring training activity is aligned to helping people to do their jobs properly and provide highly competent, but just as critically, compassionate care, are what our patients deserve and expect from us.
A bold approach to Socially Responsible Recruitment as part of a concerted approach to breaking the links between poverty and ill health and a new modern internal communications strategy that ensures our staff are fully aware of all they need to know, together with clear lines of accountability, supported by competent and consistent human resources core support, are the interventions that will enable us to produce performance consistent with our aspiration to be at the level of Scotland’s best and in the top 25 large healthcare providers in the world.

4  **Key Risks**

4.1  Approximately 50% of our annual revenue budget of £1.4bn is in staff costs. Failure to implement our people management strategies and policies will put at risk our ability to deliver our Clinical Strategy in a manner that is patient centred, safe and effective and within the available resources.

5  **Impact on Health Inequalities**

5.1  Human Resources and Organisational Development matters appear on the NHS Lothian Risk Register and are subject to regular review.

6  **Impact in Health Inequalities**

6.1  The proposals in the attachment to this report have been subject to an Equality and Diversity Impact Assessment. The assessment revealed that the proposals could be expected to enhance equality and diversity through an enlightened approach to employability and social responsibility as part of a concerted effort to break the links between poverty and ill health. Promoting a system to enable all staff to reach their maximum potential would be likely to have a beneficial impact.

7.  **Impact on Inequalities**

7.1  The provision of effective and expert human resources and organisational development services will enable best practice in the field of equality and diversity to be identified and implemented.

8.  **Involving People**

8.1  The following were informed, engaged and consulted in the design of the refreshed Human Resources and Organisational Development Strategy:

   - The NHS Lothian Partnership Forum,
   - The NHS Lothian Service Redesign Committee,
   - The Public Partnership Forum
   - The Employee Director
   - The Senior Human Resources and Organisational Development Team
All detailed proposals arising from the Human Resources and Organisational Development Strategy will be approved by the Lothian Partnership Forum.

9. Resource Implication

9.1 There are no resource implications as a direct consequence of the approved of this paper.

Failure to have appropriate people management arrangements in place in the labour intensive organisation where approximately 50% of our costs are staff related could compromise the Board’s ability to meet its financial obligations.

All proposals which might have financial implications stemming from this paper, and the attached Human Resources and Organisational Development Strategy Framework, will be considered as part of the boards financial planning processes and approved in line with the scheme of delegation and the Standing Financial Instructions by the Finance and Performance Review Committee.

Alan M Boyter
Director of Human Resources & Organisational Development
16 November 2011

List of Appendices

Appendix 1 – Human Resources and Organisational Development Strategy 2008-11 - Summary of Progress on All Actions

Appendix 2 – NHS Lothian Human Resources and Organisational Development Strategy Framework December 2011 to March 2014 – “At the level of Scotland’s best and in the top 25 large healthcare providers in the world”
## Section One: Living Values
### Chapter One: Healthy People

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<th>Date Completed/To be Completed</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1 Establish a three year Action Plan which will be delivered as part of</td>
<td>Yes</td>
<td>Ongoing</td>
<td>The manual was introduced following consultation. This was followed by extensive training and the re-introduction of Health and Safety audits. Internal audit confirmed satisfactory introduction of risk assessment, and last year satisfactory Health and Safety governance.</td>
</tr>
<tr>
<td>overall Health and Safety Management System.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2 Ensure appropriate management and partnership representation on Health and Safety Committees.</td>
<td>Yes</td>
<td>June 2011</td>
<td>All operation elements are covered by an effective Health and Safety Committee structure including partnership representation. During 2009/10, the Director of Facilities undertook a review, leading to the establishment of a separate Estates and Facilities Health and Safety Committee.</td>
</tr>
<tr>
<td>3 Health and safety compliance audit to be established.</td>
<td>Yes</td>
<td>2009</td>
<td>Initial reintroduction of Health and Safety team audits occurred. Level 2 audit procedures are now in operation, and a level 3 audit based on the ROSPA standard is being undertaken in selected areas.</td>
</tr>
<tr>
<td>4 Compliance with existing Health and Safety-related policies to be reviewed.</td>
<td>Yes</td>
<td>Ongoing</td>
<td>General reassurance has been provided by internal audit of risk assessment and health and safety governance. Audits and levels of attendance at Health and Safety training highlighted issues of compliance, both with the health and safety manual, as well as Health and Safety policies. Compliance with the Manual is being addressed through the Health and Safety committee structure, with completion of quarterly reports showing significant improvements. Policies are being reviewed and amended to facilitate compliance with particular attention on violence and aggression and manual handling.</td>
</tr>
<tr>
<td>5 Progress policy development - staff screening, health surveillance, blood borne virus, immunisation and rehabilitation and first aid.</td>
<td>Yes</td>
<td></td>
<td>All policies now approved by the Health and Safety Committee and the Lothian Partnership Forum.</td>
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<tr>
<td>6 Review all policies and procedures to ensure establishment of quality systems for OH&amp;S related training and competence assessments.</td>
<td>Yes</td>
<td></td>
<td>The two important areas are training/competence assessment for manual handling and violence and aggression. The Violence and Aggression and Lone Working policies have now been approved. In terms of manual handling, the Health and Safety Committee has approved a different system which will now be implemented.</td>
</tr>
<tr>
<td>7 Health and Safety performance measures with appropriate weights in senior manager objectives.</td>
<td>Yes</td>
<td></td>
<td>This requirement has been incorporated into 2011/12 objectives for all Senior Managers where appropriate.</td>
</tr>
<tr>
<td>8 Improve RIDDOR and sharps incidents by 30% over three years.</td>
<td>Yes</td>
<td>Ongoing</td>
<td>Since the introduction of the strategy, enhanced data recording systems such as Datix has in fact resulted in an increase in the number of reports including RIDDORS being lodged within NHS Lothian. However, since 2010 there has been a downward trend in the figures – 8.96 per 1,000wte to 8.13 per 1,000wte.</td>
</tr>
<tr>
<td>9 Achieve Healthy Working Lives Status for all NHS Lothian staff by June 2011</td>
<td>Partial</td>
<td></td>
<td>The vast majority of NHS Lothian has achieved Bronze award status or higher. The only remaining elements not to achieve bronze status are LHPs within Edinburgh CHP. In addition, activity is only now commencing in relation to the move towards the adoption of HWLs for Pentland House. It is anticipated that the City CHP will achieve bronze award early in 2012; NHS Lothian is committed to achieve the mental health commendation under HWLs, although this is dependent upon the achievement of bronze award throughout the organisation. The required mental health and wellbeing policy statement has been approved by the partnership forum, and an action plan is in place in relation to mental health wellbeing activity. The application will therefore be taken forward once bronze award status is achieved;</td>
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<tr>
<td>9</td>
<td></td>
<td></td>
<td><strong>Achieve Healthy Working Lives Status for all NHS Lothian staff by June 2011</strong> (continued)</td>
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<tr>
<td>10</td>
<td>Yes</td>
<td>May 2010</td>
<td>Achieved and in place.</td>
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</table>
| 1 Promote the Equality and Diversity agenda.                          | Yes       | 2009/10                        | Intranet site established in January 2010  
<p>| 3 Collect and analyse data to ensure appropriate service delivery.     | Yes       | Ongoing from November 2008      | Major changes to the extent to which patient diversity data is collected to ensure that services meet the needs of diverse patients. Ethnic Coding Task Force set up April 2009. Changes to TRAK to collect this data mandatory from March 2011.                                                                                                                                                                                                 |
| 4 Undertake assessment audits, including needs assessments.           | Yes       | Ongoing from November 2008      | Impact assessments carried out routinely on NHS Lothian policies and plans. 173 carried out since 2008.                                                                                                                                                                                                                                                                                                                                                                       |
| 6 Deliver training to all staff to identify acceptable/ unacceptable standards of behaviour and adopt a “no tolerance” approach to bullying and harassment. | Yes       | From November 2008, revised in mid-2009 and January 2011 | Mandatory refresher training, corporate induction and Management in Practice training all revised to develop emphasis on dignity at work.                                                                                                                                                                                                                                                                                                                                 |</p>
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<tr>
<td>8</td>
<td>Yes</td>
<td>Nov 2009, May 2010</td>
<td>Approach taken to develop Equality &amp; Human Rights Scheme 2010-13 exceeded statutory requirements. Involved establishment of steering group made up of external stakeholders, backed up by wide consultation at beginning and end of process.</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>May 2010</td>
<td>Work throughout 2009 and 2010 to build equality &amp; diversity into mainstream quality assurance and quality improvement structures. 173 impact assessments completed across NHS Lothian since 2008, with 67 of these in 2010 (and 27 so far in 2011).</td>
</tr>
<tr>
<td>10</td>
<td>Yes</td>
<td>May 2010</td>
<td>Equality &amp; Human Rights Scheme sets out a range of programmes to deliver this.</td>
</tr>
<tr>
<td>11</td>
<td>Yes</td>
<td>November 2008</td>
<td>The Black &amp; Minority Ethnic Management Mentoring Scheme has supported 20 managers and aspiring managers from across NHS Lothian since 2009.</td>
</tr>
<tr>
<td>12</td>
<td>Yes</td>
<td></td>
<td>Developing national template for equal pay audit. This work will continue into the next strategy.</td>
</tr>
<tr>
<td>13</td>
<td>Yes</td>
<td>July 2010</td>
<td>Wide range of articles and items (in excess of 20) promoting equality in Team Brief, Connections, Health Link and on intranet/internet throughout the period of this strategy.</td>
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</table>
### Section Two: Engaging Leadership
### Chapter Three: Coaching Development Plan

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<tr>
<td>2. Develop partnerships with external providers and practitioners to ensure plan is quality assured and fit for purpose.</td>
<td>Yes</td>
<td>31 December 2009</td>
<td>Network of circa six external providers (NHSS and Self-employed) and 20 practitioners in field of coaching development established. Refreshed and updated annually.</td>
</tr>
<tr>
<td>3. Develop and sustain a core group of in-house coaches to Associate Certified Coach level.</td>
<td>Yes</td>
<td>30 June 2011</td>
<td>In place, 35 current active coaches and benefit of NHSS network noted in point 2 above also allows matching across NHSS network where that is seen as beneficial.</td>
</tr>
<tr>
<td>4. Develop 100 people to Associate Certified Coach level within 18 months.</td>
<td>Yes</td>
<td>31 May 2011 and ongoing</td>
<td>Maximised, in partnership, the return on investment of the available resources to achieve 101 ‘manager as coach’ level practitioners, plus 35 full in-house coaches to date, with a further 60 ‘manager as coach’ development places booked to run March-May 2011. Total 196 people developed via three or ten day investments in coaching practice development.</td>
</tr>
<tr>
<td>Action</td>
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<tr>
<td>1 Review drivers for change and impact assessment annually.</td>
<td>Yes</td>
<td>Annually</td>
<td>These are identified in the Workforce Plan which is signed off on annual basis by the Staff Governance Committee.</td>
</tr>
<tr>
<td>2 Review supply metrics (age/retirals/turnover etc) annually to establish a skills risk assessment.</td>
<td>Yes</td>
<td>Annually</td>
<td>Achieved through the Workforce Plan.</td>
</tr>
<tr>
<td>3 Establish a new Workforce Review Board.</td>
<td>Yes</td>
<td>First meeting - November 2009</td>
<td>Workforce Review Board established and meets on a quarterly basis.</td>
</tr>
<tr>
<td>4 Develop workforce supply channels to provide 1,000 employment opportunities for people socially excluded in the Lothian area (including 50 from Mental Health and 50 from Learning Disabilities)</td>
<td>Yes</td>
<td>March 2011</td>
<td>Supported employability pathways are in place for socially excluded disadvantaged groups through opportunities such as placements, Health Care Academy, recruitment workshops and job opportunities. 11 separate projects in place including liaison with the LEAP project.</td>
</tr>
<tr>
<td>5 Redesign recruitment strategies to encourage the long-term unemployed back to work.</td>
<td>Yes</td>
<td>Developed through 2009/10 and ongoing</td>
<td>Supported pathways for long-term unemployed through government initiatives such as Future Job Fund, joint recruitment event with Jobcentreplus and Edinburgh CHP and recruitment workshops.</td>
</tr>
<tr>
<td>6 Work with colleges and universities to provide training and development opportunities for NHS staff.</td>
<td>Yes</td>
<td>Ongoing</td>
<td>Edinburgh Napier, Edinburgh University, QMU, local FE Colleges Library Service Level Agreements in a range of opportunities and courses from pre-employment healthcare academy to learning beyond registration</td>
</tr>
<tr>
<td>7 Adopt new recruitment practices to encourage mature entrants.</td>
<td>No longer applicable</td>
<td></td>
<td>Jobcentreplus have put on hold the 50+ initiative, pending government review of unemployment initiatives.</td>
</tr>
<tr>
<td>8 Establish an NHS Lothian Workforce Development Forum.</td>
<td>Yes</td>
<td>2009/10</td>
<td>Set up and lead by the Director of HR &amp; OD the group has met on three occasions and will reconvene as necessary following restructuring changes across the HR &amp; OD function.</td>
</tr>
<tr>
<td>9 Establish an Articulation Steering Group.</td>
<td>Yes</td>
<td>Ongoing</td>
<td>Occasional meetings with local internal and external stakeholders in FE, Scottish Colleges, &amp; the Scottish Funding Council re collaborative advantage and joint funding streams have taken place throughout 2010/11, linked to HCSW and Healthcare Academy developments, towards social inclusion and accreditation initiatives</td>
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<tr>
<td>10 Create and publicise career pathways for differing age groups.</td>
<td>Yes</td>
<td>Ongoing</td>
<td>The Healthcare Academy remains oversubscribed, offering preparation for work and thereafter preparation to SVQ levels 1, 2 and 3. For some this includes pre-registration matriculation and beyond. Progression is aligned to the published Scottish Career Framework levels 1 through 5.</td>
</tr>
<tr>
<td>11 Produce a corporate reputation and branding plan by June 2009.</td>
<td>No longer applicable.</td>
<td></td>
<td>Draft employer branding recruitment strategy developed but due to the changing financial environment and consequences for recruitment practices, decision not to progress taken.</td>
</tr>
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<tr>
<td>1</td>
<td>Establish the competencies required to demonstrate ability to work at supervisory, middle management and senior management level.</td>
<td>Yes</td>
<td>2009/10</td>
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<tr>
<td>2</td>
<td>Assess staff against these competencies.</td>
<td>Yes</td>
<td>Ongoing</td>
</tr>
<tr>
<td>3</td>
<td>Design personal development plans to develop competencies.</td>
<td>Yes</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4</td>
<td>Work with colleges and universities to accredit experiential learning.</td>
<td>Yes</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5</td>
<td>Put in place development opportunities for staff with potential as part of approach to succession planning.</td>
<td>Yes</td>
<td>Ongoing</td>
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<td>Action</td>
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<tr>
<td>1 Introduce a new service model to support line managers and staff</td>
<td>Yes</td>
<td>2009/10</td>
<td>Senior Employee Relations team realigned to each Business Unit to provide Senior ER support and relationship management for CHP’s, UHD, Corporate and Facilities, based on the internationally recognised Business Partnering Model.</td>
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<tr>
<td>involved in ER activity.</td>
<td></td>
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<tr>
<td>2 Introduce robust electronic file management through the development</td>
<td>Yes</td>
<td>Feb 2009</td>
<td>All ER cases are now recorded and tracked through an electronic case management system – the first of its kind in NHS Scotland. The system has been used as the ‘blue print’ for the new NHS Scotland HR System.</td>
</tr>
<tr>
<td>of the Empower HR system.</td>
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<tr>
<td>3 Empower line managers to manage people issues through the</td>
<td>Yes</td>
<td>2009 and ongoing</td>
<td>People Management Skills programme established and reviewed and refreshed annually.</td>
</tr>
<tr>
<td>implementation of a generic people management upskilling and</td>
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<tr>
<td>coaching programme.</td>
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<tr>
<td>4 Deliver an intranet product that is accessible to all our staff</td>
<td>Yes</td>
<td>2010</td>
<td>The ER Assist intranet based product provides information on core Employment Policies, with Frequently Asked Questions, Case Studies and standard documents/templates to help managers apply the policies in a consistent manner.</td>
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<td>that will provide up-to-date, relevant, information and guidance on a</td>
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<tr>
<td>&quot;how to do basis&quot; for managers.</td>
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<tr>
<td>5 Implement new model by 2009 and report on performance of new</td>
<td>Yes</td>
<td>September 2010</td>
<td>Project evaluated Sept 2010 and Steering Group disbanded, remaining actions primarily around ER Assist and new developments around the creation of pathways for the 5 core policies have been mainstreamed into the ongoing work programme for ER.</td>
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<tr>
<td>model - October 2011.</td>
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</tr>
<tr>
<td>1 Redesign all processes linked to vacancy authorisation and recruitment.</td>
<td>No longer applicable</td>
<td></td>
<td>This action was overtaken by planned workforce reduction plans and new vacancy control measures introduced July 2010</td>
</tr>
<tr>
<td>2 Reduce recruitment costs by 10% over three years.</td>
<td>Yes</td>
<td>Nov09/Oct10</td>
<td>Comment: 36% reduction in advertising costs Nov09/Oct10 compared to Nov07/Oct08</td>
</tr>
<tr>
<td>3 Introduce an Account Manager in the recruitment department.</td>
<td>Yes</td>
<td>Oct 2008</td>
<td>An Account Manager (existing member of staff) has been introduced within the Recruitment Team to manage our advertising.</td>
</tr>
<tr>
<td>4 Create a Recruitment Performance Management Report with minimum data set.</td>
<td>Yes</td>
<td>April 2011</td>
<td>Quarterly and Annual Reports developed to incorporate data set (with exception of turnover which is reported through Workforce Planning Quarterly Reports).</td>
</tr>
<tr>
<td>5 Review executive search provision by June 2009.</td>
<td>Yes</td>
<td>April 2010</td>
<td>The Executive Search provision went through a tendering exercise in 2009/10 and the tender awarded to one company.</td>
</tr>
<tr>
<td>6 Design and implement a Recruitment Strategy.</td>
<td>No longer applicable</td>
<td></td>
<td>Not developed due to the changes in recruitment practices.</td>
</tr>
<tr>
<td>7 Develop links with agencies and organisations which support disadvantaged people.</td>
<td>Yes</td>
<td>2009 and ongoing</td>
<td>Links with agencies such as Jobcentreplus, Action Group, LEAP/Access to Industry, Women onto Work.</td>
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DRAFT

NHS Lothian

Human Resources and Organisational Development Strategy

November 2011 – March 2014

“At the level of Scotlands best and in the top 25 large healthcare providers in the world”
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<td>3.</td>
<td>Promoting Organisational Values and An Aspirational Culture that Enhances Staff Engagement and Ensure that our People have the Opportunity to Reach their Maximum Potential to Drive Organisational Performance</td>
<td>7</td>
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<td>4.</td>
<td>Best Practice in Leadership, Staff Governance, Performance Management and Compliance</td>
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</tbody>
</table>
1. **Fundamental Principles**

**Living Values**

- Doing what we say we will do
- Making explicit the behaviours and attitudes expected from all staff
- Providing leadership which is visible, accessible and involved
- Enhanced Health and Safety performance

**Engaging Leadership**

- Ensuring appropriate training is provided
- Growing internal capacity to modernise roles and ways of working to deliver 21st century services to patients
- Developing and delivering coaching plan

**Delivering Quality**

- Improving our processes to deliver better health and care
- Develop our workforce to deliver person centred and compassionate care
- Develop best value plans with key strategic partners in ‘Public Scotland’
Living Values

2. Employability and Social Responsibility

2.1 The single biggest determinant of ill health is poverty. The NHS exists for two reasons: to assist people who become ill and to help people not to become ill in the first place. NHS Lothian is the region’s single largest employer. In partnership with the Scottish Government, City of Edinburgh Council, West Lothian Council, East Lothian Council, Midlothian Council we will develop pathways and entries to employment to succeed in 21st Century roles. We will further develop partnerships with Job Centre plus, the third sector, higher and further education.

2.2 The case for Socially Responsible Recruitment has never been stronger:-

The World Health Organisation describe ‘poverty is the single largest determinant of health, and ill health is an obstacle to social and economic development. Poorer people live shorter lives and have poorer health than affluent people. This disparity has drawn attention to the remarkable sensitivity of health to the social environment.

Destinations of School Leavers (Scottish Government, 2010) reflects the current difficult economic climate. The figures demonstrate that due to fewer labour market opportunities there is greater demand for places in Higher and Further Education, and increases numbers of pupils staying on at school, with correspondingly lower numbers entering employment.

The unemployment rate for 16- to 24-year-olds rose sharply in 2009, from 15% in 2008 to 19% in 2009. However, the rate had already been rising for a number of years before the recent recession, from 12% in 2004 to 15% in 2008.

Currently two-fifths of all those who are unemployed are now aged under 25. (Labour Force Survey, May 2010).

The unemployment rate for young people in the UK is around 20%. This is more than three times the unemployment rate among older workers. Young people without qualifications have an even lower chance of getting a job as more people compete for each vacancy. Long-term youth unemployment has hit a 16 year high (Princes Trust, 2010).

The profile of long-term youth unemployment is changing, the number of 16-24 year olds who have been out of work for six months or more in the UK is 388,000 this has increased almost 70 per cent since before the recession 2008.

There is a personal cost of not being in work, education or training, which goes beyond the immediate loss of earnings. Gregg and Wadsworth (2010) describe the justification for intervention to prevent long or frequent periods out of work or education among young people does not just rest on the current unemployment, but on the long term scars that these young people experience and potentially feed into the next generation. Although these scarring effects are not confined to young people, they are more common for this age group.
Educational under achievement has a substantial, and lasting, effect on individuals. Oreopoulos & Salvanes (2009) document evidence on the relationship between education and a long list of benefits; success in the labour market, better health, reduced probability of risky behaviours; trust and civic participation. At a macro-economic level, educational underachievement inevitably also affects the relative performance of the economy overtime.

Increasing employment and opportunities of employment will directly promote better health and well-being assist in reducing child poverty and poverty in later life, and raise the growth in productivity of the economy.

The health impact of unemployment is well documented with individuals who find themselves unemployed more likely to suffer from mental, physical and emotional ill-health, in addition to the effects of social isolation and exclusion unemployment brings. People who are unemployed are more to be prescribed medication for depression, anxiety and emotional instability, as well as increased incidence of smoking alcohol and substance misuse. There is also the increased risk that unemployment becomes generational within workless households, this is due to reduced aspiration, lack if availability of a positive role models aligned social and environmental issues.

2.3 In particular we will;

- Create employment and training opportunities for a minimum of 190 people per year in the 16 to 24 age group

- Further develop the eleven projects currently in place to support individuals socially excluded into employment including a review of the contribution of the NHS Lothian Healthcare Academy, a review of the possible development of the relationship with the LEAP initiative, modern apprenticeships, volunteering and work experience.

- Review internal arrangements in training and development to enhance literacy and numeracy levels of staff.

- Create a sustainable job infrastructure across Agenda for Change bands 1 to 4 so that entry level staff have realistic promotion opportunities to advance their careers based on ability and ambition. This will be designed to provide staff on bands 1 and 2 with opportunities to progress to bands 3 and 4.

- Work with higher education and regulatory organisations to create an environment whereby a combination of the accreditation of experiential learning and study will give staff in bands 1 to 4 a route into the registered workforce thereby opening up opportunities to work at band 5 and above, and opening up an additional source of recruitment that will enrich the diversity of the workforce. This will require new models for employment and employability.
3. **Promoting Organisational Values and An Aspirational Culture that Enhances Staff Engagement and Ensure that our People have the Opportunity to Reach their Maximum Potential to Drive Organisational Performance**

3.1 The health and safety of our staff will be of vital importance to us in providing person centred, safe and effective care. Indeed we can only provide a quality service if our staff work in an improving health and safety environment.

We will continue to support and develop partnership working with the trades unions and professional organisations. Working in partnership with staff side colleagues improves the quality of our plans and greatly increases the likelihood of change being implemented in a manner that is implementable and sustainable.

We will continue to develop and promote equality and diversity in the workplace and in service provision via our employment policies and practice, systems, training and no tolerance approach to inappropriate behaviours and attitudes.

We will review all of our internal communications strategies to ensure that all staff are well informed, aware of all the key issues affecting the organisation and which impact on patient centred, safe and effective care provision.

We will review all training and development activity to ensure it is aligned in a way to help staff undertake their duties and responsibilities. This will include a Performance Development Plan within one year of joining the organisation, a meaningful annual conversation with an appropriate line manager about development needs/plans, and that all mandatory training is delivered to an appropriate standard on a timely basis.

3.2 In particular we will:

- Review the development needs of shop stewards and employee relations practitioners to aid fair and consistent employee relations practice.

- Train staff in equality and diversity and ensure that we are aware of the ethnicity of a minimum of 90% of our patients to ensure services are designed in a culturally competent manner.

- Work with all relevant and appropriate interest groups to ensure all services are provided in an appropriate manner.

- Implement a new modern communication strategy

- Review all training and development activity to ensure it is aligned to service delivery and that all mandatory training is delivered to an appropriate standard by the required timescale

- Support and enable staff to maximise the services provided to patients and improve the health and safety environment at work by developing and improving the delivery of our Occupational Health and Safety service.
Engaging Leadership

4. Best Practice in Leadership, Staff Governance Standard, Performance Management and Compliance

4.1 The Staff Governance Standard places a legal obligation on NHS Lothian (and all other NHS Boards in Scotland) to demonstrate that staff are:

- Well informed
- Appropriately trained
- Involved in decisions which affect them
- Treated fairly and consistently and
- Provided with an improved and safe working environment

These standards should be the basic minimum required not be aspirational. If NHS Lothian is to improve the services it provides to patients we will require to provide our people with the best possible education in leadership skills so that they have both an evidence base for the decisions they will be faced with implementing, and the confidence to put their leadership skills into practice.

All of our employees, all of the time, must act in concert with the stated values of the organisations. These values will need to be effectively communicated through our communications strategy.

4.2 In particular we will:

- Launch a second cohort of the Masters programme in Leadership Practice in partnership with the Scottish Government, NHS Boards, Edinburgh Napier University, Harvard University, and partner organisations

- Develop a suite of leadership skills development programmes appropriate to all supervisory, management and clinical director staff levels across the organisation

- Review recruitment and selection practice to ensure that capability, competency and a compassionate service ethos is demonstrated by individuals applying to join the organisation

- For supervisors and managers and shop stewards develop programmes of employee relations and people management skills in partnership with the trades unions

- Introduce across the organisation the Institute of Healthcare Managements competent manager programme

- Review and improve honest, consistent and fair performance management arrangements

- Introduce the psychological contract with staff where by on an annual basis every member of staff will be thanked for their efforts, advised of the continuing benefits of being an employee of NHS Lothian and
reminded of the core values and absolute dos’s and don’ts of being an employee.

- Introduce a motivational strategy to ensure that staff are motivated and incentivised to provide the best possible care to patients

- Launch in partnership with the Healthcare Faculty and Business School of Edinburgh Napier University the International Centre for Healthcare Leadership and Productivity to make Edinburgh and the Lothians a recognised Centre of Excellence in Healthcare Leadership
5. Engaging Leadership

5. Managing Change – Organisational Design, Development, Implementation and Sustainability

5.1 Given the nature of the purpose of the NHS, the single most important strategy is the Clinical Strategy. All other strategies and policies should be designed to support the Clinical Strategy and be affordable, implementable and sustainable. In addition, wherever possible, resources should be directed to delivering patient care. At one level descriptions of front line and back room or clinical an non-clinical services is not helpful. Modern healthcare is delivered by teams of professional dedicated people working together. Where a service can be shared within the public sector and where the quality of the service can be maintained or improved, and where this releases resources that can provide additional or enhanced services, then this should be implemented wherever possible.

5.2 In particular we will:

- Support the implementation of the Clinical Strategy through organisational development and service redesign
- Bring forward both within the NHS and with other partners options to consider shared services, both local, national and international,
- Ensure within all leadership, employee relations, and people management skills training programmes that specific investment is made in the development of managers who have the responsibility for the design, implementation and sustainability of organisational change for improvement in both national, regional and local programmes of work.
6. Workforce Planning and Redesign, Modernisation and Productivity

6.1 Workforce Planning is easy to describe and difficult to do well. At one level it is about ensuring you have the right staff in the right place at the right time. It might be appropriate to add, and motivated to do a good job. It is difficult because of the variables involved; demographics/demand for services; available resources; advances in modern medicine; advances in pharmaceutical science; rising patient expectations; changing government targets/policies; advances in information and other technology; changes in undergraduate and postgraduate training; and legislative changes.

Given all of this, together with salary costs in the region of £635m, the contribution appropriate workforce planning can make cannot be underestimated. The maximising and utilisation of staff resources is key to the successful delivery of our Clinical Strategy. In the course of last year (2009/2010) and the current year (2010/11) we will have reduced the size of our workforce by a minimum of 1468 wte posts. This has made a critical contribution to our financial position and was achieved against a background of reducing sickness absence, reducing overtime costs, reducing reliance and the cost of supplementary staffing (i.e. bank and agency staffing). Productivity has increased. We now have staffing levels akin to 2006/07 but have maintained our current activity levels. If we are to continue to develop services and maintain quality, we cannot go on solely relying on reducing the size of the workforce. The key will be getting the balance right between workforce numbers, skill mix and efficient/effective ways of working.

6.2 In particular we will:

- Investigate the extent to which the layers of management ensure clear lines of accountability, and consistent communications and support decision making

- Ensure working patterns are based on, and are supportive of, service need

- Design and recruit to new rotes (e.g. the healthcare technician pilot) based on 21st Century models to support person centred care

- Promote attendance and wellbeing at work and aim to achieve a sickness absence rate averaging 3.5%.
Delivering Quality

7. Provision of Care and Expert Human Resources and Organisational Development Services and Systems

7.1 In an organisation of some 28,000 people across 700 square miles, deployed 24/7, 365 days a year, core and expert human resources management and organisational development advice needs to be in place. This keeps the organisation safe and legal, and provides the platform from which to build our people development approach.

7.2 In particular we will:

- Support the implementation of the NHS Scotland new national HR IT system as a pilot implementer.

- Apply LEAN business process re-engineering techniques to all transactional personnel support services to maximise efficiency and productivity

- Deliver and seek to improve the Occupational Health and Safety Service specification

- Ensure that a senior and experienced human resources practitioner is available at all times out of hours to provide advice to managers and staff to handle critical HR incidents that occur out of normal working hours

- Develop a cadre of internal capability in relation to using mediation to resolve disputes before costly legal processes are necessary

Alan M Boyter
Director of Human Resources & Organisational Development
November 2011
FINANCIAL POSITION TO 30 SEPTEMBER 2011

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 six 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 £2.172m as at the end of September 2011.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an over spend of £2.172m for the first six months of financial year 2011/12: under delivery of £1.180m against the Local Reinvestment Plan (LRP) target (also referred to as efficiency target) and £0.992m of overspends on other budgets. This is an improvement on the August position.

3.2 In view of demographic related pressures across a number of areas, non recurring NRAC support of £2.04m has been provided; and £1m of funding to offset unavoidable prescribing price increases. This has been provided from flexibility within the strategic reserves, identified as part of the analysis for the Quarter 1 review, and the value is unchanged from August.

3.3 The formal Mid Year Review is near completion and will be reported to the Executive Management Team in December, along with the October results. Early indications suggest that break even is achievable, not withstanding the focus in ensuring delivery of recurring savings and the unexpected prescribing overspend position, also reflected across other NHS Boards in Scotland.

3.4 The month 6 results are summarised in Table 1 below:
Table 1 – Financial Position to 30 September 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>(1,086)</td>
<td>(248)</td>
<td>(838)</td>
</tr>
<tr>
<td>CH(C)Ps</td>
<td>(3,606)</td>
<td>(753)</td>
<td>(2,853)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(553)</td>
<td>0</td>
<td>(553)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>34</td>
<td>(179)</td>
<td>213</td>
</tr>
<tr>
<td>NRAC/prescribing support</td>
<td>3,039</td>
<td>0</td>
<td>3,039</td>
</tr>
<tr>
<td>Under/(Over)spend</td>
<td>(2,172)</td>
<td>(1,180)</td>
<td>(992)</td>
</tr>
</tbody>
</table>

Income and Allocations

3.5 Work is nearing completion to ensure performance against income budgets can be reported; it is expected that this will allow reporting from month 7. The delay in concluding this work was due to changes to the financial system in the early part of the year.

University Hospitals Division

3.6 The University Hospitals Division is reporting an overspend of £1.086m for the period to date: underspend of £0.017m against baseline budgets; slippage of £0.248m against the agreed LRP target; and a shortfall of £0.821m against local Divisional savings. The in month improvement relates to over achievement on LRP of £0.6m from Cancer and Children’s services.

3.7 Nursing costs appear to have stabilised, although there remain concerns in Critical Care, Older People and Cancer services. Clinical supplies costs are increasing, largely driven by higher emergency activity. Drugs expenditure remains volatile. Offsetting some of the overspend are continued medical staff cost savings.

3.8 As reported last month, the position on local savings has improved as a result of rephrasing; however it is important to note that the half year results include only 39% of the annual target of £26.8m. Subject to the LRP and Waiting Times target risks, breakeven against the Divisional baseline budget for the year remains achievable, through measures to address the remaining LRP slippage and other non recurrent measures.

Primary and Community

3.9 The CHPs / CHCP / Primary Care services are reporting a net overspend of £3.606m for the period, an adverse movement of £0.48m in the month. This over spend comprises three broad issues: prescribing (£3.052m); slippage on non-prescribing LRP (£0.281m) and HCH/GMS services (£0.273m).

3.10 The Prescribing budget is £3.052m overspent (approximately 5%), of which £0.472m relates to slippage on the savings target. Without any remedial action, this would result in an overspend of £6.1m against the available budget for the year.
Prescribing volumes continue to run above expectations in most areas and prices remain higher than predicted. The current forecast for the year anticipates delivery of £2m LRP delivery, which is £1m short of the target. Prescribing volumes are influenced by the impact of public health campaigns (for example smoking cessation) and more targeting of QOF indicators.

Prescribing expenditure exceeds plan across many areas but smoking cessation, dementia, diabetes, respiratory and infections are significant contributors to this growth. It is possible that free prescriptions may be driving volumes as there appears to be additional volumes of drugs now being prescribed which can be bought over the counter. High prices remain a major factor within the overall overspend as does the prices of drugs in short supply in the market.

A prescribing recovery plan has been drawn up across the CHPs which concentrates on tackling the issues of unmet LRP and volumes, and to identify how the CHPs can get the overspend back on budget.

3.16 Slippage on the LRP target is largely attributable to the Edinburgh CHP, Midlothian CHP and (as noted above) Prescribing. Within all CHPs there is still £5.7m of the annual LRP target for which schemes have not yet been fully developed. Prescribing accounts for 44% of this slippage.

Corporate Budgets

3.17 There is broadly a break even position on Corporate Budgets after six months (£0.03m underspend). Slippage on the delivery of LRP has been reduced substantially to £0.18m; an improvement of £0.54m. The previous overspend in eHealth has been reduced from £0.26m to £0.09m due to benefits on the O2 mobile telecoms contract. Facilities Management continues to overspend against baseline budget (£0.5m), with issues relating to rates; extraordinary maintenance; and above inflation cost increases in the Consort contract.

Strategic Budgets

3.18 Strategic Budgets are reporting a £0.553m over spend, which remains largely related to UNPAC costs (£0.998m), offset by extra recoveries on clinical claim legal costs (£0.323m) and ACT costs (£0.08m). Management actions to address the cost implications of high cost Psychiatric/ Learning Disability referrals are partly underway via the Director of Public Health / Acting Director of Strategic Planning.

Efficiency & Productivity

3.19 Whilst there remains a gap in the level of savings identified to date, £49.4m of plans have been identified against the £50.1m savings target required. The plans include £6.2m of non recurrent schemes. As highlighted in the following table, £17.7m of savings have been achieved during the first six months of the year; this represents 35% of the target. It is important to note that the full year effect of the schemes generating these savings is in the region of £36.1m, and this is underpinned by 337 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 - Sept Target £000</th>
<th>April - Sept Actual £000</th>
<th>April – Sept Slippage £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHD</td>
<td>26,840</td>
<td>26,378</td>
<td>10,495</td>
<td>10,247</td>
<td>(248)</td>
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<tr>
<td>CH(C)Ps/PCCO</td>
<td>14,514</td>
<td>14,222</td>
<td>4,255</td>
<td>3,502</td>
<td>(753)</td>
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<tr>
<td>Corporate Budgets</td>
<td>7,005</td>
<td>6,988</td>
<td>3,212</td>
<td>3,033</td>
<td>(178)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>1,771</td>
<td>1,778</td>
<td>886</td>
<td>886</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50,130</strong></td>
<td><strong>49,366</strong></td>
<td><strong>18,848</strong></td>
<td><strong>17,668</strong></td>
<td><strong>(1,179)</strong></td>
</tr>
</tbody>
</table>

**Capital**

3.20 Investment of £28.5m has been delivered at the end of September, reflecting progress with the reprovision programme. Major areas of expenditure 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 3.

**Activity**

3.21 Appendix 4 contains high level acute activity figures for the six months to 30 September 2011, with the same months’ activity during the two previous years shown for comparative purposes. Average activity in the 12 month period October 2010 to September 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.

3.22 In summary, the activity position for the period April to September 2011, compared to the same period in 2010, is as follows:

- Decrease in elective admissions of 1,297 admissions (equating to just below 8%)
- Increase in emergency admissions of 2,090 admissions (5.6%)
- Overall for inpatient admissions an increase of 793 (an increase of 1.5%)
- Day case activity is just under 22 cases down from last year (less than 0.1%)
- Decrease in new outpatients of 2,272 (1.9%)
- Increase in births of 59 over all sites, or 1.2% (increase of 66 births on RIE site)
- A very large increase in intensity of workload in the Neonatal Unit with intensive care occupied bed days up over 38% in the 6 months (although this ha decreased substantially since last month ), and a 5.5% increase in total occupied bed days in the NNU
- Increase in diagnostic procedures of just over 13%, an additional 1,641 procedures, (as efforts were made to achieve the 6 week maximum wait by the end of May, and to sustain the position thereafter)
4 Risk Register

4.1 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.

5 Impact on Health Inequalities

5.1 This document is to advise the Board of work undertaken and performance against financial targets. An equality impact assessment is not required.

6 Impact on Inequalities

6.1 Refer to 5.1 above.

7 Involving People

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

8 Resource Implications

8.1 The resource implications are described in above.

Carol Potter
Associate Director of Finance
14 November 2011
carol.potter@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Financial Position by Service Area April - Sept 2011
Appendix 2: NHS Lothian Capital Expenditure Position April – Sept 2011
Appendix 3: NHS Lothian Activity Summary Sept 2011
### NHS Lothian Expenditure Summary September 2011

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget 2010/11</th>
<th>YTD Budget</th>
<th>YTD Actuals</th>
<th>Variance</th>
<th>Prior year variance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td><strong>UNIVERSITY HOSPITAL DIVISION</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Medical</td>
<td>116,629</td>
<td>58,777</td>
<td>59,541</td>
<td>(765)</td>
<td>(1,418)</td>
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<tr>
<td>REAS &amp; MOE</td>
<td>65,626</td>
<td>32,409</td>
<td>32,703</td>
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<td>(112)</td>
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<td>Surgical</td>
<td>75,063</td>
<td>37,468</td>
<td>37,501</td>
<td>(33)</td>
<td>(1,061)</td>
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<td>Labs, A&amp;T, Critical Care, HDSU</td>
<td>114,662</td>
<td>57,670</td>
<td>57,865</td>
<td>(195)</td>
<td>(2,141)</td>
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<tr>
<td>Women &amp; Children &amp; Neuroscience</td>
<td>88,228</td>
<td>43,061</td>
<td>42,972</td>
<td>89</td>
<td>(758)</td>
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<td>Radiology, Cancer &amp; Head &amp; Neck</td>
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<td>47,776</td>
<td>48,189</td>
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<td>(968)</td>
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<td>Corporate</td>
<td>20,640</td>
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<td>1,566</td>
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<td><strong>Total</strong></td>
<td><strong>575,400</strong></td>
<td><strong>281,552</strong></td>
<td><strong>282,638</strong></td>
<td><strong>(1,086)</strong></td>
<td><strong>(4,892)</strong></td>
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<tr>
<td><strong>CHCP/CHPs/PCCO</strong></td>
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<td>East Lothian CHP</td>
<td>60,194</td>
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<td>(463)</td>
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<td>Edinburgh CHP</td>
<td>236,900</td>
<td>121,530</td>
<td>123,519</td>
<td>(1,988)</td>
<td>(1,453)</td>
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<td>Midlothian CHP</td>
<td>67,956</td>
<td>34,191</td>
<td>34,762</td>
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<td>(316)</td>
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<td>West Lothian CHP</td>
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<td>45,365</td>
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<td>(185)</td>
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<td>PCCO</td>
<td>19,258</td>
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<td>(3,821)</td>
<td>31</td>
<td>(14)</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>478,158</strong></td>
<td><strong>228,161</strong></td>
<td><strong>231,767</strong></td>
<td><strong>(3,606)</strong></td>
<td><strong>(2,431)</strong></td>
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<td></td>
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<tr>
<td><strong>STRATEGIC BUDGETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLAs/UNPACs/Non Contract Activity</td>
<td>9,886</td>
<td>5,125</td>
<td>6,124</td>
<td>(998)</td>
<td>(156)</td>
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<tr>
<td>Capital charges and Asset Impairments</td>
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<td>18,772</td>
<td>18,772</td>
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<tr>
<td>Provisions for Pension Costs and Claims</td>
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<td>1,841</td>
<td>1,684</td>
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<tr>
<td>Commissioning from 3rd Sector</td>
<td>12,909</td>
<td>6,345</td>
<td>6,297</td>
<td>47</td>
<td>(155)</td>
</tr>
<tr>
<td>Reserves and Uncommitted Allocations</td>
<td>28,850</td>
<td>(1,160)</td>
<td>(1,400)</td>
<td>240</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>101,990</strong></td>
<td><strong>30,923</strong></td>
<td><strong>31,476</strong></td>
<td><strong>(553)</strong></td>
<td><strong>(125)</strong></td>
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<tr>
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<tr>
<td><strong>CORPORATE BUDGETS</strong></td>
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<tr>
<td>Chief Executive’s Department</td>
<td>525</td>
<td>263</td>
<td>255</td>
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<td>Medical Director</td>
<td>982</td>
<td>252</td>
<td>203</td>
<td>50</td>
<td>15</td>
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<td>Consort</td>
<td>42,970</td>
<td>21,464</td>
<td>21,517</td>
<td>(52)</td>
<td>32</td>
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<tr>
<td>Communications</td>
<td>572</td>
<td>285</td>
<td>289</td>
<td>(4)</td>
<td>4</td>
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<tr>
<td>Ehealth</td>
<td>25,445</td>
<td>9,794</td>
<td>9,888</td>
<td>(94)</td>
<td>(115)</td>
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<td>Facilities Management</td>
<td>77,135</td>
<td>36,741</td>
<td>37,388</td>
<td>(647)</td>
<td>(1,073)</td>
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<td>Finance and capital planning</td>
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<td>5,344</td>
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<td>9</td>
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<tr>
<td>Human Resources &amp; OH&amp;S</td>
<td>10,231</td>
<td>4,236</td>
<td>4,272</td>
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<td>(216)</td>
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<td>Nursing</td>
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<td>1,163</td>
<td>1,070</td>
<td>93</td>
<td>33</td>
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<td>Pharmacy</td>
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<td>5,985</td>
<td>5,524</td>
<td>462</td>
<td>214</td>
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<td>1,432</td>
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<td>1,669</td>
<td>73</td>
<td>82</td>
</tr>
<tr>
<td>Other</td>
<td>80</td>
<td>(502)</td>
<td>(508)</td>
<td>7</td>
<td>0</td>
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<td><strong>Total</strong></td>
<td><strong>192,466</strong></td>
<td><strong>88,375</strong></td>
<td><strong>88,341</strong></td>
<td><strong>34</strong></td>
<td><strong>(892)</strong></td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td>Reserves and other</td>
<td>14,404</td>
<td>2,039</td>
<td>0</td>
<td>2,039</td>
<td>2,500</td>
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<tr>
<td>Allocations to support Prescribing</td>
<td>1,000</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
<td>0</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,363,419</strong></td>
<td><strong>632,050</strong></td>
<td><strong>634,222</strong></td>
<td><strong>(2,172)</strong></td>
<td><strong>(5,840)</strong></td>
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</table>
### APPENDIX 2

**NHS Lothian Capital Expenditure Position April – September 2011**

<table>
<thead>
<tr>
<th>PROJECT SPECIFIC FUNDING</th>
<th>Agreed Programme £m</th>
<th>Expenditure to date £m</th>
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</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital</td>
<td>23.664</td>
<td>12.325</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children</td>
<td>4.310</td>
<td>3.796</td>
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<tr>
<td>Musselburgh Primary Care Centre</td>
<td>12.014</td>
<td>6.926</td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>(0.802)</td>
<td>0.880</td>
</tr>
<tr>
<td>Dalkeith Medical Centre</td>
<td>2.104</td>
<td>2.112</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>1.000</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>1.813</td>
<td>0.420</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>1.552</td>
<td>(0.092)</td>
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<tr>
<td>West End Medical Practice</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Gullane Medical Practice</td>
<td>0.000</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>2.199</td>
<td>0.000</td>
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<tr>
<td><strong>SCHEMES OVER DELEGATED LIMIT</strong></td>
<td><strong>52.511</strong></td>
<td><strong>26.367</strong></td>
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<table>
<thead>
<tr>
<th>FORMULA FUNDING</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Compliance</td>
<td>2.858</td>
<td>0.529</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>6.729</td>
<td>0.928</td>
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<tr>
<td>E-Health Strategic Priorities</td>
<td>2.087</td>
<td>0.377</td>
</tr>
<tr>
<td>National PACS Refresh 2007-17</td>
<td>0.129</td>
<td>0.115</td>
</tr>
<tr>
<td>Traffic management</td>
<td>0.398</td>
<td>0.168</td>
</tr>
<tr>
<td>Expansion of renal capacity RIE</td>
<td>1.068</td>
<td>0.000</td>
</tr>
<tr>
<td>Chemotherapy e-Prescribing &amp; Administration System</td>
<td>0.133</td>
<td>0.042</td>
</tr>
<tr>
<td>Observation Ward A&amp;E RIE</td>
<td>0.339</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>0.132</td>
<td>0.000</td>
</tr>
<tr>
<td>Birthing suite (SJH)</td>
<td>0.413</td>
<td>0.003</td>
</tr>
<tr>
<td>Birthing suite (RIE)</td>
<td>1.910</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>SCHEMES FUNDED BY FORMULA</strong></td>
<td><strong>16.196</strong></td>
<td><strong>2.162</strong></td>
</tr>
</tbody>
</table>

| OTHER                                         |                       |                       |
| Asset Sales                                   | (2.585)               | 0.000                 |

| OTHER SCHEMES                                 |                       |                       |
| (2.585)                                       | 0.000                 |

| TOTAL                                         | 66.122                | 28.529                |
## Elective Inpatient Admissions by CMT

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>343</td>
<td>357</td>
<td>259</td>
<td>53</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>2948</td>
<td>2835</td>
<td>2660</td>
<td>444</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>191</td>
<td>233</td>
<td>151</td>
<td>27</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>4325</td>
<td>4354</td>
<td>4132</td>
<td>693</td>
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<tr>
<td>Musculo-Skeletal</td>
<td>2254</td>
<td>1952</td>
<td>1929</td>
<td>317</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>1833</td>
<td>1432</td>
<td>1128</td>
<td>227</td>
</tr>
<tr>
<td>Oncology</td>
<td>1939</td>
<td>1602</td>
<td>1449</td>
<td>251</td>
</tr>
<tr>
<td>Critical care</td>
<td>25</td>
<td>23</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>3743</td>
<td>3399</td>
<td>3137</td>
<td>518</td>
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<tr>
<td>East Lothian CHP</td>
<td>283</td>
<td>175</td>
<td>178</td>
<td>29</td>
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<tr>
<td>West Lothian CHP</td>
<td>51</td>
<td>75</td>
<td>101</td>
<td>16</td>
</tr>
<tr>
<td><strong>All elective inpatient admissions</strong></td>
<td><strong>17935</strong></td>
<td><strong>16437</strong></td>
<td><strong>15140</strong></td>
<td><strong>2578</strong></td>
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</table>

## Emergency Inpatient Admissions by CMT

<table>
<thead>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>17816</td>
<td>18449</td>
<td>19636</td>
<td>3258</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>1467</td>
<td>1476</td>
<td>1631</td>
<td>275</td>
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<tr>
<td>MOE/Stroke, REAS</td>
<td>439</td>
<td>386</td>
<td>620</td>
<td>92</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>6364</td>
<td>6195</td>
<td>6601</td>
<td>1073</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>1780</td>
<td>1670</td>
<td>1556</td>
<td>263</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>1575</td>
<td>1585</td>
<td>1723</td>
<td>280</td>
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<tr>
<td>Oncology</td>
<td>1068</td>
<td>1104</td>
<td>1177</td>
<td>199</td>
</tr>
<tr>
<td>Critical Care</td>
<td>506</td>
<td>530</td>
<td>631</td>
<td>106</td>
</tr>
<tr>
<td>Women &amp; Children (excl Maternity)</td>
<td>5334</td>
<td>5252</td>
<td>5212</td>
<td>883</td>
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<tr>
<td>East Lothian CHP</td>
<td>222</td>
<td>239</td>
<td>205</td>
<td>34</td>
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<tr>
<td>West Lothian CHP</td>
<td>217</td>
<td>180</td>
<td>164</td>
<td>26</td>
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<tr>
<td><strong>All emergency inpatient admissions</strong></td>
<td><strong>36788</strong></td>
<td><strong>37066</strong></td>
<td><strong>39156</strong></td>
<td><strong>6489</strong></td>
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</tbody>
</table>

## Births

<table>
<thead>
<tr>
<th></th>
<th>Apr - Sept 2009</th>
<th>Apr - Sept 2010</th>
<th>Apr - Sept 2011</th>
<th>Mthly Ave Oct 10 to Sept 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births - RIE</td>
<td>3297</td>
<td>3436</td>
<td>3502</td>
<td>575</td>
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<tr>
<td>Births - St John's</td>
<td>1544</td>
<td>1431</td>
<td>1431</td>
<td>243</td>
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<td>Home Births</td>
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<td>82</td>
<td>75</td>
<td>12</td>
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<td><strong>Births - Total</strong></td>
<td>4939</td>
<td>4949</td>
<td>5008</td>
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## Neonatal Unit Occupied Bed Days

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<tr>
<td>Intensive care</td>
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<td>1079</td>
<td>1490</td>
<td>209</td>
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<tr>
<td>High dependency</td>
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<td>1211</td>
<td>1104</td>
<td>208</td>
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<tr>
<td>Special Care</td>
<td>3489</td>
<td>3569</td>
<td>3587</td>
<td>611</td>
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<tr>
<td><strong>All NNU Bed Days</strong></td>
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<td>5859</td>
<td>6181</td>
<td>1028</td>
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<tr>
<td>Day cases by CMT</td>
<td>Apr - Sept 2009</td>
<td>Apr - Sept 2010</td>
<td>Apr - Sept 2011</td>
<td>Mthly Ave Oct 10 to Sept 2011</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Medical</td>
<td>466</td>
<td>421</td>
<td>414</td>
<td>66</td>
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<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>1849</td>
<td>1449</td>
<td>1455</td>
<td>227</td>
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<tr>
<td>General Surgery &amp; Urology</td>
<td>3385</td>
<td>3396</td>
<td>3275</td>
<td>555</td>
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<tr>
<td>Musculo-Skeletal</td>
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<td>1356</td>
<td>1282</td>
<td>225</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>5444</td>
<td>5864</td>
<td>5546</td>
<td>938</td>
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<tr>
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<td>9752</td>
<td>10302</td>
<td>10934</td>
<td>1734</td>
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<td>Anaesthetics &amp; Theatres</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Women &amp; Children (excl maternity)</td>
<td>7259</td>
<td>6819</td>
<td>6719</td>
<td>1112</td>
</tr>
<tr>
<td>East Lothian CHP</td>
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<td>165</td>
<td>123</td>
<td>20</td>
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<tr>
<td>All day cases</td>
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<td>29776</td>
<td>29754</td>
<td>4878</td>
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</table>

<table>
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<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>GI</td>
<td>9142</td>
<td>10025</td>
<td>11494</td>
<td>1744</td>
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<td>Urology</td>
<td>2145</td>
<td>2423</td>
<td>2595</td>
<td>434</td>
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<tr>
<td>All scopes</td>
<td>11287</td>
<td>12448</td>
<td>14089</td>
<td>2178</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>14389</td>
<td>14237</td>
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<td>2454</td>
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<td>15059</td>
<td>14547</td>
<td>2460</td>
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<td>Head &amp; Neck</td>
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<td>27202</td>
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<td>7009</td>
<td>7759</td>
<td>1231</td>
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<td>676</td>
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<td>24859</td>
<td>4164</td>
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<td>East Lothian CHP</td>
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<tr>
<td>West Lothian CHP</td>
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<td>1309</td>
<td>1299</td>
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<tr>
<td>All new outpatients</td>
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<td>117956</td>
<td>115684</td>
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1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board on the most recently available 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

3.1 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>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>
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<td></td>
</tr>
<tr>
<td>Lung</td>
<td>96.3%</td>
<td></td>
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</tr>
<tr>
<td>Lymphoma</td>
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<td></td>
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</tr>
<tr>
<td>Melanoma</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
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<td>Ovarian</td>
<td>90%</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Urological</td>
<td>100%</td>
<td></td>
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</tr>
<tr>
<td><strong>95%</strong></td>
<td><strong>98.4%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Suspicion of Cancer referrals (62 days)</strong></td>
<td></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>85%</td>
<td>90.6%</td>
<td>✓</td>
</tr>
<tr>
<td><strong>New outpatients</strong> - max 12 weeks from referral</td>
<td>0</td>
<td>25</td>
<td>X</td>
</tr>
<tr>
<td><strong>Inpatient Case</strong> - max 9 weeks from referral</td>
<td>0</td>
<td>416</td>
<td>X</td>
</tr>
<tr>
<td><strong>Drug and Alcohol Treatment</strong> - max 5 weeks from referral</td>
<td>65%</td>
<td>74%</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Wait for key diagnostic tests &gt; 4 weeks</strong></td>
<td></td>
<td></td>
<td></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>
<td></td>
</tr>
<tr>
<td>Upper endoscopy</td>
<td>109</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower endoscopy</td>
<td>64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>148</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>321</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E Waits</strong> - % of patients waiting 4 hours or less</td>
<td>98%</td>
<td>RIE – 96.7%</td>
<td>SJH – 98%</td>
</tr>
<tr>
<td><strong>Cataract Waiting Times</strong> - max wait 18 wks outpatient and inpatient combined</td>
<td>0</td>
<td>31</td>
<td>X</td>
</tr>
<tr>
<td><strong>Hip Surgery Waiting Times</strong> - % of Hip Fracture operations within 24 safe operating hours</td>
<td>98%</td>
<td>100%</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> – Compliance with 12 week stage of treatment milestone from March 2011. (Progress towards an 18 week pathway due December 2011).</td>
<td>0</td>
<td>22</td>
<td>X</td>
</tr>
</tbody>
</table>

### 3.2 In the latest period, the following six 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
4 Key Risks

The following performance measures are those where NHS Lothian are currently not achieving expected performance.

4.1 Outpatient Standard, Inpatient/Day Case Standard and Cataract Standard

Despite anticipating meeting targets in all specialties (except scoliosis) at the end of September, this has not proved possible in ENT and Ophthalmology. Difficulties in recruiting and retaining locum medical staff has led to patients waiting longer than agreed standards for both the outpatient and inpatient timescales of 12 and 9 weeks, as summarised in the table below. 31 ophthalmology patients also were waiting longer for the operative stage of their treatment for the same reason.

Actions to address these issues include:
- Additional theatre sessions within Ophthalmology all day Thursday, Friday mornings and at weekends
- The implementation of the Scottish Government’s Eyecare Project which is developing processes for how patients can be managed more appropriately within Primary Care
- The planned introduction of a single clinical template from early 2012 meaning the patients will only be booked to see the most appropriate consultant
- The introduction of two additional all day weekend theatre sessions from November within ENT
- The introduction of consultant expert clinics to ensure that patients are seen by an appropriately senior clinician to avoid re referrals

<table>
<thead>
<tr>
<th></th>
<th>Outpatients</th>
<th>Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>ENT</td>
<td></td>
<td>342</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>25</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>416</td>
</tr>
</tbody>
</table>

Discussions are continuing with the Scottish Government Access Support Team over Scoliosis and whether the current proposal offers the best solution.

As from October 2011 patients are no longer being offered treatment in England. The Medical Director is currently leading a review group to ensure future practice is strictly in line with Scottish Government guidance on New Ways.

The Board’s Chief Operating Officer is reviewing capacity locally to ensure that this is maximised. As well as this, contact has been made with other surrounding NHS Boards to source any additional capacity that they may have available.
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 was not met at the end of August but was achieved again at the end of September.

At the end of September there were 321 patients waiting between 4 and 6 weeks for these tests. Waits for the four key Radiology tests and flexible cystoscopies remain at less than four weeks.

Work is continuing to ensure that surveillance patients are brought in for their investigations within the appropriate timescale.

4.3 **A&E Waits**

As at end of September, performance fell just short of meeting the 98% target, sitting at 97.6%. This continues to be an area of focus to improve 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**

At the end of September there were a total of 22 patients waiting over 12 weeks for either a first contact appointment or from assessment to fitting of a hearing aid. This has decreased considerably from the high numbers being reported previously and is subject to manual checking of patients to ensure that New Ways rules are applied consistently to Audiology waiting times.

By the end of 2011, waits are to be reduced to a total pathway time of 18 weeks (nine weeks for each stage), and highlighted above, waits over the milestone of 12 weeks, which was due at the end of March, persist.

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 those waiting times standards stated above.

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Associate Director, Strategic Planning

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NHS LOTHIAN

Board Meeting
23 November 2011

Acting Director of Strategic Planning (Executive Lead)

TACKLING DELAYED DISCHARGE

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 September and October 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) NHSL target - 66</th>
<th>Complex Codes</th>
<th>6 Weeks+ (National standard - 0)</th>
<th>Short Stay (Target - 0)</th>
<th>Average length of stay Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>141</td>
<td>105</td>
<td>36</td>
<td>27</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>October</td>
<td>129</td>
<td>90</td>
<td>39</td>
<td>17</td>
<td>1</td>
<td>29</td>
</tr>
</tbody>
</table>

3.3 At census point in September, NHS Lothian continued to report high numbers of patients delayed along similar numbers as July and August. The most recent census in October has seen an improvement, with a lower overall number delayed, a drop in the number delayed over 6 weeks and a lowering of the average length of stay. The improved figures are predominantly within City of Edinburgh, a consequence of slightly better access to care homes as well as improvements in the speed of arranging home care packages.
3.4 The table below sets out the performance across the Partnership areas for September and October. In line with information governance guidance, numbers less than 5 are not reported 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>Sep</td>
<td>Oct</td>
<td>Sep</td>
<td>Oct</td>
</tr>
<tr>
<td>Overall</td>
<td>87</td>
<td>69</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Over 6 weeks</td>
<td>26</td>
<td>17</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 81 and 69 delays in September and October, with 26 and 17 delayed over six weeks in the same time frame. Care home choice remains the largest challenge, both in terms of overall capacity and patients who are deemed too frail to have more than one move after discharge, so interim placements to temporary care/nursing homes are clinically not advised.

3.6 East Lothian, despite a rise from 10 to 15 delayed across September to October, there have been no patients delayed over 6 weeks this financial year. In addition East had no patients within the complex category of delays in October.

3.7 Midlothian has figures below well below 10 in September and below the reportable number in October with no delays over 6 weeks and indeed none for the 10th month in succession.

3.8 West Lothian have returned to having Zero patients delayed in both September and October.

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 September and October.

<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>Sep</td>
<td>Oct</td>
<td>Sep</td>
<td>Oct</td>
</tr>
<tr>
<td>Complex Codes</td>
<td>23</td>
<td>27</td>
<td>&lt;5</td>
<td>0</td>
</tr>
</tbody>
</table>

3.10 There has been a slight increase in the number of patients who are coded as complex, rising to 39 in October. The increase is attributable to an increase in the number of patients who are waiting on their chosen single home having a vacancy, predominantly within establishments that have dementia units. This is an area of work that is progressing through the change fund initiatives and work through the Integrated Resource Framework.

3.11 Despite the increase in overall numbers, the average length of stay continues to be brought down, currently at 124 days compared to 201 days in October 2010 and 233 days in October 2009.
4  New National Standards for Delayed Discharge Patients

4.1  The Cabinet Secretary for Health, Wellbeing and Cities Strategies announced on 21 October at the Scottish National Party Conference, new national standards for delayed discharges. These will form part of Boards HEAT targets for 2012/13 and beyond. These are that::

- By April 2013, no individual patient waiting more than four weeks
- By April 2015, no individual patient waiting more than two weeks.
- Move to beds lost (local discussion on % reductions from a base line to be agreed and monitored) - what is included has yet to be agreed nationally

4.2  Work will now commence to review NHS Lothian and its partners agreed plans for how we will work towards these new targets. This will need to be complete before the beginning of the next financial year.

4.3  To assist partnerships to work towards the delivery of the above standards work through the change fund should be modelled against the trajectories. All partnerships have now started to established new services or enhance current services i.e. re-ablement; care at home packages; night sitter services; crisis responses etc. In addition to this there is also work against community enhancement through working with the third sector and older people themselves. Information on the capacity of these new services need to be matched against the new targets as part of our modelling work.

5  Key Risks

5.1  The key risks are the increasing number of delays and the resulting pressure this creates on patient flow across health and social care.

5.2  The Southern Cross Care Homes Group (circa 10% of care home beds across Lothian) moved to new Ownership from 1 November. NHS Lothian and Councils continuing to monitor the situation to ensure there is no adverse effect. Seven out of eight Southern Cross care homes in Lothian have moved to new operators, the other, which is in West Lothian, continues to be monitored and supported by the council.

6  Risk Register

6.1  The risks associated with delayed discharge continue to be managed in partnership with local authorities.

7  Impact on Health Inequalities

7.1  This section is not relevant to this performance report.
8 Impact on Inequalities

8.1 As stated above having an impact on inequalities is implicit within the drive to reduce the length of delay that people may face post admission which may cause reduction in functioning and independence for some.

9 Involving People

9.1 The work around tackling delays is multi partnership and requires this on an ongoing basis. We also need to involve patients and their relatives in decision making and this is an area that will increasingly become more important.

10 Resource Implications

10.1 There are no direct resource implications associated with this report.

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14 November 2011
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QUALITY AND OUTCOMES FRAMEWORK 2010/11

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the achievement of the Lothian GP practices in the 2010/11 Quality and Outcomes Framework (QOF).

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

2 Recommendations

The Board is recommended to:

2.1 Recognise the continuing high level of achievement of the Lothian GP practices, with Lothian going up from 6th place to 4th place overall in Scotland.

2.2 Note the increasing numbers of Lothian patients with specific medical conditions being identified and managed in primary care, with a resultant reduction in the workload for secondary care. For example, most patients with Type 2 diabetes are now managed primarily by general practice.

2.3 Recognise that the proactive management and improved anticipatory care for patients with a wide range of chronic conditions contributes to the delivery of the board's HEAT targets. Examples of HEAT targets which are facilitated by the QOF work in primary care include:

- Target T6, the delivery of reductions in the rates of hospital admissions and bed days of patients with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Asthma, Diabetes or Coronary Heart Disease (CHD)
- Target T9, improvements in the early diagnosis and management of patients with dementia
- Target T10, shifting the balance of care, with reductions in the rates of attendance at A&E

HEAT: Health, Efficiency, Access, Treatment
2.4 Acknowledge that this high level of performance has been achieved at a reduced level of expenditure compared to earlier years.

3 Discussion of Key Issues

3.1 QOF represents one of the main sources of potential income for general practices (GP surgeries) across the UK. It is a major part of the new General Medical Services (GMS) contract, introduced on 1 April 2004. Participation by general practices in the QOF is voluntary: all Lothian practices participate. QOF measures achievement against a range of evidence-based clinical and non-clinical indicators, with 1,000 points available and payments awarded according to the level of achievement. In Lothian, the 2010/11 QOF expenditure is £19.5m.

3.2 The average level of QOF achievement for the Lothian practices in 2010/11 was 98.14%, compared to the Scottish average of 97.23%.

3.3 The main impact of the introduction of QOF has been the case-finding of patients with a range of defined diseases; and the call and recall of these patients with a view to implementing evidence based intervention in primary care. Figure 1 highlights the result of case-finding for three disease areas since the introduction of QOF in 2004/05, while Figure 2 highlights improvements in clinical outcomes in relation to cholesterol.

Figure 1

![Patients on GP Disease Registers](image_url)

3.4 Recent research has confirmed the expectation that improvements in QOF performance are associated with some modest but measurable improvements in
subsequent hospital costs and mortality, particularly for stroke care. In addition, a recent report found an association between mean QOF achievement and emergency admission rates for some conditions.

3.5 Looking at Coronary Heart Disease (CHD), more practices in both Lothian and Scotland have achieved greater population coverage of their CHD patient population in terms of lowering cholesterol since 2005/06. Lothian’s Measuring Quality in Primary Care Group (now Monitoring Impact of Primary Care Group) found that Lothian’s improvement has, however, been more marked, with an increase in median achievement from 72% to 78%, as demonstrated in Figure 2. It is in the interests of Lothian’s population that the curves in this table move as far to the right and become as vertical as possible. It should be noted that maximum QOF payment is obtained at 70% achievement, with no additional QOF payment for achievement greater than 70%.

Figure 2

Percentage of GP practices in Lothian meeting QOF achievement for CHD 08 (% cholesterol < 5) (denominator - population coverage)

3.6 The Monitoring Impact of Primary Care Group is updating and expanding its previous 2008 nGMS Impact Report to quantify the effect of QOF in additional disease areas. The new report is expected to be finalised in early 2012. This work links into the work stream developing primary care effectiveness measures within the Lothian Delivering Quality in Primary Care action plan. A further report on quality indicators will be brought to the Board in January.

4 Measuring Quality in Primary Care, report to Executive Management Team, by NHS Lothian Measuring Quality in Primary Care Group, September 2011
3.7 The value of the 2010/11 QOF achievement to the Lothian practices is £19.5m. Changes in the national methodology used to weight payment for the number of patients on each disease register, introduced in 2009/10 and 2010/11, reduced the value of QOF points to Lothian GPs by c £0.6m overall. Despite this reduction in income the Lothian GPs have continued to deliver a high level of patient care within the QOF.

4 Key Risks
4.1 There are no risks attached to the recommendations.

5 Risk Register
5.1 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 the outcome of the 2010/11 QOF. An equality impact assessment is not required.

7 Impact on Inequalities
7.1 Work that is undertaken in primary care and through general practice has a particular focus on addressing inequalities in both health and social care.

8 Involving People
8.1 This paper does not specifically propose any strategy / policy or service change.

9 Resource Implications
9.1 The QOF achievement value of £19.5m is fully funded. There are no additional resource implications.

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NHS LOTHIAN

Board Meeting
23 November 2011

Acting Director of Strategic Planning (Executive Lead)

NHS LOTHIAN CORPORATE OBJECTIVES 2011/12

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the NHS Lothian Board on the current position in relation to the NHS Lothian Corporate Objectives 2011/12.

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 current position and actions being taken to ensure delivery of the corporate objectives by March 2012.

3 Discussion of Key Issues

3.1 The content of the NHS Lothian Corporate Objectives 2011/12 has been produced and agreed in collaboration with Executive Director colleagues and were formally signed off by the Board at the May 2011 meeting.

3.2 The HEAT targets agreed with the Scottish Government as part of the Local Delivery Plan are also included as part of the organisation’s overall corporate objectives.

4 Key Risks

4.1 As a report on progress, Directors have been asked to ensure any risks associated with their objectives are managed appropriately to ensure delivery of objectives by end of March 2012.
5 Risk Register

5.1 Responsible Directors have been asked to ensure that any risks associated with their objectives have been clearly identified within the risk register where appropriate.

6 Impact on Health Inequalities

6.1 A key focus for the NHS Lothian Corporate Objectives, in addition to meeting our Local Delivery Plan commitments, is to drive forward the agenda for tackling health inequalities as well as cost versus quality and driving the agenda around patient experience and safety.

6.2 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. Any proposed changes arising from individual objectives will be subject to the agreed processes for involving people as appropriate.

9 Resource Implications

9.1 The resource implications are as per individual areas of work identified throughout the workplan.

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9 November 2011  9 November 2011
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List of Appendices

Appendix 1: Corporate Objectives - 6 month report to end of September 2011
## OBJECTIVE 1:
**BY THE END OF MARCH 2012, CONTINUE TO DELIVER BEST VALUE FOR MONEY WHILST ENSURING PATIENT SAFETY THROUGH MAXIMISING OUR RESOURCES (HUMAN, PHYSICAL AND FINANCIAL)**

<table>
<thead>
<tr>
<th>ACTIONS: Delivery of the six high level corporate objectives outlined below will be measured through the specific metrics/actions identified within each section</th>
<th>TIMING</th>
<th>LEAD BOARD MEMBER</th>
<th>PROGRESS AGAINST ACTIONS (please note if complete or on target; otherwise please provide a brief update of progress to date)</th>
</tr>
</thead>
</table>
| **HUMAN**  
Implement action plans with Executive Colleagues for the continuous improvement of the Healthcare Governance and Risk Management Standards | Ongoing | DF | On target - HG&RM Committee agenda changed to focus on safe, effective and patient centred care. The quality report is a main agenda item at Board meetings. |
| Develop a Performance Management System that effectively supports performance management across NHS Lothian. | March 2012 | AMcM/DF | Being developed as part of Clinical Framework linking to Quality Indicator work to ensure synergy |
| Review the current Human Resources & Organisational Development strategy working with Executive Directors and the Lothian Partnership Forum | March 2012 | AB | On target for refreshed HR&OD Strategy to November 2011 Board meeting. |
| Continue to implement programmes to support the reduction in sickness and absence levels targeting short term absence and maintain the target level of 4% | Ongoing | AB/All | On target |
| Manage the national phased reduction in overall doctors in training numbers through workforce planning and alternative professional role development | March 2012 | DF/JKS | Workshops organised with the services that are most at risk of a reduction in trainees – A&E, Anaesthetics, Radiology, Medical, Mental Health, and O&G. |
| Support the continued implementation of leadership and succession planning programmes across NHS Lothian to retain best talent | March 2012 | AB/All | On target |
| **IMPROVING HEALTH FOR ALL**  |
| **NHS LOTHIAN CORPORATE OBJECTIVES 2011/12 – progress report as at 30 September 2011** |

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target Date</th>
<th>Responsible Lead</th>
<th>Progress</th>
</tr>
</thead>
</table>
| Continue to implement the Scottish Patient Safety Programme to deliver reductions in standardised hospital mortality rate and in adverse events recorded | March 2012 | DF | • All 3 acute sites remain less than 1 for HSMR, with WGH being one of the lowest HSMR in Scotland. RIE has reduction in HSMR of 6.5%, WGH reduction of 3.7%, St. Johns no change.  
• NHS Lothian has demonstrated a 42% reduction in the adverse event rate against 30% target. |
| Operate within our capital resource limit; meet their cash requirement | March 2012 | SG | On target |
| NHS Boards to deliver a 3% efficiency saving to reinvest in frontline services | March 2012 | SG | On target |
| To reduce energy-based carbon emissions by 3% or greater | March 2012 | JKS | At the end of Q1, 10/11 NHS Lothian has achieved a 10.35% reduction in CO2 emissions compared to the baseline of April-June 2009 figures, against a target of a 3% reduction per year. |
| **PHYSICAL** | | | |
| To plan and design clinical services which will meet the changing needs of our population and which are available to all of them who may benefit through the development of our clinical strategy | December 2012 | AMcM | Draft paper to Board on 28 November |
| To adopt evidence based best practice and models of health care which focus on patients and clients to ensure that we achieve the best outcomes for our population | Ongoing | AMcM | As above and links to objective re: Performance Management |
| **FINANCIAL** | | | |
| Implement NHS Lothian 5 year financial plan to achieve breakeven position in 2011/12. To achieve best value in our use of resource available to us, obtaining greatest health benefit | March 2012 | SG | On target |
**IMPROVING HEALTH FOR ALL**  
**NHS LOTHIAN CORPORATE OBJECTIVES 2011/12 – progress report as at 30 September 2011**

| for the greatest numbers of people | March 2012 | SG | On target - All projects are currently on plan for delivery. The Capital Programme is monitored through various committees, including Lothian Capital Investment Group, Executive Management Team and Finance & Performance Review and budgets scrutinised to ensure they are within budget and in line with the financial plan. |
| Ensure the Capital Programme is delivered within a robust financial planning and governance framework, incorporating a revision of the 5 year Capital Plan to support NHS Lothian’s strategic objectives and which manages risk in relation to the economic position | March 2012 | SG | On target, schemes backloaded, Revised target of £50m |
| Ensure the Efficiency & Productivity Programme delivers the required LRP target of circa £52m for 2011/12 | March 2012 | SG | On target, schemes backloaded, Revised target of £50m |
| Continue to reduce all bank and agency costs but with particular emphasis on decreasing nursing and medical spend | March 2012 | MH/DF | • Nursing: achieving 13% reduction in bank use against 20% target. Achieving 5% reduction in spend  
• Medical Locums: Growth in use but achieving 19% reduction in spend  
• Other disciplines: achieving 95% reduction in spend and use |
| Develop programme budgeting using the Integrated Resource Framework as a basis | March 2012 | SG/AMcM | Work is underway to update health data/finance for 2009/10 and 2010/11 by end of calendar year. Work is on track to deliver programme costs by March 2012 |
## OBJECTIVE 2:
THROUGH A RANGE OF MEASURES IDENTIFIED BELOW, CONTINUE TO SHIFT THE BALANCE OF CARE FROM HOSPITAL TO PRIMARY/COMMUNITY CARE, RANGING FROM 4% TO 40% ACROSS IDENTIFIED SPECIALISMS OVER THE NEXT FIVE YEARS

<table>
<thead>
<tr>
<th>ACTIONS: Delivery of the six high level corporate objectives outlined below will be measured through the specific metrics/actions identified within each section</th>
<th>TIMING</th>
<th>LEAD BOARD MEMBER</th>
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</tr>
</thead>
<tbody>
<tr>
<td>By December 2011, through the development of the clinical strategy, we will agree an actual figure for the overall shift in the balance of care to be delivered in the next five years</td>
<td>December 2011</td>
<td>AMcM</td>
<td>Scottish Government are now using the HEAT target on reducing emergency admissions to over 75’s/bed reductions, the current position is above trajectory</td>
</tr>
<tr>
<td>Work effectively with partners in social care, voluntary organisations, staff and public to gain support and synergy in progressing our objectives</td>
<td>March 2012</td>
<td>AMcM</td>
<td>NHS Lothian has been assessed by the Scottish Health Council at level 4 for two sections of the standard three in the Participation Standard and working towards level 3 in the third. This is external validation of our standards and governance of participation and partnership working.</td>
</tr>
<tr>
<td>Continue to work with Partner Authorities to deliver the Delayed Discharge standards contained in the Local Delivery Plan and ensure no delays over 6 weeks. No patients delayed in short stay beds with an agreed monthly maximum of 66 delayed discharge patients overall on a consistent basis 365 days per year</td>
<td>March 2012</td>
<td>AMcM</td>
<td>Delayed discharges in Edinburgh continue to be outwith the agreed local target and we are working with them to bring this into line by end of November. The implementation of the Change Fund work will begin to support a reduction in the number of delays.</td>
</tr>
<tr>
<td>Continue to work with Partner Authorities to deliver the agree metrics to support the implementation of the Change Plans across four partners</td>
<td>March 2012</td>
<td>AMcM</td>
<td>National metrics have been issued, with local more operational metrics being consistent with the national metrics.</td>
</tr>
</tbody>
</table>
## NHS Lothian Corporate Objectives 2011/12 – Progress Report as at 30 September 2011

<table>
<thead>
<tr>
<th>Objective</th>
<th>Start Date</th>
<th>Responsible Parties</th>
<th>Progress/Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree Single Outcome Agreements with each of the four Local Authorities and use these to drive forward the shift in the balance of care</td>
<td>June 2011</td>
<td>GMs / AMcM</td>
<td>Single Outcome Agreement progress discussed at September EMT and agreed to take paper to November Board</td>
</tr>
<tr>
<td>Ensure that winter pressures are effectively managed and that activity is managed to reflect seasonal pressures</td>
<td>Ongoing</td>
<td>JKS / AMcM / GMs</td>
<td>First draft of Winter Plan discussed at EMT in October. UHD first formal winter meeting - 10 October. Good discussion and key themes agreed.</td>
</tr>
<tr>
<td>Jointly develop services for patients requiring low secure facilities from Carstairs and the Orchard Centre to ensure timely transfer of patients assessed as being ready for discharge</td>
<td>Ongoing</td>
<td>AMcM</td>
<td>Business cases are being developed.</td>
</tr>
</tbody>
</table>
| Support the implementation of the Palliative Care strategy to achieve a shift in the balance of care in respect of place of death:  
  - Decrease the proportion of deaths occurring in Acute Hospitals from 42.3% of all Lothian deaths (2008 baseline) to 38% by 2015  
  - Increase the proportion of deaths occurring in community residential settings from 34.4% of all Lothian deaths to 38.8% by 2015 | Ongoing    | AMcM                | 2011/12 Qrt 1 performance is not favourable compared to our position in 2010/11. A higher proportion of deaths occurred in acute hospitals, and a slightly lower proportion of deaths occurred in community residential settings, rather than the desired shift from acute hospital to more residential based care. EMT reporting of this local target has now started. This will support a system wide focus on actions required to achieve the shifts specified. NHS Lothian has reviewed its Living and Dying Well Delivery plan and will update the plan fully by 31 March 2012 (phase – 1 of strategy implementation). A service redesign exercise is planned to support changes required to deliver the objectives of the strategy by 2015/16. |
| Support 2% reduction in the rates of attendance at A&E between 2009/10 and 2013/14 | March 2012 | AMcM                | HEAT T10 performance has varied over the year with activity month on month running above and below trajectory. Current activity is running slightly above, but parallel to trajectory. The mix of existing and planned T10 related work is designed to have a |
## IMPROVING HEALTH FOR ALL
### NHS LOTHIAN CORPORATE OBJECTIVES 2011/12 – progress report as at 30 September 2011

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target Date</th>
<th>Sponsor</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the Learning Disabilities strategy, reducing from 78 to 54 beds</td>
<td>March 2016</td>
<td>AMcM</td>
<td>On target - with an initial report submitted to ICIC 7 October 2011</td>
</tr>
<tr>
<td>over the next five years (31% reduction)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to implement the Physical &amp; Complex Disability strategy</td>
<td>March 2012</td>
<td>AMcM</td>
<td>On target - agreed projects are progressing as planned</td>
</tr>
<tr>
<td>Increase the balance of care to 40% against a baseline of 30.5% in relation</td>
<td>March 2016</td>
<td>AMcM</td>
<td>This is no longer a HEAT target, however is continuing to be included</td>
</tr>
<tr>
<td>to older people supported with complex packages of care against the</td>
<td></td>
<td></td>
<td>within the local metrics for the joint plans for older people and the</td>
</tr>
<tr>
<td>number of people in care homes and continuing care</td>
<td></td>
<td></td>
<td>Change Fund. On target.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## OBJECTIVE 3:
**IMPROVE HEALTH INEQUALITIES AND HEALTH DEPRIVATION BY PROVIDING BETTER ACCESS TO SERVICES AND RESOURCES TO MEET THE NEEDS OF THE MOST VULNERABLE GROUPS**

### ACTIONS:
Delivery of the six high level corporate objectives outlined below will be measured through the specific metrics/actions identified within each section

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD BOARD MEMBER</th>
<th>PROGRESS AGAINST ACTIONS (please note if complete or on target; otherwise provide a brief update of progress to date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>AKM</td>
<td>Agreeing SLAs for 2011-14 HIF projects. Reports have been produced on City Centre Southern Arc ADF and background papers on Edinburgh Local Development Plan (June 2011). Long Term Conditions Model for primary care finalised and used in presentations/reports.</td>
</tr>
<tr>
<td>March 2012</td>
<td>AKM</td>
<td>Implementing the WHO report, “Putting our own house in order – Lothian”</td>
</tr>
<tr>
<td>March 2014</td>
<td>AKM</td>
<td>Health and Wellbeing Partnerships in place and working on domestic violence, housing, health literacy, migrant health, homelessness prevention.</td>
</tr>
<tr>
<td>March 2012</td>
<td>AKM</td>
<td>On target. 3,422 health checks completed by Keep Well as of 30 September 2011</td>
</tr>
<tr>
<td>March 2014</td>
<td>AKM</td>
<td>Delivery of Lothian’s new H2 target for 2010-14 has already begun and is on trajectory via Childsmile nurseries where all 3-4 year olds in the 20% most deprived SIMD category nurseries are offered two fluoride varnish applications per year. No official data available yet.</td>
</tr>
<tr>
<td>March 2012</td>
<td>AKM</td>
<td>CP Alert numbers going thru TRAK system are available. For Q1 in 2011 there were 62 CP alerts in</td>
</tr>
</tbody>
</table>
### IMPROVING HEALTH FOR ALL  
**NHS LOTHIAN CORPORATE OBJECTIVES 2011/12 – progress report as at 30 September 2011**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Date</th>
<th>Responsible Party</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAK CP Alerts and cancer screening services across Lothian</td>
<td></td>
<td></td>
<td>A&amp;E, 36 inpatient alerts and 42 DNA outpatient appointment alerts. Figures for alerts for unborn babies are expected to be available shortly.</td>
</tr>
<tr>
<td>Deliver agreed completion rates for child healthy weight intervention programme through combined approach of prevention and treatment</td>
<td>March 2012</td>
<td>AKM</td>
<td>We are delivering a balanced approach to prevention and treatment. Negotiations are at an advanced stage with schools, school nursing and health promotion, to deliver a health improvement in 17 schools across Lothian (total school roll 3450). The Get Going weight management programme is being enhanced through the development of an adolescent programme and boosting the clinical support for the service.</td>
</tr>
<tr>
<td>Deliver agreed, extended 2011/12 Alcohol Brief Interventions target – 9938 additional interventions</td>
<td>March 2012</td>
<td>AMcM</td>
<td>Ahead of trajectory (Aug. fig is 4,445 interventions completed) and will deliver on the HEAT target for 2011/12</td>
</tr>
<tr>
<td>Deliver smoking cessation services to support the reduction in the number of people smoking by 2014</td>
<td>March 2012</td>
<td>JF/AKM</td>
<td>On target. The service continues to provide open access groups and other user friendly services targeting those from Lothian’s most deprived communities to seek innovative ways of engaging smokers.</td>
</tr>
<tr>
<td>Ensure the transfer of prison healthcare to NHS Lothian from Addiewell and Edinburgh on 1 November 2011</td>
<td>November 2011</td>
<td>AMcM/DS</td>
<td>The transfer of prison healthcare is on schedule for 1 November at which point East Lothian CHP will take on operational management. Paper taken to EMT on 18 October.</td>
</tr>
</tbody>
</table>
| Ensure progress is maintained with our partners in implementing Getting It Right for Every Child in each CHP/CHCP and Local Authority | March 2012 | AMcM              | Work is continuing to roll out the implementation of Getting it Right for every child in each Local Authority area.  
A Regional Lead on GIRFEC for the SEAT region has recently been appointed, with this post being hosted by NHS Lothian. |
| Implement the recommendations from the 2010/11 5x5x5 in reducing inequalities | March 2012 | AKM               | Recommendations have been developed and named leads identified. Scottish Govt.’s NUG has agreed to |
| | develop CHSPs. Gillian Garvie in Scottish Govt. has now been tasked with establishing a short life working group. This group will develop the dataset for the 24-30 month child health check. Work on implementation of the check in Lothian will incorporate their recommendation. |
**OBJECTIVE 4:**
**DELIVER THE AGREED ACCESS AND TREATMENT TARGETS AS SET OUT BY SCOTTISH GOVERNMENT WITHIN THE TIMESCALES OUTLINED**

<table>
<thead>
<tr>
<th>ACTIONS:</th>
<th>TIMING</th>
<th>LEAD BOARD MEMBER</th>
<th>PROGRESS AGAINST ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure the delivery of the 90% composite target for 18 week RTT by December 2011</td>
<td>December 2011</td>
<td>JKS / AMcM</td>
<td>Performance on the 18 week referral to treatment target is now above 90%. This target is still being measured through “fuzzy matching”, although progress has been made in recording pathways on TRAK, initially in Orthopaedic Surgery. A key focus is to improve rates of outcome of outpatient appointments.</td>
</tr>
<tr>
<td>Maintain National waiting standards for cataracts, CHD, Hip Fracture and Unscheduled Care</td>
<td>Ongoing</td>
<td>JKS</td>
<td>Performance on the 4 hour standard has been consistently between 97% and 98% in the first 6 months of the year 2010-11, meeting 98% in the month of August – see table below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>RIE</th>
<th>WGH</th>
<th>St John’s</th>
<th>RHSC</th>
<th>All sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>95.7%</td>
<td>97%</td>
<td>98.6%</td>
<td>99.4%</td>
<td>97.2%</td>
</tr>
<tr>
<td>May</td>
<td>96.1%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>99.6%</td>
<td>97.5%</td>
</tr>
<tr>
<td>June</td>
<td>95.9%</td>
<td>96.7%</td>
<td>98.5%</td>
<td>99.4%</td>
<td>97.2%</td>
</tr>
<tr>
<td>July</td>
<td>96%</td>
<td>99%</td>
<td>97.1%</td>
<td>99.4%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Aug</td>
<td>97.2%</td>
<td>98.4%</td>
<td>98.7%</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>Sept</td>
<td>96.8%</td>
<td>97.8%</td>
<td>98%</td>
<td>99.2%</td>
<td>97.6%</td>
</tr>
</tbody>
</table>

This continues to be an area of focus to improve performance through:
- ensuring 100% performance for Flow 1 (minors)
IMPROVING HEALTH FOR ALL
NHS LOTHIAN CORPORATE OBJECTIVES 2011/12 – progress report as at 30 September 2011

- 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

**FNOF:**
Performance against this target has been as follows:
- April – 93.5%
- May – 100%
- June – 98%
- July – 99%
- August – 84%
- September – 100%

---

**Maintain National access targets**
- Diagnostics – 6 weeks
- Outpatients – 12 weeks
- Day/Inpatients – 9 weeks

**March 2012 JKS**

Several specialties (notably ENT, Ophthalmology, pain control, as well as Scoliosis) have experienced difficulty in meeting the 12 week maximum wait for an outpatient appointment and the 9 week wait for inpatient/day case treatment in the first 6 months of the year (see table below). This is due to increased referrals, capacity constraints, and difficulties in recruiting and retaining key locum medical staff.

<table>
<thead>
<tr>
<th></th>
<th>Outpatients &gt; 12 wks</th>
<th>Inpatients/day cases &gt; 9 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>39</td>
<td>80</td>
</tr>
<tr>
<td>May</td>
<td>120</td>
<td>188</td>
</tr>
</tbody>
</table>
With regard to waiting times for the 8 key diagnostic tests, waits for 5 of these (the 4 Radiology tests and flexible cystoscopies) have been consistently at a maximum of 4 weeks in the 6 months April to September 2011. The Scottish Government Health department has agreed that waits for 3 diagnostic tests (upper and lower endoscopy and colonoscopy) will fluctuate between four and six weeks. Numbers waiting over 4 and over 6 weeks at month end are shown in the table below.

<table>
<thead>
<tr>
<th>Over 4 weeks</th>
<th>Over 6 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>210</td>
</tr>
<tr>
<td>June</td>
<td>316</td>
</tr>
<tr>
<td>July</td>
<td>478</td>
</tr>
<tr>
<td>Aug</td>
<td>615</td>
</tr>
<tr>
<td>Sept</td>
<td>321</td>
</tr>
</tbody>
</table>

From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral

<table>
<thead>
<tr>
<th>March 2012</th>
<th>JKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target - the cancer targets have been consistently met. For the quarter to end June 2011 performance was 99% for the 31 day target and 98.4% for the 62 day target from receipt of an urgent referral with a suspicion of cancer to first cancer treatment.</td>
<td></td>
</tr>
</tbody>
</table>

Ensure the implementation of the Clinical Quality indicators for referral management and unscheduled care as part of the Quality Outcomes Framework

<table>
<thead>
<tr>
<th>March 2012</th>
<th>AMcM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal and external peer reviews now in place with every GP practice in Lothian to the 3 areas of work i.e. medicine management, referral pathways and unscheduled care. Full reports by end of March</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Start Date</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Ensure robust and meaningful engagement with primary care contractors through Primary Care Forward Group to both drive forward strategic development and efficiency but also to enhance the quality of care delivered within the wider primary care arena</td>
<td>Ongoing</td>
</tr>
<tr>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</td>
<td>March 2012</td>
</tr>
<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; and 18 weeks referral to treatment for Psychological Therapies from December 2014</td>
<td>March 2012</td>
</tr>
<tr>
<td>Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors</td>
<td>March 2012</td>
</tr>
<tr>
<td>To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013</td>
<td>March 2012</td>
</tr>
</tbody>
</table>
Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.

<table>
<thead>
<tr>
<th></th>
<th>March 2012</th>
<th>AKM</th>
<th>Current SAB rate (Apr-Sep 2011) – 0.31</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Current CDI rate (Apr-Sep 2011) – 0.37</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SAB target by 2012 – 0.32</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CDI target by 2012 – 0.41</td>
</tr>
</tbody>
</table>
### OBJECTIVE 5:
DEVELOP AND IMPLEMENT INNOVATIVE MODELS OF CARE AND PATIENT PATHWAYS TO IMPROVE PATIENT SAFETY AND ACHIEVE BEST VALUE AS PART OF SERVICE REDESIGN, SUPPORTED WHERE APPROPRIATE BY THE USE OF LEAN AND OTHER IMPROVEMENT METHODOLOGIES

**ACTIONS:**
Delivery of the six high level corporate objectives outlined below will be measured through the specific metrics/actions identified within each section

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</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>AMcM</td>
<td>Action Plan in place and being implemented. The £2.8m new Lothian Birth Centre at the Royal Infirmary of Edinburgh opened in October 2011. Awaiting confirmation from the Scottish Government on the additional funding to be provided for the implementing the Refreshed Framework for Maternity Care.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>DF / JKS</td>
<td>Regular meetings organised with John Iredale, Hugh Edmonson and others, to improve links between NHS, University and Bioquarter.</td>
</tr>
<tr>
<td>March 2012</td>
<td>DF</td>
<td>A new eHealth Strategy reflecting the changes contained within the revised National Strategy launched by the Cabinet Secretary on 12/9/11 is poised to be discussed at EMT in the coming weeks. In addition, the corporate eHealth forum under the auspices of the eHealth Strategy Group which aims to further enhance the level of clinical engagement in eHealth has been reinstated and has already had its inaugural meeting.</td>
</tr>
<tr>
<td>March</td>
<td>MH</td>
<td>Pilot and Phase 1 on target.</td>
</tr>
<tr>
<td>Objective</td>
<td>Year</td>
<td>Responsible Body</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td>Acute care and reduce by 20% in agreed pilot wards</td>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>Develop the new Mental Health and Wellbeing Strategy 2011-2015 and commence the first phase of implementation</td>
<td>March 2012</td>
<td>AMcM</td>
</tr>
<tr>
<td>Develop and take forward the implementation of four change plans in relation to the development of intermediate care services for older people</td>
<td>March 2012</td>
<td>AMcM/GMs/JKS</td>
</tr>
</tbody>
</table>
Helpfully there will be national guidance developed later this year, which the Strategic Programme Manager for Older people has assisted to develop, therefore there is consistency with the good practice across Lothian.
### OBJECTIVE 6:
**PLAN, DEVELOP AND IMPLEMENT A PROGRAMME OF GOVERNANCE AND EFFICIENCY MEASURES WHICH ENSURE TRANSPARENCY, OPENNESS AND FAIRNESS IN DEALING WITH ALL MATTERS IN RELATION TO STAFF, PATIENTS AND THE PUBLIC**

<table>
<thead>
<tr>
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<th>TIMING</th>
<th>LEAD BOARD MEMBER</th>
<th>PROGRESS AGAINST ACTIONS</th>
</tr>
</thead>
</table>
| To support organisational innovation and learning, using opportunities to adopt new technologies and learning to improve outcomes | March 2012 | MH | • Organisational learning shared pan Lothian through substance misuse and orthotic service improvement plans.  
• Releasing time to care programme supporting innovation and sharing effective practice across ward and community teams.  
• E-triage being introduced to dermatology and orthotic services through lean projects.  
• E-anticipatory care plans being introduced for frequently attending COPD patients.  
• Pilot of tele-pulmonary rehabilitation underway as part of 5x5x5 patient experience implementation. |
<p>| Ensure the Implementation of the Equality &amp; Human Rights Scheme in all Divisions and Departments of NHS Lothian | March 2012 | AB | On target |
| Implement the Quality Improvement Strategy and report twice yearly to HG&amp;RM Committee | March 2012 | DF | First 6-month report due December 2011 to HCGRM Committee. |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>Timeframe</th>
<th>Responsible</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Continue to support use of LEAN methodologies across NHS Lothian and use  | March 2012| MH / AMcM   | • On target to deliver annual work programme as agreed by EMT. 8 lean events delivered to date and 5 more currently underway.  
• Recruitment of 2 additional Service Improvement Managers to support Quality and Efficiency Plan underway. Workplan will be revised as required as Clinical Framework develops.  
• 2 further change agent cohorts trained in lean methodology (49 staff) enhancing capability for process improvement. |
| Use lean methodology to support the implementation of the Clinical and     |           |             |                                                                iska Service strategies                                                                                                                                                                            |
| Service strategies                                                        |           |             |                                                                                                                                                                                                      |
| Forge international links to both learn from and inform development of    | March 2012| DF          | During 2011 NHS Lothian has participated fully in the McKinsey LSN Cardiac Improvement Network with partners in Singapore, Hong Kong, Victoria (Aus) and Queensland (Aus). The annual LSN member meeting was held in October in Paris and was attended by the CEO and Head of HIU where the improvement programme for 2012 was discussed and a greater emphasis on hospital indicators agreed. NHS Lothian has been approached to partner other LSN members in a range of hospital service improvement programmes including the Basque Health Region in Spain, further work with Queensland and several projects with colleagues in Singapore. |
| best practice including benchmarking and study visits, including          |           |             |                                                                iska participation in Health Tracker                                                                                                                                                              |
| participation in Health Tracker                                           |           |             |                                                                                                                                                                                                      |
| Establish 2011/12 5x5x5 projects and their teams, supporting the projects | March 2012| AMcM        | On target - each of the 5 teams will present to a Directors’ Informal meeting during Oct/Nov                                                                                                             |
| to be ready to report back to the 2012 Planning for the Future event      |           |             |                                                                                                                                                                                                      |
| Implement and monitor the agreed Community Planning Framework action      | Ongoing   | AMcM        | On target - continued support across CPPs to drive forward health priorities                                                                                                                            |
| plan across the 4 local authority areas                                  |           |             |                                                                                                                                                                                                      |
### NHS Lothian Corporate Objectives 2011/12 – Progress Report as at 30 September 2011

<table>
<thead>
<tr>
<th>Objective</th>
<th>Timeframe</th>
<th>Responsible</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure robust arrangements are in place to manage communicable disease outbreaks and healthcare associated infection with targeted plans in place to deliver continued reduction in rates of healthcare associated infection (this includes HEAT Target T11)</td>
<td>Ongoing</td>
<td>AKM</td>
<td>The health protection team have managed 15 incidents to date this year. Arrangements are in place to review cases and incidents regularly with the multi-disciplinary team. In addition, new arrangements have been put in place to increase effective working between health protection and the HAI team to ensure effective management of joint issues. The health protection work plan is supported by a specific Quality Improvement Plan, both of which are reviewed quarterly.</td>
</tr>
<tr>
<td>Continue to test and improve Business Continuity Plans (BCP) ensuring clear accountability arrangements</td>
<td>March 2012</td>
<td>AMcM</td>
<td>Accountability arrangements have been strengthened following internal report. Currently recommendations of Healthcare and Clinical Governance Committee are being pursued to further support system.</td>
</tr>
</tbody>
</table>
| Ensure robust arrangements are in place for emergency planning and to manage major incident | March 2012 | AKM | Emergency Planning is on target.  
- Recently reported by DPH to SCG, issue of gap in the provision of a Post Disaster Psychosocial Support Service following major incident. Multi-agency plan drafted in 2004 by City of Edinburgh Council but never ratified and issued. Concepts in psychosocial support have moved on and development of new plan underway.  
- Developing new Port Health procedures for cruise liner and cargo terminals at Leith Docks and cruise liner terminal at Hound Point, River Forth.  
- A number of exercises held / to be held validating SCG and NHS Lothian planning arrangements |
| Risk Management arrangements reviewed | Quarterly | DF | Work is ongoing to improve the risk register |
## NHS Lothian Corporate Objectives 2011/12 – progress report as at 30 September 2011

<table>
<thead>
<tr>
<th>Objective</th>
<th>Date</th>
<th>Responsible Officer</th>
<th>Progress</th>
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</table>
| Regularly by both Healthcare Governance & Risk Management Committee at bi-monthly meeting and by Audit committee |          |                     | Management in the following ways:  
  - Improve alignment with corporate objectives.  
  - Accurately define areas of residual risk.  
  - Improve the escalation process from service to Board. |
| Implement the new complaints function to ensure single point of access, pro-active response and learning across the organisation as well as meeting targets to ensure a timely response | March 2012 | MH                  |  
  - Patient feedback coming to the Complaints Team from 15 May 2011.  
  - Scottish Prisons health complaints coming to NHS Lothian from 1 November 2011 – new process approved and being circulated to prisoners next week.  
  - Acknowledgement - National target 90% of complaints responded to in 3 days – NHS Lothian at 90% at end September, local NHS Lothian stretched target of 90% in 2 days – 98% at end September.  
  - National target of 85% of complaints responded to within 20 days – NHS Lothian at 83% in July |
<p>| Continue to implement the agreed NHS Lothian PR &amp; Communications Strategy to support effective communication both internally and externally | March 2012 | AB                  | On target |
| Maximise staff engagement using focus groups and a range of communication media to raise awareness of staff ‘rights and responsibilities’. Support the fair and consistent treatment of staff | Ongoing   | AB                  | On target |
| Continue to implement Involving People Improving the Patient Experience Strategy and Action Plan including the implications of Patients Right Act | March 2012 | MH / AMcM           | Participation Standard assessment demonstrates NHS Lothian governance and strategic approach as level 4 continuously improving, i.e. have evaluated and are improving all aspects of our |</p>
<table>
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<tr>
<th>Objectives</th>
<th>Due Date</th>
<th>Responsible Party</th>
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<tbody>
<tr>
<td>Participation in the Better Together national patient experience programme and ongoing national surveys</td>
<td>March 2012</td>
<td>MH</td>
</tr>
<tr>
<td>Work with our partners in ensuring services treat and support children and young people in accordance with the UN Convention on the Rights of the Child (UNCRC)</td>
<td>March 2011</td>
<td>AMcM</td>
</tr>
<tr>
<td>Review and implement the NHS Lothian Nutritional Care framework to ensure patients receive appropriate food, fluid and nutrition and that NHS Lothian achieve required national standards</td>
<td>March 2011</td>
<td>MH / JKS</td>
</tr>
<tr>
<td>Develop the work on Compassionate Care and Releasing Time to Care</td>
<td>March 2012</td>
<td>MH</td>
</tr>
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</table>

Survey results published in August 2011 and reports to Division, CH(C)Ps, EMT, HG&RM and the Board. NHS Lothian shows most improvement of all mainland Boards in Scotland and has improved against peers.

The Children & Young Peoples strategy which is being developed for 2012-17 will have ensuring children’s rights as a central theme. Presentations on UNCRC have been made to the Area Clinical Forum in May and the Lothian Area Nursing and Midwifery Committee in October to raise awareness. School nurses scheduled for November.

Work is also underway on highlighting this on the intranet site.

NHS Lothian will be making a response in November to the Scottish Government consultation on the Rights of Children and Young People Bill.

Review of the NHS Lothian Nutritional Care Framework is on target to be launched in November and implemented over next 4 months. Nutrition Education strategy and nutrition quality dashboard also to be launched and implemented from November. Continue to assure Board of NHS Lothian attaining national standards. (Food Fluid & Nutritional Care Standards QIS 2002)
## NHS Lothian Corporate Objectives 2011/12 – Progress Report as at 30 September 2011

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<tr>
<th>Objective</th>
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<tr>
<td>Twenty nine participants progressing through the Delivering Better Care Leadership Programme due to complete in January 2012. Successful International Conference with nearly 300 delegates took place in June 2011. Metrics and questionnaires being piloted in practice by leadership programme participants. Final project report delayed (Due September 2011) but workplans in place to complete by end of November 2011. Evaluation event held with range of NHS Lothian staff, report will direct continued development and mainstreaming of compassionate care. Cohorts 1-6 completed with over 350 teams facilitated through the Foundation modules Cohort 7 presently underway with the final cohort commencing January 2012, by which time the project will have covered every clinical team RTC team working with AHP colleagues to pilot an AHP project from January 2012 Plans in place to extend facilitators secondments from March 2012 to August 2012 to help with sustainability issues</td>
<td>Ongoing</td>
<td>AB</td>
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Ensure an integrated approach continues to be taken in strategic workforce planning in both a local, regional and national context which meets the standards contained in the National Workforce Plan. Reduce our workforce in accordance with our LRP plans.
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<th>Objective</th>
<th>Status</th>
<th>Responsibility</th>
<th>Progress/Details</th>
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<tbody>
<tr>
<td>Sustain the Organisational Development Programme to support the delivery of the benefits of single system working</td>
<td>Ongoing</td>
<td>AB</td>
<td>On target</td>
</tr>
<tr>
<td>Support the effective functioning of SEAT in taking forward Regional Issues to ensure further modernisation of services across SEAT partners</td>
<td>March 2012</td>
<td>AMcM</td>
<td>5 Shared Services workstreams looking at Rebalancing Care, Performance Standards, Min Variation, Learning Disabilities, IM&amp;T re: Radiology and shared services around HR</td>
</tr>
<tr>
<td>Ensure ongoing compliance of information governance policies including Caldicott Guardianship</td>
<td>Ongoing</td>
<td>AKM</td>
<td>198 requests for Caldicott approval have been received this financial year so far. Caldicott instruction is provided during new Consultant inductions for NHS Lothian. A research Safe Haven and portal have been established. Also, R&amp;D are in the process of agreeing a governance process between PHHP and R&amp;D which will enable appropriate CG approval of R&amp;D projects. More complex studies will be escalated to AKM/R&amp;D Director/depute who will meet bimonthly. A record of all requests will form part of R&amp;D/CG records to be defined by end 2011.</td>
</tr>
<tr>
<td>Foster a quality research culture by investing in R&amp;D infrastructure as appropriate</td>
<td>Ongoing</td>
<td>DF</td>
<td>NHS Lothian R&amp;D secured £2,643,733 (from CSO)-which generated 56.82 posts to directly support research infrastructure</td>
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</tbody>
</table>
| Provide quality teaching and R&D support across NHS Lothian              | Ongoing  | DF             | NHS Lothian R&D supports research in many ways: 3 clinical research facilities; clinical trials generally through investigator and service support costs; imaging for research and working with Director of Laboratories to support tissue being made available for research. NHS Lothian has the highest number of UK
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<th>To Date</th>
<th>Responsible</th>
<th>Status</th>
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<tbody>
<tr>
<td>Implement the NMAHP Research and Development strategy and Clinical Academic Career Pathway</td>
<td>March 2012</td>
<td>MH</td>
<td>On Target</td>
</tr>
<tr>
<td>Government appointed Speciality groups (SGs) leads, 11, and one chair-this equates to £286,000 of funding (from CSO) NHS Lothian R&amp;D administered approximately £54M from its research activities in 2010/11, of this £11M was from CSO.</td>
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<tr>
<td>2 of 3 CARC sites now up and running. 3rd with QMU advertised (2 PhD/Band 6 posts). Progress with implementation of NMAHP Research and Development Strategy including identification of 12 ‘research clusters’, funding of early career opportunities, appointment of an honorary research consultant from Edinburgh Napier University, development of NMAHP research website and newsletter, creation of Lothian NMAHP researcher database as starting point for networking.</td>
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<tr>
<td>Develop research strategy to support R&amp;D capability and capacity in Public Health</td>
<td>Ongoing</td>
<td>AKM</td>
<td>R&amp;D with PHHP has agreed the development of Research Records portal (Safe Haven) in NHS Lothian, aligning with Scottish Health Informatics Programme (SHIP). This is now operational and will further support data linkage studies in PH. Also, individual staff in Public health have had 13 articles published, done 4 presentations, produced 3 posters and carried out 2 reviews so far this year.</td>
</tr>
<tr>
<td>Continue to develop the work on the corporate ‘shared services’ programme with health and other partner agencies</td>
<td>Ongoing</td>
<td>AB</td>
<td>On target</td>
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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 of the Meticillin Resistant *Staphylococcus aureus* screening programme.
- Continuing communications about the importance of hand hygiene.
- Clinical teams’ utilisation of performance indicator reports to progress compliance with best practice for antimicrobial prescribing, to support the reduction of antimicrobial associated *Clostridium difficile* Infections.
- Recognise the need for ongoing work to maintain standards in anticipation of announced and unannounced Healthcare Environment Inspectorate visits.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 26 episodes of *Staphylococcus aureus* Bacteraemia recorded in October 2011 (5 Meticillin Resistant *Staphylococcus aureus*, 21 Meticillin Sensitive *Staphylococcus aureus*), compared to 27 in September 2011 (3 Meticillin Resistant *Staphylococcus aureus*, 24 Meticillin Sensitive *Staphylococcus aureus*). 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, with a current rate of 0.32.

3.2 *Clostridium difficile* Infection: there were 24 episodes of *Clostridium difficile* Infection in patients aged 65 or over in October 2011, compared to 27 in September 2011. Although there is a slight variation on the previous month, 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, with a current rate of 0.37.

3.3 Hand hygiene: the fifteenth bi-monthly national hand hygiene audit report was published on 28/9/2011. This indicated that NHS Lothian is achieving a hand hygiene compliance of 96%, exceeding the overall national average compliance of 95%. All staff groups achieved a hand hygiene compliance of 94% to 97% throughout this audit period. Ongoing work continues to focus on improving and sustaining hand hygiene compliance amongst medical staff and areas of non-compliance.

3.4 Meticillin Resistant Staphylococcus aureus National Screening Programme: to date the Screening Programme has screened more than 2,500 patients. NHS Lothian is achieving over 90% compliance with the use of the clinical risk assessment, 100% compliance with the screening of identified high risk patients and 50% 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. Rollout of new policy is on track for completion by December.

3.4.1 Process development: further enhancements to the TRAK system were introduced in September to enhance the data collection.

3.4.2 Communications: ward level workshop communications sessions were held with all phase 2 wards and planning completed for staff and patient roadshow events and for the distribution of new patient information leaflets.

3.5 Mandatory Surveillance: the National Point Prevalence Survey has been completed in all acute areas within NHS Lothian and 25% of non-acute areas, as per Health Protection Scotland requirements.

3.6 Healthcare Environment Inspectorate: the Healthcare Environment Inspectorate have advised have NHS Lothian of an announced Healthcare Environment Inspectorate Inspection to Liberton Hospital on 8-9-12/2011. Following the unannounced inspection to the Royal Infirmary Edinburgh on 188/2011, the final report and action plan were published on 28/9/2011, outlining nine requirements and two recommendations. On 7/11/2011, a meeting requested by the Director of Public Health and Health Policy for NHS Lothian took place with representatives from NHS Lothian, Health Protection Scotland, Health Facilities Scotland and Healthcare Improvement Scotland to discuss actions and progress following this inspection. The Healthcare Environment Inspectorate has asked for the Healthcare Associate Infection Self Assessment to be updated and returned by 25/11/2011.

3.7 Antimicrobial Management Team update:

3.7.1 In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is at target level (95%) for the Royal Infirmary Edinburgh but slightly below target level for the Western General Hospital. Documentation of indication for antibiotic treatment remains at or just below the target level of 95% documentation of indication for both the Royal Infirmary Edinburgh and the Western General Hospital. For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy and administration of single dose antibiotic prophylaxis are both currently at the target level (95% compliance with guidelines and administration of a single dose).
3.7.2 Antibiotic expenditure: the total expenditure for 2011/12 is down 23% from the same period in 2010/11. There appears to be an increase in expenditure on oral agents and a decrease in parenteral agents. Reducing the use of parental agents supports efforts to reduce *Staphylococcus aureus* Bacteraemias.

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia has a 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 Meticillin Resistant *Staphylococcus aureus* as part of the Meticillin Resistant *Staphylococcus aureus* Screening programme.
- Failure to comply with hand hygiene has the potential risk of transmission of infection.
- Usage 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 covers norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Health Inequalities

6.1 There have been no specific issues with the Equality Diversity Impact Assessment as Healthcare Associated Infection is an ongoing issue. 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.

Fiona Cameron
Head of Service, Infection Prevention and Control
10 November 2011
fiona.cameron@luht.scot.nhs.uk

List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
APPENDIX 1

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This section of the HAIRT covers Board wide infection prevention and control activity and actions. For reports on individual hospitals, please refer to the ‘Healthcare Associated Infection Report Cards’ in Section 2.

A report card summarising Board wide statistics can be found at the end of section 1

Key Healthcare Associated Infection Headlines for October 2011

- During October 2011 there were 26 episodes of SAB recorded in NHS Lothian (5 MRSA, 21 MSSA)
- There were 24 episodes of CDI in patients aged 65 or over in October 2011

Staphylococcus aureus (including MRSA)

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive Staphylococcus aureus (MSSA), but the more well known is MRSA (Meticillin Resistant Staphylococcus aureus), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

Staphylococcus aureus: http://www.nhsinform.co.uk/Health-Library/Articles/S/staphylococcal-infections/introduction

MRSA: http://www.nhsinform.co.uk/Health-Library/Articles/M/mrsa/introduction

NHS Boards carry out surveillance of Staphylococcus aureus blood stream infections, known as bacteraemias. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemias for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for Staphylococcus aureus bacteraemias can be found at:

http://www.hps.scot.nhs.uk/haic/sshai/publicationsdetail.aspx?id=30248

Staphylococcus aureus Bacteraemia: there were 26 episodes of Staphylococcus aureus Bacteraemia recorded in October 2011 (5 Meticillin Resistant Staphylococcus aureus, 21 Meticillin Sensitive Staphylococcus aureus), compared to 27 in September 2011 (3 Meticillin Resistant Staphylococcus aureus, 24 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 with a current rate of 0.32.
**Clostridium difficile**

*Clostridium difficile* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at: [http://www.nhsinform.co.uk/Health-Library/Articles/C/clostridium-difficile/introduction](http://www.nhsinform.co.uk/Health-Library/Articles/C/clostridium-difficile/introduction)

NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridium difficile* infections can be found at: [http://www.hps.scot.nhs.uk/haiic/sshaip/clostridiumdifficile.aspx?subjectid=79](http://www.hps.scot.nhs.uk/haiic/sshaip/clostridiumdifficile.aspx?subjectid=79)

*Clostridium difficile* Infection: there were 24 episodes of *Clostridium difficile* Infection in patients aged 65 or over in October 2011, compared to 27 in September 2011. Although there is a slight variation on the previous month, NHS Lothian remains on target with a current rate of 0.37 against the Health Efficiency Access Treatment Target of 0.39 cases or fewer by 1000 acute bed days by March 2013.

**Hand Hygiene**

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be found at: [http://www.washyourhandsofthem.com](http://www.washyourhandsofthem.com)

NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non compliance. The hand hygiene compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national hand hygiene monitoring can be found at: [http://www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx](http://www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx)

The 15th bi-monthly national hand hygiene audit report was published on 28/09/2011. This indicated that NHS Lothian is achieving a hand hygiene compliance of 96%, exceeding the overall national average compliance of 95%. All staff groups achieved a hand hygiene compliance of 94% to 97% throughout this audit period. Ongoing work continues to focus on improving and sustaining hand hygiene compliance amongst medical staff and areas of non-compliance.

**Cleaning and the Healthcare Environment**

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%. The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at: [http://www.hfs.scot.nhs.uk/online-services/publications/hai/](http://www.hfs.scot.nhs.uk/online-services/publications/hai/)

Healthcare environment standards are also independently inspected by the Healthcare Environment Inspectorate. More details can be found at: [http://www.nhshealthquality.org/nhsqis/6710.140.1366.html](http://www.nhshealthquality.org/nhsqis/6710.140.1366.html)
Outbreaks

Norovirus

A point prevalence report is submitted weekly to Health Protection Scotland and published on their website. Within NHS Lothian the first case of norovirus outbreak for season 2012-2013 was recorded at the WGH during August 2011. To date there have been 13 incidents of gastro-enteritis investigated in NHS Lothian. Of these, norovirus has been confirmed in five (38%) of the incidents by the Virology laboratory. In the remaining eight (62%) the cause was not identified. This was due to norovirus not being detected or no samples received from affected patients or samples not yet tested by the laboratory.

Other HAI Related Activity

Healthcare Environment Inspectorate

The Healthcare Environment Inspectorate have advised NHS Lothian of an announced Healthcare Environment Inspectorate Inspection at Liberton Hospital on 8th and 9th December 2011. Following the unannounced inspection at the Royal Infirmary of Edinburgh on 18 August 2011 the final report and action plan was published on 28/9/2011 which outlined nine requirements and two recommendations. On Monday 7 November 2011, a meeting took place requested by the Director of Public Health and Health Policy for NHS Lothian with representatives from NHS Lothian, Health Protection Scotland, Health, Health Facilities Scotland and Healthcare Improvement Scotland to discuss actions/progress following the inspection in August. The Healthcare Environment Inspectorate has asked for the Healthcare Associate Infection Self Assessment to be updated and return by 25 November 2011.

Antimicrobial Management Team update

In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is at target level (95% compliance with Guidelines) for the Royal Infirmary of Edinburgh but slightly below target level for the Western General Hospital. Documentation of indication for antibiotic treatment remains at or just below the target level of 95% documentation of indication for both the Western General Hospital and the Royal Infirmary of Edinburgh. For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy and administration of single dose antibiotic prophylaxis are both currently at the target level (95% compliance with Guidelines and administration of a single dose).

Antibiotic expenditure: the total expenditure for 2011/12 is down 23% from the same period in 2010/11. There appears to be an increase in expenditure on oral agents and a decrease in parenteral agents. Reducing the use of parental agents supports efforts to reduce Staphylococcus aureus Bacteraemias.

Meticillin Resistant Staphylococcus aureus National Screening Programme

To date the Screening Programme has screened more than 2500 patients. NHS Lothian are achieving over 90% compliance with the use of the clinical risk assessment, 100% compliance with the screening of identified high risk patients and 50% 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. Rollout of new policy on track for completion by December.
Process development: Further enhancements to the Trak system were introduced in September to enhance the data collection.

Communications: Ward level workshop communications sessions held with all phase 2 wards, planning completed for Staff and patient road show events and for the distribution of new patient information leaflets.

Mandatory Surveillance
The National Point Prevalence Survey has been completed in all acute areas within NHS Lothian and 25% of non-acute areas as per Health Protection Scotland requirements.
NHS Lothian

**SAB** There were 26 SAB recorded during October 2011 (5 MRSA & 21 MSSA). The lowest number recorded in the last 12 month period is 14 (June 2011).

**CDI** There were 33 CDI recorded in October 2011, of these 24 were in aged 65 & over. February 2011 recorded the lowest number in the last 12 month period with 19 cases.

**SAB HEAT Target** Currently, NHS Lothian is on trajectory to achieve the set target of 0.26 or less cases per 1000 AOBDS by March 2013. The challenge going forward is to reduce even further.

**CDI HEAT Target for Patients aged 65 and over** Currently, NHS Lothian is on trajectory to achieve the set target of 0.39 or less cases per 1000 OBDS. The challenge going forward is to maintain this or reduce even further.

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

![Graph of Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over]

### MSSA Bacteraemia Cases

![Graph of MSSA Bacteraemia Cases]

### MRSA Bacteraemia Cases

![Graph of MRSA Bacteraemia Cases]
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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Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of ‘Report Cards’ that provide information, for each acute hospital [and key community hospitals – delete if appropriate] in the Board, on the number of cases of Staphylococcus aureus blood stream infections (also broken down into MSSA and MRSA) and Clostridium difficile infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from outwith hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridium difficile infections (CDI) and Staphylococcus aureus bacteraemia (SAB) cases are presented for each hospital, broken down by month. Staphylococcus aureus bacteraemia (SAB) cases are further broken down into Meticillin Sensitive Staphylococcus aureus (MSSA) and Meticillin Resistant Staphylococcus aureus (MRSA). Data are presented as both a graph and a table giving case numbers. More information on these organisms can be found on the NHS24 website:

Clostridium difficile: [http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1)

Staphylococcus aureus: [http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346)

MRSA: [http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1)

For each hospital, the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the “out of hospital” report card.

Understanding the Report Cards – Hand Hygiene Compliance

Good hand hygiene is crucial for infection prevention and control. More information can be found from the Health Protection Scotland’s national hand hygiene campaign website:


Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The first page of each hospital report card presents the percentage of hand hygiene compliance for all staff in both graph and table form.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:


The first page of each hospital Report Card gives the hospitals cleaning compliance percentage in both graph and table form.

Understanding the Report Cards – ‘Out of Hospital Infections’

Clostridium difficile infections and Staphylococcus aureus (including MRSA) bacteraemia cases are all associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes and. The final Report Card report in this section covers ‘Out of Hospital Infections’ and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital. Given the complex variety of sources for these infections it is not possible to break this data down in any more detail.
**Royal Infirmary of Edinburgh**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 7 SAB during September 2011 and 12 SAB during October 2011.

**Clostridium difficile Infection (CDI)**
There were 6 CDI during September 2011 and 15 CDI during October 2011.

This is the new Report Card Format introduced by Scottish Government July 2011

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**Estates Monitoring Compliance**

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

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**MSSA Bacteraemia Cases**

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**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

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**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 5 SAB recorded during September 2011 and 5 during October 2011.

**Clostridium difficile Infection (CDI)**
There were 10 CDI during September 2011 and 6 CDI during October 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**

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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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St Johns Hospital

Staphylococcus aureus Bacteraemia (SAB)
There were NO SAB recorded during September and October 2011.

Clostridium difficile Infection (CDI)
There was 6 CDI recorded during September and 4 during October 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

MSSA Bacteraemia Cases
Liberton Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during September and NO SAB during October 2011.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during September and NO CDI during October 2011.

This is the new Report Card Format introduced by Scottish Government July 2011.
**Royal Hospital for Sick Children**

**Staphylococcus aureus Bacteraemia (SAB)**
There were NO SAB recorded in September and 1 in October 2011.

**Clostridium difficile Infection (CDI)**
There were 2 CDI recorded in September and NO CDI in October 2011.

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**Hand Hygiene Monitoring Compliance**

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**

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This is the new Report Card Format introduced by Scottish Government July 2011.
Royal Victoria Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There were 2 SAB recorded during September and NO SAB during October 2011.

**Clostridium difficile Infection (CDI)**
There were NO CDI recorded during September and October 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**

<table>
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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 were 2 CDI recorded during September and 1 during October 2011.

This is the new Report Card Format introduced by Scottish Government July 2011

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<th>MSSA Bacteraemia Cases</th>
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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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<td>S-11</td>
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<tr>
<td>O-11</td>
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</table>
**Out of Hospital Infections**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 12 SAB recorded during September and 8 SAB during October 2011 that were identified as Out of Hospital Infections.

**Clostridium difficile Infection (CDI)**
There were 7 CDI recorded during September and 11 CDI during October 2011 that were identified as Out of Hospital Infections.

This is the new Report Card Format introduced by Scottish Government July 2011.
NHS LOTHIAN

Board Meeting
23 November 2011

Acting Director of Strategic Planning (Executive Lead)

CHANGE FUND: FINANCIAL ARRANGEMENTS

1 Purpose of the Report

1.1 To advise the Board of the updated position of Change Fund projected spend within each of the four Lothian Partnerships, as summarised in Appendix 1, along with the committed spend by year end, and the arrangements for payment and management of any slippage.

1.2 To lay out the financial model for future developments and investments to support the Change Fund in its delivery of reshaping the balance of care in NHS Lothian.

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 payment methodology to NHS, council and third party partners, which has been ratified at the EMT on 15.11.11

2.2 Acknowledge the management arrangements for slippage and under spend against the national guidance, which were ratified at the EMT on 15.11.11

2.3 Recognise the link between the Change Fund acting as a catalyst for sustainable shift in the balance of care through the redesign of services, as highlighted in 3.1.

3 Discussion of Key Issues

3.1 The mid year returns by the four Lothian partnerships to Scottish government associated with the Change Fund allocations for the four Local Transformation Plans¹ against national Reshaping Care for Older People² agenda were noted by EMT on the 21st September 2011. The Ministerial Steering Group was pleased with the quality of plans submitted and commended in particular efforts made across partnerships to engage partners within voluntary and independent sectors in the short timescales available.

¹ http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-plans/
² www.scotland.gov.uk/topics/health/care/reshaping
The key themes within the four Lothian Plans are in line with the three current national work streams;

- co-production, building community capacity, including carer support
- housing support and care settings
- effective care pathways

Some of the key developments and outcomes of this year thus far include;

- East Lothian’s Emergency Care Service has had 598 referrals since going live, with 332 of these cases being falls, the majority of whom are now assessed and supported on an ongoing basis at home, who previously would have otherwise been admitted to hospital for assessment

- Midlothian’s implementation of establishing 6 Intermediate Care beds within care home environments, with enhanced services to prevent admissions and enable discharges, resulting in a consistently low level of delayed discharges, with last census reporting only 5 delays under 6 weeks, and none over 6 weeks

- West Lothian’s Intensive Management of patients with long term conditions through anticipatory care planning and prevention of crisis and thus hospital admissions being prevented and sustaining zero delays in discharges across the two standards being measured

- Edinburgh’s model of care implementation is being supported to sustain the reduction in length of stay within the orthopaedic rehabilitation pathway in ward 6 at the Royal Victoria Hospital form 64.2 days to 45.8 days a reduction of 18.4 days, and an increase in throughput of 44%. The model of care continuation has also resulted in length of stay reduction within stroke rehabilitation from 80 days to 55 days

- The model of care changes for older people with mental health problems, including dementia sees a more comprehensive community infrastructure to support those with behaviours that challenge, which has resulted in a decrease in the demand for hospital interventions

- All of these developments have contributed to NHS Lothian being able to be ahead of the trajectory for the acute bed days rate of emergency admissions for those over 75 years, (HEAT T12), and the ongoing reported fewer than expected deaths in hospital, as a result of the local transformation plans having a focus on robust end of life care, from both health and social care support perspectives. The work streams are contributing to the national measures that have been agreed\(^3\), covering;

  - nationally available outcome measures
  - local improvement measures
  - partnership resource use

\(^3\) [http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/improvement-measures/]
These along with the more the local measures, highlighted in 3.6 below, provide a comprehensive suite of measures.

- All of the work streams indicated in Appendix 1 from each of the partnerships support the national vision of health and social care working better together;
  - Older people are supported to live well at home or in the community for as much time as they can
  - They have a positive experience of health and social care when they need it

The most recent guidance to Chief Executives from the Scottish government and COSLA on the 11th November 2011 restates the pathway focus for the application of the 2012/13 Change Plans, which the four Lothian partnerships will develop by the end of February 2012. The work streams within the four current Change Fund Transformation Plans are all well placed to respond to the national themes for 2012/13;

- preventative and anticipatory care
- proactive care and support at home
- effective care at time of transition
- hospital and care homes
- enablers

3.2 It is important that proper governance surrounds all change fund financial transactions but also that the process is kept as simple as possible. Partnerships are expected to have worked up detailed proposals to include proper financial analysis. A summary of projects have been drawn up, as indicated in Appendix 1, and allocations to partners will be made quarterly on the basis of projected expenditure on each project for that quarter.

The Finance department within NHS Lothian has agreed with partners the following method of payment which has been communicated to Health and Council colleagues:

- NHS associated components will be drawn directly to their budgets
- Council and 3rd Sector payments will be released quarterly to the Council, based on the agreed spending plan
- All payments will be made on the basis that clear impact on the agreed national and local metrics agreed at previous EMT meetings, can be demonstrated.

The updated spend position, along with the key projects that have been agreed through the Community Planning Partnerships as priorities for delivery for the four Lothian Partnerships, is indicated in Appendix 1.

It is evident that significant investments are being made to support growth in packages of care; re-ablement; night services; carer support; dementia care and support; community rehabilitation and nursing capacity as well as overarching community capacity building.
3.3 **Management of slippage and under-spend:** the national overview on the Partnership mid year progress reports was highlighted in the letter from the Joint Improvement Team, (JIT), to Reshaping Care operational and strategic leads at the end of September 2011, and indicated that good progress is being made, and that generally:

- **Partnerships have firm plans in place to utilise resources in line with originally agreed or modified Change Plans but have experienced under-spend due to the pace of expenditure (i.e. commitments are in place although all staff not yet recruited); therefore consideration to the utilisation the funds in the early part of 2012-13 is being explored.**

- **Some partnerships are unable to spend all of the resource this year in line with the original change plan but wish to consider investing the resources non-recurrently in a way which contributes to the overall themes/objectives of the change plan and allows for flexibility i.e. managing winter pressures.**

The letter further indicated that the decision by Partnerships with regard to how they manage any under spend will be influenced by (a) materiality, (b) the nature of the reason for the carry forward, and (c) confidence in the governance of partnerships. JIT indicated that it was for Partnerships to agree locally how to deal with under spend /slippage as long as this meets the objectives of our Change Plans. Discussions have been ongoing with health and council partners regarding the management of any slippage through Joint Directors, General Managers, finance and strategic planning colleagues.

3.4 **Mechanism for future Investments:** Partnership Transformational Plans suggest that as Change Fund projects generate reductions in the requirement for in-patients and other acute hospital activity, particularly around the reduction in the number of emergency admissions for over 75, and the number of people delayed in the acute system, that the benefit of the schemes will be factored into how we prioritise funding across the whole system moving forward. Principles for both slippage and future investments will be developed with partnerships, to ensure the recent JIT guidance provides an opportunity to maximise the full value of the Change Fund.

3.5 Partnerships are making significant effort to ensure that work commissioned through the Change Fund across the four partnerships supports service redesign within the acute sector and the wider community and primary care environments, ensure shifting the balance of care can be achieved and measured.

3.6 The redesign of services has taken a whole pathway approach to delivery of care for older people. At the EMT meeting on 7th September, it was agreed that a small number of key NHS measures would provide an indicative view on progress within the first year of the change fund monies being utilised. Information will be shared weekly between senior management in acute care and each CH(C)P together with Strategic Planning and finance who will co-ordinate the information sharing.

- Rate of emergency admissions – aligned to the HEAT T12⁴
- Number of delayed discharges

⁴ T12: reduction in emergency inpatient bed days rate for 75+yrs age group
- Number of people waiting for packages of care and packages of care of less than 14 hours
- Length of time for social work assessment

As indicated above, improvements are noted for HEAT T12, and Delayed Discharge are reported on an ongoing basis, with recent shifts in Edinburgh activity being welcomed. Robust systems are now in place for reporting the latter metrics from the beginning of November 2011, and will be reported in the future, and will play into the development of the 2012/13 change Fund Transformational Plans.

3.7 Along with the endorsement of Local Transformation Plans, the Scottish Government issued ‘A Programme for Change 2011-21’ indicating their headline ambitions for Reshaping Care for Older People in Scotland with a first wave of key actions required to deliver those ambitions and setting out the national framework, within which local partnerships will develop joint strategies and commissioning plans, and restating the national vision and policy goals:

- Older people in Scotland are a valued asset
- To optimise the independence and wellbeing of older people at home or in a homely setting. This will involve a substantial shift in focus of care from institutional settings to care at home.

3.8 Scottish government have reiterated the framework for improvement, that will be delivered as part of the Reshaping Care agenda, and supported by the additional Change Fund allocations up to March 2015, announced as part of the recent spending review, which will include:

- Consistency of approach across Scotland
- Application in every council and health board area
- Statutory support underpinning improvements
- Integrated budget to deliver some acute, community and social care services
- Someone clearly accountable for delivering agreed outcomes
- Professionally led by clinicians and social workers
- Simplifies rather than complicates existing bodies and structures, and
- Wherever possible, it should be achieved with minimal disruption to staff and services.

3.9 This development work is being taken forward, led in the NHS by the Community Health Partnership General Manager and Joint Directors, and supported by Strategic Planning and finance, to develop the four joint commissioning plans and future change fund plans for older people across Lothian. These will build on current agreed older peoples strategies and work within Reshaping Care and framework for improvement agendas. Initial timescale for the production of these plans will be the end of February 2012. These plans will have to be taken through CHCP governance structures to ensure local agreement and will also require scrutiny at EMT.

5 www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/
4 Key Risks

4.1 The majority of schemes are at planning and recruitment stage. Extensive work has been undertaken to ensure a robust performance management framework which can demonstrate a shift in the balance of care.

5 Risk Register

5.1 There is potential risk to ensuring the maximisation of flow and capacity within acute services. This is already on the risk register under Delayed Discharges. The successful application of Transformation and redesign plans is intended to mitigate this as will a phased approach to service redesign ensuring community capacity is in place and success is monitored.

6 Impact on Inequalities and Health Inequalities

6.1 Each of the four joint plans/strategies for older people have undergone impact assessments as has other work related to this activity. Findings indicate the redesign and shift in the balance of care will improve privacy and dignity, patient experience and quality of environment.

7 Involving People

7.1 Each partnership joint strategies/plan has had extensive involvement across communities: the local transformation plans being signed off through the community planning processes; these had also been considered by colleagues within NHS Lothian acute, CH(C)Ps, Strategic Planning and Finance teams.

8 Resource Implications

8.1 The resource implications are highlighted in section 3 above.

Katie McWilliam  Lynne Hollis
Strategic Programme Manager  Associate Director of Finance
Older People
15 November 2011
katie.mcwilliam@nhslothian.scot.nhs.uk  lynne.Hollis@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Partnership allocations, financial and work stream summaries – full year position
APPENDIX 1

Lothian Partnership Financial and Work Stream Summaries

Full year position

Table 1 - Distribution of Allocations to Lothian Partnerships

This allocation was calculated by Scottish Government, based on NRAC and grant aided expenditure. Lothian has been allocated 14% of the national allocation.

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<th>Local Authority/Third Sector/Independent Sector</th>
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<td>Midlothian</td>
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<td>West Lothian</td>
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* note that Third Party payments are included in the Local Authority allocations
## Local Authority Change Fund Proposals

### Table 2 – East Lothian Partnership

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<td>Intermediate Care beds</td>
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<td>Crisis admission prevention and supporting discharges beds</td>
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<td>OT Complex end stage dementia</td>
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<td></td>
<td><strong>291,000</strong></td>
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<td>Responsive and rapid respite for carers to support discharge, reduce readmission</td>
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<td>Carer Emergency Plans</td>
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<td>Short Breaks (Respite) Development</td>
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<td>Good Neighbours Service</td>
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<td>Palliative and End of Life Care</td>
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<td>Third and independent sector innovations fund</td>
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<td>Volunteering development</td>
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<td>Home safety Service</td>
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<td>Capacity Building to manage CF process</td>
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<td>Common Outcomes Monitoring Framework</td>
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<td>Telehealthcare Manager</td>
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<td>SDS Dementia and telecare conference</td>
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<td>Staff/carer training &amp; development on new models of care</td>
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<td>Start-up &amp; innovations support to all CF partners</td>
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<td><strong>116,925</strong></td>
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<td>Total fund managed through ELC</td>
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<tr>
<td>Palliative and end of life care training - 0.6 WTE band Macmillan nurse posts</td>
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<td>Telecare &amp; dementia - early intervention 0.5 OT post</td>
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<td>Challenging Behaviour Service</td>
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<td>Community Response and Rehabilitation service</td>
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<td>East and Midlothian Anticipatory Care Service</td>
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<td>Total fund managed through NHS-CHP</td>
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### Table 3 – West Lothian Partnership

**West Lothian Council**

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</tr>
<tr>
<td>Support investment for growth of safe at home technology</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Community Capacity Building</td>
<td>300</td>
<td>380</td>
</tr>
<tr>
<td>Develop comprehensive out of hours crisis response and care management service</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>West Lothian Council Total</strong></td>
<td><strong>1,200</strong></td>
<td><strong>1,280</strong></td>
</tr>
</tbody>
</table>

**NHS Lothian**

<table>
<thead>
<tr>
<th>Project</th>
<th>Original Spend</th>
<th>Revised Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Intensive Case Management for Patients with Long Term Conditions</td>
<td>300</td>
<td>220</td>
</tr>
<tr>
<td><strong>NHS Lothian Total</strong></td>
<td><strong>300</strong></td>
<td><strong>220</strong></td>
</tr>
</tbody>
</table>

**West Lothian Partnership Total**

<table>
<thead>
<tr>
<th>Project</th>
<th>Original Spend</th>
<th>Revised Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>West Lothian Partnership Total</strong></td>
<td><strong>1,500</strong></td>
<td><strong>1,500</strong></td>
</tr>
</tbody>
</table>

### Table 4 – Midlothian Partnership

**Change Fund - Midlothian Partnership**

**TABLE 1**

**Change Fund 2011-12 - SUMMARY**

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Social Work £</th>
<th>Vol Orgs £</th>
<th>NHS £</th>
<th>Total £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and Step-Down beds in Highbank</td>
<td>120,000</td>
<td>100,000</td>
<td>220,000</td>
<td></td>
</tr>
<tr>
<td>AHP time to enhance Community Rehab.</td>
<td></td>
<td>30,000</td>
<td></td>
<td>30,000</td>
</tr>
<tr>
<td>Hospital In Reach and needs assessment</td>
<td>82,800</td>
<td>35,000</td>
<td>117,800</td>
<td></td>
</tr>
<tr>
<td>Day treatment in local community hospital</td>
<td></td>
<td>40,000</td>
<td></td>
<td>40,000</td>
</tr>
<tr>
<td>24-hour falls response service inc SAS referral</td>
<td>23,000</td>
<td></td>
<td></td>
<td>23,000</td>
</tr>
<tr>
<td>Increased skills to support people to die at home/in care homes</td>
<td>27,000</td>
<td></td>
<td></td>
<td>27,000</td>
</tr>
<tr>
<td>Medication management in social care sector</td>
<td></td>
<td>30,000</td>
<td></td>
<td>30,000</td>
</tr>
<tr>
<td>Specialist input on respiratory conditions</td>
<td>80,000</td>
<td></td>
<td></td>
<td>80,000</td>
</tr>
<tr>
<td>Nursing input to care homes to manage end of life care</td>
<td></td>
<td>55,000</td>
<td></td>
<td>55,000</td>
</tr>
<tr>
<td>Quality assurance of independent sector</td>
<td>28,000</td>
<td></td>
<td></td>
<td>28,000</td>
</tr>
<tr>
<td>Develop extra care housing</td>
<td>43,000</td>
<td></td>
<td></td>
<td>43,000</td>
</tr>
<tr>
<td>Day support - social isolation</td>
<td>95,000</td>
<td>35,000</td>
<td></td>
<td>130,000</td>
</tr>
<tr>
<td>Local authority and independent CAH providers reablement and rehabilitation</td>
<td>120,000</td>
<td></td>
<td></td>
<td>120,000</td>
</tr>
<tr>
<td>Small Repairs and Handyman service</td>
<td></td>
<td>15,000</td>
<td></td>
<td>15,000</td>
</tr>
<tr>
<td>Telecare/Telehealth</td>
<td>80,000</td>
<td></td>
<td></td>
<td>80,000</td>
</tr>
<tr>
<td>Dementia Demonstrator workstream</td>
<td>40,000</td>
<td></td>
<td></td>
<td>40,000</td>
</tr>
<tr>
<td>Carers Education</td>
<td></td>
<td>35,000</td>
<td></td>
<td>35,000</td>
</tr>
<tr>
<td>Short Breaks</td>
<td>100,000</td>
<td></td>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>758,800</strong></td>
<td><strong>120,000</strong></td>
<td><strong>335,000</strong></td>
<td><strong>1,213,800</strong></td>
</tr>
</tbody>
</table>

To be funded from -

| Change Fund                                                              | 556,000        | 85,000      | 335,000 | 976,000  |
| Council Monies - Carers                                                  | 100,000        |             |        | 100,000  |
| Funding assessment & step-down beds in Highbank & opening shortfall (council funds) | 102,800        |             |        | 102,800  |
| Council Monies - Carers Education                                        |                | 35,000      |        | 35,000   |
| **Total**                                                                 | **758,800**    | **120,000** | **335,000** | **1,213,800** |
# Edinburgh Partnership

## Table 5 - Edinburgh Partnership

<table>
<thead>
<tr>
<th>Proposals</th>
<th>Full Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Pathways and Complex Care</strong></td>
<td>2,705,850</td>
</tr>
<tr>
<td>Re-ablement</td>
<td>1,145,060</td>
</tr>
<tr>
<td>Community Therapy Services</td>
<td>1,069,340</td>
</tr>
<tr>
<td>Day Services</td>
<td>134,000</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>97,722</td>
</tr>
<tr>
<td>Equipment and Adaptations</td>
<td>131,552</td>
</tr>
<tr>
<td>Transport and Support Costs</td>
<td>100,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,677,674</td>
</tr>
</tbody>
</table>

| **Care Settings**                        | 1,503,250       |
| Medication Procedure for CaH (recurring) | 120,000         |
| Medication Proposal 2 - Medication review| 60,130          |
| Telehealth (Revenue)                     | 120,260         |
| Telehealth (Capital)                     | 63,000          |
| Telecare (Capital)                       | 180,000         |
| Home Care / Care at Home                 | 600,000         |
| 2 overnight teams                        | 300,000         |
| **Total**                                | 900,000         |
| Dementia support - Behaviour Support     | 329,865         |
| Dementia support - Carers are Assets     | 80,000          |
| **Total**                                | 409,865         |
| Case Finding & Mgmt and Anticipatory Care| 90,195          |
| Equipment and adaptations                | 75,163          |
| **Total**                                | 2,018,613       |

| **Community Capacity**                   | 1,202,600       |
| Community Connectors                     | 400,000         |
| Supported Carers                         | 100,000         |
| Community Transport                      | 150,000         |
| Building Org Capacity                    | 140,000         |
| Innovation Pilot                         | 412,600         |
| **Total**                                | 1,202,600       |

| **Training, Development, Evaluation, Comm &** | 601,300 |
| Transformation Station                   | 135,000 |
| Project Support, Research, Plan & Comm, Fin | 187,659 |
| Telecare Change Manager                  | 44,261  |
| On-Going Support Costs                   | 150,000 |
| **Total**                                | 516,920 |

**ALLOCATION**                              | 6,013,000      |
**Committed**                                | 6,415,807      |
NHS LOTHIAN

Board Meeting
23 November 2011

Acting Director of Strategic Planning (Executive Lead)

SINGLE OUTCOME AGREEMENTS 2010/11

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the progress made in delivering the outcomes of the 2010/11 Single Outcome Agreements across the four Community Planning Partnerships.

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 achievement made in delivering the 2010/11 Single Outcome Agreements and the ongoing opportunities for NHS Lothian in working with Community Planning Partnerships

3 Discussion of Key Issues

3.1 Single Outcome Agreements (SOAs) are the means by which Community Planning Partnerships (CPPs) agree their strategic priorities for their local area and express those priorities as outcomes to be delivered by the partners, either individually or jointly, while showing how those outcomes should contribute to the Scottish Government's relevant National Outcomes.

3.2 NHS Lothian continues to be actively involved in the SOA process across CPPs. CH(C)Ps, with support from Strategic Planning, are actively engaged in leading the development and delivery of the health related outcomes within the SOAs, with clear performance processes in place.

3.3 There continues to be local governance and accountability for SOAs through CH(C)P sub-committee’s and the development of the SOAs for 2011/12 have been agreed through these structures. This has ensured that local priorities have been at the forefront of SOAs in driving forward improvements in health outcomes.
3.4 The guidance from Scottish Government on the annual reporting mechanisms for SOAs 2010/11 has recently been circulated, indicating that these should be submitted by 30 November 2011. However each CPP in Lothian has already produced an annual performance report and theses has been submitted to Scottish Government, copies of which can be made available on request. The progress against the agreed indicators and targets for 2010/11 is outlined in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Targets on schedule</th>
<th>Targets making progress*</th>
<th>Targets behind schedule</th>
<th>Data not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>50%</td>
<td>13%</td>
<td>14%</td>
<td>23%</td>
</tr>
<tr>
<td>West Lothian</td>
<td>61%</td>
<td>8%</td>
<td>7%</td>
<td>24%</td>
</tr>
<tr>
<td>East Lothian</td>
<td>46%</td>
<td></td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Midlothian</td>
<td>50%</td>
<td>38%</td>
<td></td>
<td>12%</td>
</tr>
</tbody>
</table>

*East Lothian and Midlothian only measure a target as being on or behind schedule

3.5 The variation on performance across CPPs reflects the different measures and outcomes within each SOA as well as the lifecycle of the document, with some targets due for delivery in 2011 and others the following year(s). The impact of the economic situation is now being reflected in the SOAs, with many targets related to employment and the economy not being met, hence the number which are behind schedule. There is work ongoing to review these targets and to amend accordingly. The issue of data not being available relates to the time-lag associated with accessing national data or where there is no baseline information available due to it being a new target. There is further work being done locally to identify data that is more readily available in order to better manage performance.

3.6 Whilst the above provides a numerical overview of the SOAs, the following demonstrates the range of impacts that have been achieved by community planning partners during 2010/11, reflecting the wide scope of local priorities:

**Edinburgh**
- 525 new homes completed through the Affordable Housing Investment Programme against a target of 505 for 2010/11
- 66.1% of children are walking or cycling to school against a target of 64%
- 72% of children start school with no dental caries against a target of 60%
- 43.7% of newborn children exclusively breastfed at 6-8 weeks exceeding the national average of 26.1%
- The proportion of people cared for at home during 2010/11 continues to increase, up 20% from 2007/08
- There has been a reduction in the number of accidental house fires from 640 in 2007/08 to 590 in 2010/11
- The number of people killed or seriously injured in road traffic collisions continues to reduce, down to 144 against a target of 174
- The percentage of people who feel ‘very’ or ‘fairly safe’ in their neighbourhood after dark has increased significantly since 2008 to 81% in 2010/11

**East Lothian**
- 256 affordable and specialist houses were built by the Council and its partners ahead of the anticipated target of 243.
• 86.1% of school leavers entered ‘positive destinations’ – a 2.7% increase on the previous year.
• The number of Looked After Children attaining at least SCQF Level 3 in English and Maths increased to 67% - far exceeding the target set of 50%.
• East Lothian had the highest proportion of pupils travelling to school on foot or by bike or scooter in Scotland.
• The ecological footprint of East Lothian residents reduced by 11% to 4.78 global hectares per capita (SEI 2010)
• ELC and Lothian & Borders Police installed charging infrastructure for electric vehicles in Musselburgh, Macmerry and Haddington

Midlothian
• 180 adults recovering from drug or alcohol misuse moving back to education, training and employment as part of their recovery programme against a target of 135
• 509 disadvantaged families with young children benefitted from a range of parenting and family support services against a target of 287
• 81% of community care service users saying they have the support that keeps them participating in their community and living at home
• 307 Carer Assessments completed against a target of 128
• Reduction in recorded crimes from 5246 to 4603 during 2010/11 and a drop in reported repeat incidents of domestic violence to 572 from 596
• The number of alcohol-related antisocial behaviour incidents involving young people has dropped by 13.5% from 683 in 2008/09 to 591.
• Increase in % of people who rate their quality of life as 8 or more out of 10 up from 46% to 65%

West Lothian
• Exercise Referrals from health professionals continue to grow with the total number of referrals since the programme started now exceeding 3,700
• At 6.5%, the local level of child obesity is significantly lower that of Scotland (8.2%) and demonstrates a reduction in obesity levels from 9.0% in 2004/5
• The proportion of homeless applicants assessed as not being in priority need decreased in 2010/11 to 10.2% compared to previous years (15% in 9/10 and 21.1% in 8/9)
• Hate Crime in West Lothian has seen a steady reduction in incidents recorded, overall a decrease of 26%
• Accidental fires continue to decrease in West Lothian, with an 18% decrease in the number in 2010 compared to the previous three-year average
• The percentage of pupils attaining 5+ passes at Level 4 (Standard Grade General or equivalent) has risen to 81%, and is above both the national and comparator average for 2010

3.7 The partnership working continues across CH(C)Ps and directorates within NHS Lothian with community planning partners to deliver the key priorities in the SOAs for 2011/12, building on the outcomes achieved over the previous years. There are further opportunities to better align the work of NHS Lothian within CPPs and over the last year there has been an increase in the number of strategies and plans which have been endorsed by CPPs such as Sense of Belonging, our joint mental health strategy.
3.8 A key piece of work over the coming months will be to discuss the Clinical Strategy with community planning partners, recognising their role in improving the health of people in Lothian. There is also a further exercise being developed in Midlothian with Senior Finance Officers from CPPs beginning the process of identifying spend against the outcomes in the SOA. This will be progressed over the coming months and will have direct connections to work on the Integrated Resource Framework.

3.9 In line with the guidance from Scottish Government for future Single Outcome Agreements, there is a commitment locally that SOAs are reviewed and refreshed in the light of changing circumstances to ensure they remain effective in supporting the delivery of outcomes at a local level, and also to ensure they reflect an appropriate local response to the national priorities set out in the Government’s strategic policy announcements. In particular, the Government expects its overarching priorities of supporting economic growth and a decisive shift to a preventative approach to be fully embedded into SOAs and this will be taken forward with Community Planning partners.

4 Key Risks

4.1 The key risk is being able to adequately demonstrate tangible outcomes for people and communities through the delivery of the SOA given the longer-term, strategic nature of the outcomes, which are difficult to performance manage effectively on an annual basis.

5 Risk Register

5.1 There are no direct implications for the NHS Lothian Risk Register associated with this report.

6 Impact on Health Inequalities

6.1 There are Equality Diversity Impact Assessments undertaken on all SOAs and the outcomes of these are reflected in the final documents.

7 Impact on Inequalities

7.1 The priorities within all 4 SOAs include a specific focus on address inequalities.

8 Involving People

8.1 The development of the SOAs are based on engagement with communities, reflecting local needs and priorities.

9 Resource Implications

9.1 There are no direct resource implications associated with this report.

Allister Short
Strategic Programme Manager (Community Planning)
14 November 2011
Allister.Short@nhslothian.scot.nhs.uk
RESPONSE TO THE CONSULTATION ON THE REVISED SPECIFIC DUTIES OF THE EQUALITY ACT 2010

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the response to the Scottish Government consultation on the revised Specific Duties of the Equality Act 2010.

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

2 Recommendations

The Board is recommended to:

2.1 Approve the response to the consultation on the Specific Duties, attached as Appendix 1.

3 Discussion of Key Issues

3.1 The Equality Act 2010 came into force on 1 October 2010 and dramatically changed the legislative framework for equality & diversity across the UK, replacing 119 individual sets of regulation. A number of sections of the Act required secondary legislation to introduce appropriate detail, such as the specific duties for public sector organisations (the “Public Sector Equality Duty”).

3.2 The Scottish Government introduced a set of specific duties for consultation in December 2010, which were unexpectedly rejected by the Scottish parliament in April 2011.

3.3 The Scottish Government has issued revised draft specific duties, with the consultation period for these running from 9 September until 25 November 2011. Broadly speaking, NHS Lothian is in a strong position to meet these proposed new duties given the comprehensive and ambitious nature of the Board’s equity strategy, the Equality & Human Rights Scheme 2010-13.
4 Key Risks

4.1 There are no risks associated with this paper as it is a consultation response. The proposals being consulted upon will not increase any risks as NHS Lothian is well prepared for the likely provisions in the duty.

5 Risk Register

5.1 Risk 2819 (Non-Compliance with Statutory Equality Duties) is relevant here but is unlikely to be affected by the results of this consultation as NHS Lothian is well prepared for the new duty.

6 Impact on Health Inequalities

6.1 This is a consultation response and as such does not require impact assessment in its own right.

7 Impact on Inequalities

7.1 See 6.1 above.

8 Involving People

8.1 The attached consultation response has been developed taking into account views from across NHS Lothian including Human Resources, Public Health, Strategic Planning, the CHP/CHCPs and acute services. The response was approved by the Mutuality & Equality Governance Committee at its meeting in October, with amendments which have now been incorporated into this final version.

9 Resource Implications

9.1 No consultation with patients or communities is required as this is a consultation being carried out by the Scottish Government. This response was developed following widespread consultation with staff.

James Glover  
Head of Equality & Diversity  
11 October 2011  
James.glover@nhslothian.scot.nhs.uk

List of Appendices

Public Sector Equality Duty – Revised Draft Regulations

RESPONDENT INFORMATION FORM

Please Note this form must be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name
NHS Lothian

Title  Mr ☑  Ms ☐  Mrs ☐  Miss ☐  Dr ☐  Please tick as appropriate

Surname
Glover

Forename
James

2. Postal Address

Waverley Gate
2-4 Waterloo Place
Edinburgh
Email: James.glover@nhslothian.scot.nhs.uk

Postcode EH1 3EG  Phone 0131 465 5720
3. Permissions

I am responding as.....

Individual / Group/Organisation

<table>
<thead>
<tr>
<th>(a)</th>
<th>Do you agree to your response being made available to the public (in Scottish Government library)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please tick ONE of the following boxes</td>
</tr>
<tr>
<td></td>
<td>Yes, make my response, name and address all available</td>
</tr>
<tr>
<td></td>
<td>Yes, make my response available, but not my name and address</td>
</tr>
<tr>
<td></td>
<td>Yes, make my response and name available, but not my address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(b)</th>
<th>Where confidentiality is not requested, we will make your responses available to the public on the following basis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please tick ONE of the following boxes</td>
</tr>
<tr>
<td></td>
<td>Yes, make my response, name and address all available</td>
</tr>
<tr>
<td></td>
<td>Yes, make my response available, but not my name and address</td>
</tr>
<tr>
<td></td>
<td>Yes, make my response and name available, but not my address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(c)</th>
<th>The name and address of your organisation will be made available to the public (in the Scottish Government library)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are you content for your response to be made available?</td>
</tr>
<tr>
<td></td>
<td>Please tick as appropriate</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(d)</th>
<th>We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please tick as appropriate</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
Consultation Questions

Question 1: Do you agree that if a public authority’s equality outcomes do not cover all relevant protected characteristics, it should publish the reason(s) why?

☑ Yes  ☐ No  ☐ Don’t Know

Please provide further information

All public authorities should be able to objectively justify their choice of equality outcomes. This should include being able to say why they chose not to address particular protected characteristics in setting their priorities. Public authorities will naturally consider a wide range of factors in prioritising certain outcomes over others, such as the views of stakeholders with an interest in particular protected characteristics, the range of data they have available, the extent to which an outcome supports their mainstream aims and the practical feasibility of taking action to work towards the outcome. It should not therefore be burdensome to publish the reasons why they may choose not to cover a particular characteristic.

Question 2: Do you agree that a public authority should publish the results of equality impact assessment?

☑ Yes  ☐ No  ☐ Don’t Know

Please provide further information

Publishing the findings of impact assessments is a straightforward way of improving transparency and accountability, particularly as public authorities have increasingly challenging decisions to make in relation to efficiency. However it would be helpful if the proposed regulations did not specify precisely how impact assessments should be published and left it to individual organisations to decide. This is because the volume of impact assessments carried out by some organisations is significant – in NHS Lothian this year we will complete around 120 impact assessments, in other Health Boards there is greater use of screening so the numbers will be significantly higher.

There is no requirement for organisations’ impact assessments and consultations to meet the quality standards required to evidence compliance.
**Question 3:** Do you agree that a public authority’s impact assessments should consider relevant evidence including any received from people with relevant protected characteristics in relation to the policy or practice in question?

☐ Yes  ☑ No  ☐ Don’t Know

Please provide further information

We do not believe that it is necessary to include this in the regulations. For all impact assessments we seek to consider the relevant evidence – whether it is from our own service data or from interested stakeholders. While it is fair to say that we are still developing the best ways of ensuring that this happens routinely, we are very aware of the increasing volume of litigation in this area and the entirely reasonable findings in cases such as that involving Birmingham City Council (http://www.equalityhumanrights.com/news/2011/may/commission-comment-on-birmingham-council-care-ruling/) which strongly emphasise the need for careful consideration of evidence when carrying out impact assessment. Including such a requirement in the regulations would therefore be redundant, as any competent public authority will seek to do this anyway and there are legal remedies already in existence where this does not occur.

**Question 4:** Do you agree that a public authority should make arrangements to review and where necessary change or revise existing policies and practices to ensure that these do not have a detrimental effect on its ability to fulfil the general duty?

☑ Yes  ☐ No  ☐ Don’t Know

Please provide further information

Competent and well-managed public authorities should already have robust arrangements in place to ensure that policies, plans and functions are reviewed regularly and subjected to impact assessment where necessary. However including this as a requirement under the regulations will encourage them to further mainstream impact assessment into policy revision arrangements.

**Question 5:** Do you agree that a public authority should not be required to undertake an impact assessment where the policy or practice in question has no bearing on its ability to fulfil or otherwise the general duty (eg, purely technical or scientific matters)?

☐ Yes  ☑ No  ☐ Don’t Know
Please provide further information

It is not always immediately obvious where a proposal might or might not have an impact on equality. For authorities to determine this effectively they would need to do a screening impact assessment anyway, as is currently the case. Including this as a requirement adds no additional value and may have the negative effect of allowing some authorities to adopt a default position of “no impact” where they may seek to claim that many policies and plans are of a technical nature when in fact they are not. Seeing as most authorities have developed pragmatic approaches to impact assessment whereby they avoid expending significant resources on assessing in detail those proposals unlikely to have an impact on equality, we would suggest maintaining established approaches whereby a policy or plan is deemed to have a potential impact until demonstrated otherwise.

Financial decisions are an example, where it is not always obvious that there may be an equality impact. There are no adverse consequences on public sector bodies whose investment strategies run counter to these duties, for example, by transferring funding earmarked for the groups covered by this duty to services that are already accessed disproportionately by those who are already more advantaged. In addition to the gender pay gap, organisations should be required to demonstrate how their investment decisions facilitate or hinder compliance. At a micro level, Keep Well in Lothian provides an excellent case study of this issue and how impact assessment can be used as a decision making tool as well as a means of identifying impacts.

In addition, it is difficult to see in advance which policies, services or plans could not be redesigned to have a more positive impact on inequity. Our experience of implementing a whole system approach to tackling health inequity recognises the pervasiveness of stigma and discrimination. Their presence reduces levels of health and wellbeing across the country, is evident in the levels of self medication, self harm and interpersonal aggression in our society. They diminish our society and our ability to weather and recover from the recession. The structural nature of stigma, discrimination and inequality is seen in differential access to education, employment and the full range of health services. Without a requirement for universal impact screening, culture and behaviour will not change sufficiently rapidly to improve the quality of public services and reduce the current levels of harm, minimise variation and waste associated with stigma, discrimination and lack of cultural competence.

| Question 6: Do you agree that authorities subject to the specific duties should be required to take reasonable steps to gather information on the relevant protected characteristics of employees, including information on the recruitment, retention and development of employees? |
|-------------|------------------|------------------|
| [ ] Yes     | [ ] No           | [ ] Don’t Know   |
Please provide further information

This is sensible and reflects widespread developments in workforce monitoring. There is still significant work to do to develop approaches to routine gathering of more sensitive data such as religion and sexual orientation, and it is unlikely that it will ever be pragmatic for authorities to routinely gather Transgender status from all employees, but the emphasis on “reasonable” is noted and supported.

Organisations should be required to comply with Caldicott principles in relation to their employees’ data. This is particularly relevant in the health service where employees will also be patients of NHS Scotland. The standards of information governance, therefore, would be the same as those for patient data. This would provide employees with greater confidence regarding the quality of controls around their use.

**Question 7:** Do you agree that authorities subject to the specific duties should be required to use the employment information which they have gathered to assist progress on the general duty?

☑ Yes ☐ No ☐ Don’t Know

Please provide further information

It is sensible for authorities to use this workforce data to support those equality outcomes that relate to their function as an employer.

However monitoring employees should not be the only measure of fostering good relations. Through inclusive commissioning of services with voluntary sector providers there is an opportunity to bridge the barriers which currently separate communities. This will help to achieve more cohesive communities as well as removing unnecessary duplication of services and ensuring equitability of access and outcomes.

**Question 8:** Do you agree that authorities subject to the specific duties should be required to report on progress on gathering and using employment information, including an annual breakdown of information gathered, within the mainstreaming report.

☑ Yes ☐ No ☐ Don’t Know
It is sensible to include progress in these areas in an authority’s mainstreaming report. This will increase expectations of monitoring across all protected characteristics to avoid a hierarchy of equality. However the duty should be sensitive to the need to allow time to develop robust data systems in place for this.

**Question 9:** Do you agree that authorities with more than 150 employees should publish an equal pay statement, the first covering gender and the second and subsequent statements covering gender, disability and race?

☐ Yes  ☑ No  ☐ Don’t Know

The regulations should not be as specific as in the consultation document. Authorities should be required to publish equal pay statements on protected characteristics other than gender as they develop their workforce monitoring approaches for those characteristics. It will take some time to develop these approaches, as discussed above in the answer to question 6. The emphasis should be on publishing equal pay statements for characteristics other than gender after a reasonable amount of time.

**Question 10:** Do you agree that where a listed authority is a contracting authority and proposes to enter into a relevant agreement on the basis of an offer which is the most economically advantageous it must have due regard to whether the award criteria should include considerations relevant to its performance of the general duty?

☐ Yes  ☑ No  ☐ Don’t Know

Public authorities are already required to pay due regard to the general duty in carrying out their procurement functions, and will be required to apply the specific duty to these functions in terms of impact assessment and monitoring. This proposal does not add value and is unnecessary.

**Question 11:** Do you agree that where a listed authority is a contracting authority and proposes to stipulate conditions relating to the performance of a relevant agreement it must have due regard to whether the conditions should include considerations relevant to its performance of the general duty?

☑ Yes  ☐ No  ☐ Don’t Know
Please provide further information

It is sensible that all an authority’s contracts should ensure that the access needs of people with protected characteristics are routinely considered to ensure equitable access to services. This will help to mainstream the general duties in to all aspects of our work. It is very important in terms of tackling health inequality and also supporting the building of more inclusive and cohesive communities.

Procurement provides an important lever for ensuring that contractors engaged by the public sector work towards the spirit of the general duty. This also provides an opportunity to benefit from the improved levels of employee attendance, productivity and retention that result from improvements in organisational justice. The procurement duty should complement other aspects of sustainability as aspects of securing best value. This would ensure that securing local employment and quality of service were not sacrificed.

Question 12: Do you have any other comments on the proposed draft Regulations?

Please provide further information

These regulations are welcome and will be supportive of NHS Lothian’s efforts to promote equality. The Scottish Government Equality and Diversity Impact Assessment of these proposals and the Scottish Government response provide some reassurance regarding the goals of the duty. Overall, there is much to be commended about the proposals. There are several gaps in the current proposals, however, that will limit their ability to deliver the stated outcomes. These are:

1. The lack of attention to socioeconomic status as a source of discrimination in its own right.
2. The amplification effect of low socioeconomic status on the health and well-being of individuals and communities of people with protected characteristics. Specifically:
   a. The increased likelihood that people with a protected characteristic will have lower income and assets than the majority population and the amplification effect on need
   b. The excess costs of participating in society faced by most people with a protected characteristic
   c. Lack of recognition of social stratification within ethnic groups
   d. Differences in the current quality of response to people from protected groups as individuals and communities of interest
   e. Differential access to a healthy built and social environment because of the geographical distribution of individuals and communities with higher levels of protected characteristics.
3. A focus on the experience of individuals alone will not deliver the social and structural change required to assure Scottish Government of compliance with the duty across the public sector.
We are inviting responses by 25 November 2011.

Please send this questionnaire with the completed Respondent Information Form to:

equalityduty@scotland.gsi.gov.uk

or by post to:

Graeme Bryce
Equality Unit
The Scottish Government
Area 2G
Victoria Quay
Edinburgh
EH6 6QQ
HEALTHCARE ENVIRONMENT INSPECTORATE:
CARE OF OLDER PEOPLE IN ACUTE SETTINGS

1 Purpose of the Report

1.1 The purpose of this report is to set out the expansion of the Healthcare Environment Inspectorate (HEI) inspections to include care of older people in acute settings and the national dementia standards and to report on the preparations in NHS Lothian.

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 expansion of the inspectorate to include care of older people in acute settings and dementia care standards.

2.2 Note the preparations in NHS Lothian and the expected timelines for inspections.

2.3 Note the executive and senior leadership responsibilities and accountabilities needed to embed consistent high quality, safe, effective and person centred care across NHS Lothian.

2.4 Note that the Executive Nurse Director is the executive lead, with operational leadership from the Chief Operating Officer UHD and the General Manager East and Midlothian CHPs.

3 Discussion of Key Issues

3.1 The Board was advised at its July meeting in a paper entitled ‘Delivering Better Care – Nursing and Midwifery Care Governance in NHS Lothian’ of work in progress to improve the care we provide to patients by bringing together key work streams (Compassionate Care, Leading Better Care and Releasing Time to Care) and focusing on improving the delivery of better essential care to all patients.
3.1.1 The paper also advised that the Cabinet Secretary had announced the expansion of the current Healthcare Environment Inspectorate to include care of older people in acute settings and care of people with dementia. This announcement was made alongside the publication of the Standards of Care for Dementia in Scotland (June 2011). The Chief Nursing Officer was directed to lead this work in conjunction with NHS Health Improvement Scotland and Scotland’s Executive Nurse Directors Group and a steering group was established to advise on standards, methodology, assessments etc. NHS Lothian had two experienced senior nurses on this national group which also had multidisciplinary representation from professional bodies.

3.1.2 Over the summer there has been considerable activity to revise previous older people’s standards developed in 2002 by the Clinical Standards Board for Scotland, devise a self assessment pro-forma and guidance, an evidence list as well as ‘grow’ the infrastructure with HEI to deliver the expanded inspection portfolio. NHS Lothian was represented by two senior nurses at the initial meeting and one senior nurse sits on the national reference group.

3.1.3 Nationally it was also set out that the traditional HEI (cleanliness, infection control etc.) standards and inspections would a) be incorporated into the expanded care of older people/dementia inspections in those hospitals where care of older people is being delivered and b) that HEI would continue to inspect all other hospitals for the original HEI standards.

3.1.4 NHS Lothian was informed on 4 October 2011 that the hospitals which will be inspected are: RIE, RVH, St Johns, Liberton, WGH and Roodlands. RHSC was also listed for the core HEI inspection.

3.1.5 The timetable that is known at the time of writing this paper is:

- The older peoples standards inspection ‘commenced’ on 3 October 2011 with the publication of the self assessment tool and other preparation guidance.
- Each Board was asked to complete a self assessment against the standard and NHS Lothian’s was returned to HEI on 4 November 2011.
- HEI will commence the revised inspection from 17 November 2011 in three Boards (NHS Lothian, Tayside, Greater Glasgow and Clyde).
- Four weeks notice is given for an announced visit and this has been confirmed as 8 and 9 December 2011 in NHS Lothian at Liberton Hospital.

3.1.6 The domains of the self assessment are:

a) Screening and initial assessment
b) Person centred assessment and care planning
c) Safe and effective care and services
d) Enabling approaches to promote independence
e) Supporting older people to manage their conditions and medicines
f) Identifying vulnerable patients and those at risk of early re-admission
g) Needs of those with communication or cognitive impairment
h) Clinical and care governance/staff awareness

The self assessment framework is attached at Appendix 1.
3.1.7 A main focus of the inspection will be direct observation of clinical care and scrutiny of clinical documentation. NHS Lothian has asked for clarification about the legal rights of the Inspectors generally and specifically to access patients clinical records. NHS Health Improvement Scotland is awaiting a conclusive statement from the Central Legal Office but have offered the following with regard to their general duties:

“Healthcare Improvement Scotland has a general duties under sections 10C and 10I of the National Health Service (Scotland) Act 1978 (the Act) to support, ensure and monitor the quality of healthcare provided or secured by the health service and inspect any service provided under the health service. There is no limitation on the extent or scope of the inspection other than that set out in section 10I(2) of the Act, which states that inspections should in accordance with a plan which follows best regulatory practice and be approved by Scottish Ministers. Further, under section 10M of the Act Healthcare Improvement Scotland must inspect any service provided under the health service for the purpose specified when requested to do so by Scottish Ministers.

The inspection of the care for older people falls into the category of Section 10M.

The inspections will be undertaken by persons authorised to do so by Healthcare Improvement Scotland. These ‘Authorised Persons’ will have written confirmation of their status as such and will be able to produce it on demand. We are currently working on a staff procedure that details the practicalities of accessing personal records which has been informed by the test inspections.”

3.2 Dementia Standards

3.2.1 NHS Lothian has welcomed the introduction of the Dementia standards and work is well under way to deliver the requirements of these. There are now several pan Lothian work streams in place inclusive of education and training, identifying dedicated staff to support this work and the taking forward of the action plan developed though the 5x5x5 ‘vulnerable patients in acute hospital settings’. This work will also be supported by two staff from NHS Education Scotland and the introduction of the dementia champions programme for which NHS Lothian has 16 funded places. Some of the initial recommendations of the 5x5x5 which focused on the care of vulnerable patients in hospital have been progressed e.g. implementation of core recommended signage to all wards and departments, development of a vulnerable patients Intranet site which signposts staff to good practice resources.

Through the work of the Alzheimer’s Scotland Nurse Consultant five beacon wards have already progressed many of these initiatives and improvements can now be demonstrated. These include increase in staff competence and confidence in managing patients with challenging behaviours and reducing length of stay. Plans are in place to see a rollout of this work across NHS Lothian.

Work is now progressing to develop and implement a mental health liaison team for acute services.
3.3 HEI preparation

3.3.1 NHS Lothian has operationalised preparation for HEI inspections through site leads, directors of operations and UHD/CH(C)P senior management. Various tools are now available and in the process of systematic implementation. These include:

- Core local induction standards for nursing and midwifery in UHD agreed.
- Core corporate and local standards for medical staff and junior doctors being developed.
- Nursing and Midwifery Leadership and Management Standards (2011) approved.
- Leading Better Care (Senior Charge Nurse role modernisation programme) and Clinical Quality Indicators well established.
- NHS Lothian Quality Improvement Strategy, Quality Indicators and measurement framework.
- Better Together Adult inpatient patient experience reports for eight sites and Fast Frequent Feedback rolling out across NHS Lothian.
- Leadership and Governance framework setting out staff accountabilities in UHD.
- Compassionate Care programme.

3.3.2 NHS Lothian has also had a PEAT (Patient Experience Audit Team) programme of internal inspections. This has been reviewed, updated and integrated to include Health and Safety audits, Healthcare Acquired Infections, cleaning, risk assessment etc. This new internal inspection tool, to be called Patient Quality Indicators (PQI) is being finalised. These individual audit tools and the collective PQI are available for use and a pan Lothian systematic roll out will be put in place by the start of January 2012.

3.3.3 Internally the Observation Recording Guidance for Inspectors (Appendix 2), issued to the HEI inspectors, will be used as part of peer review assessments. The UHD Divisional Nurse Director and UHD Chief Nurses are already involved in local clinical observation visits on a weekly basis (in uniform).

3.4 Preparations to date

- Corporate and local communications and awareness raising in place including new intranet page.
- Awareness sessions held for staff on each site.
- Mock inspections undertaken/planned for RIE, St Johns, Roodlands, Royal Victoria, Liberton and Western General hospitals.
- Evaluation templates distributed to Senior Charge Nurses.
- Letter sent via management lines to all staff. This reinforces personal and professional accountabilities.
4 Key Risks

4.1 The key risks are as follows:

- This is an untried standards tool and self assessment framework.
- Specifically the dementia standards are new and it is highly unlikely any Board will meet all of them.
- Potential impact on staff moral of a further inspection with potentially negative media and professional impact.
- Potential impact on public reputation and trust in our services.

However the standards bring together many of the quality ambitions and existing work streams into a helpful focus on care of older people. There are therefore many potential benefits to a pan Lothian integrated response to quality standards of care for older people.

5 Risk Register

5.1 Issues related to poor care, reputation management, complaints, litigation etc. are already on the local and corporate risk registers. Recent HEI reports have resulted in negative media coverage which is an ever present potential outcome from spot check inspections.

6 Impact on Health Inequalities

6.1 A focus on driving up standards for care of older people will focus on person centred, safe and effective standards for all patients. Older people’s care and associated vulnerability from dementia, aging etc. are areas where the public and patients would wish to see evidence of improvements and consistency in care.

7 Impact on Inequalities

7.1 There is no evidence that the assessment framework or any of the associated documentation has been equality impact assessed nationally.

8 Involving People

8.1 Nationally patient and carer representatives have been involved in the standards revisions (older people) and the dementia standards development. HEI have public (lay) representatives on the inspection teams. Locally in NHS Lothian a wide range of groups and networks will be engaged, for example in PEAT/PQI audits, networks etc.
9 Resource Implications

9.1 There are no direct resource implications from this paper but as with other HEI inspections a range of improvements, environmental and otherwise are required. NHS Lothian is currently funding a range of developments in dementia development. It is difficult to quantify the range of investments, specifically for older people’s care as generally investment is for all adult care groups.

Pat Dawson
Associate Nurse Director
15 November 2011
Pat.Dawson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Older People in Acute Care Self Assessment Framework
Appendix 2: Observation Recording Guidance for Inspectors
Older People in Acute Care: Self Assessment
## A- Screening and Initial Assessment

### Self Assessment Question

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard Statement</th>
<th>Initial Assessment Settings</th>
<th>Examples of Evidence Required</th>
</tr>
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</table>
| 1   |                   | Older People being treated in initial assessment settings\(^1\) are appropriately screened and assessed. Where need is recognised, assessment by a multidisciplinary team is carried out and if admission is needed, it must occur promptly. | • Screening/ initial assessment tools used indicating in which settings they are used.  
• Referral protocols for more detailed multidisciplinary assessment and information on demand, capacity and flow for specialist inpatient assessment. |
|     |                    | Please describe how the NHS board ensures: that older people are screened for cognitive impairment; inclusive of delirium/dementia, functional problems, existing home support, their current medicines ascertained and describe how this is applied at weekends or out of hours. |                              |
|     |                    | that where initial screening assessment identifies the need for more detailed multidisciplinary inpatient assessment, this is commenced by the right team in the most appropriate setting within 24 hours of admission to acute care. |                              |

### Questions to consider in your response

- Can the NHS board demonstrate that relevant information from the initial assessment is communicated to appropriate others eg. multidisciplinary staff within hospital; primary care/community team, other agencies?
- Can the NHS board demonstrate that older people and their carers are meaningfully involved in the assessment process and communicated with as to assessment outcomes/decisions?
- Are risk assessments or alert mechanisms used as part of the assessment process?
- Can the NHS board demonstrate that common and important clinical issues in later life such as continence, tissue viability, sensory deficits, nutrition, falls risk and pain are addressed on initial assessment and throughout the patient stay?
- Do the NHS board’s initial assessment settings have agreed procedures in place to identify vulnerable adults?
- How does the NHS board perform against the 4 hour waiting time standard? Is your performance for older people proportionate?
- If required, can a clinician access specialist geriatric assessment, psychiatric assessment, specialist respiratory team, rapid transfer for hip fracture or admission to stroke unit for the older person within 24 hours of admission to acute care?
- Can the NHS board demonstrate that they have a plan for implementation of Medicine Reconciliation that includes older people

\(^1\) eg. outpatient clinic, A&E and first 24 hours of admission into any setting in hospital
**B- Safe, Effective and Person Centred Assessment and Care Planning**

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<th>No. 2</th>
<th>Self Assessment Question</th>
<th>Examples of Evidence Required</th>
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| Standard Statement 38 | **Person Centred Assessment and Care Planning**  
An outcome focussed and multidisciplinary/multi-agency approach to care is taken which meaningfully involves the patient and their carer.  
Can the NHS board describe how it ensures a holistic and multidisciplinary/multi-agency approach to care (clinicians, nurses, AHPs, other professionals, other agencies eg. Social Work) and provide evidence of how this approach has a focus on outcomes that are important for the older person and their carer? | • Assessment and care planning tools including integrated care plan tools indicating where they are used.  
• Results of care plan audits/clinical documentation over the past 12 months.  
• Policies, protocols and audits in relation to Palliative/End of Life Care/DNACPR. |

**Questions to consider in your response**

- How well is outcomes focused care planning embedded in wards that manage older people?  
- Please specify which types of ward settings currently use this approach?  
- How do the care planning tools used promote shared decision making?  
- How does the NHS board ensure that older people and their carers’ are engaged and their views and knowledge contribute to the care plan?  
- How does the NHS board access and make use of Anticipatory Care Plans (ACP)?  
- Describe the implementation of the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy.  
- How are wards using prognostic indicators to prompt timely discussions about ACP, DNACPR and use of the Liverpool Care Pathway?  
- How does the NHS board apply the above procedures in the context of older people who lack capacity?  
- How does the NHS board ensure that older people with acute or chronic pain are effectively assessed?  
- Do hospitals have access to clinical pharmacy services to review and advise on medicine use and facilitate transfer of care between care settings?  

**Response**
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<tr>
<th>No. 3</th>
<th>Self Assessment Question</th>
<th>Examples of Evidence Required</th>
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<tr>
<td></td>
<td><strong>Safe and Effective Care and Services</strong>&lt;br&gt;The management of risk and clinical and care governance are at the heart of ensuring safe and effective care and services for older people&lt;br&gt;Please describe how the NHS board manages risk and delivers clinical and care governance to ensure the delivery of safe and effective care and services for older people.</td>
<td>• Recent reports from CQI.&lt;br&gt;• Bed management policy and any audits of all internal transfers of older people.&lt;br&gt;• Medicine review during admission.&lt;br&gt;• Guidance on management of behavioural problems in confused patients and those with dementia.&lt;br&gt;• Falls pathway including list of medicines that could be associated with falls.&lt;br&gt;• Guidance for medicine administration where swallowing problems exist.&lt;br&gt;• Self administration assessment for certain conditions eg. Parkinson’s disease.&lt;br&gt;• Guidance on prescribing in frail adults.</td>
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<td>Please give a brief overview on how the NHS board manages the prescribing and management of medicines for older people in acute care settings</td>
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<td><strong>Questions to consider in your response</strong></td>
<td>• Please describe how the NHS board uses Leading Better Care Clinical Quality Indicators on Food, Fluid and Nutrition, Falls Risk Assessment and Pressure Ulcer Care to provide effective care to older patients.&lt;br&gt;• Can the NHS board demonstrate that they are using data from their HAI performance to contribute to and support the above initiatives and enhance the broader quality improvement agenda?&lt;br&gt;• Please provide evidence that older people are transferred between wards only in accordance with their clinical needs</td>
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<td><strong>Response</strong></td>
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File Name: Appendix 1 - Older People in Acute Care Self Assessment Framework.doc<br>Version: 1.0<br>Date: 30 September 2011<br>Produced by: Winnie Burke<br>Circulation type (internal/external): External
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<th>No. 4</th>
<th>Self Assessment Question</th>
<th>Examples of Evidence Required</th>
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|       | Enabling Approaches to Promote Independence | • Information on demand, capacity and activity for inpatient and post acute rehabilitation services for older patients.  
• Guidelines/criteria/policies on the transfer of older patients to other clinical areas. |
| Standard Statement | Older people in acute care who need rehabilitation and enablement – whether uni or multidisciplinary – must have this as soon as their clinical condition permits and rehabilitation and enablement will continue throughout the journey of care and link with post acute rehabilitation services. Please describe how the NHS board uses a whole team approach to rehabilitation and enablement to build confidence, promote independence and optimise recovery of older people following acute illness. |
|       | Questions to consider in your response |       |
|       | • How does the NHS board meet the inpatient rehabilitation and enablement needs of older people? |
|       | • Does the NHS board provide an AHP service out of hours and at weekends? If so, please describe what impact this has had on outcomes such as length of stay, patient experience etc. |
|       | • Can the NHS board evidence that roles and responsibilities within the multi-disciplinary team in relation to rehabilitation and enablement are clear including which members of the team will follow the patient through their journey? |
|       | • Describe the range of rehabilitation services which are provided by the NHS board? (eg. stroke rehabilitation units, geriatric orthopaedic units, geriatric assessment, surgical liaison, supported discharge services, residential intermediate care etc) |
|       | • How can the NHS board evidence effective and efficient use of these services to minimise delays in older people accessing rehabilitation? |
|       | • How are older people and carers involved in agreeing rehabilitation goals? |
| Response |       |       |
| Evidence |       |       |
### Self Assessment Question

Supporting Older People to Manage their Conditions and Medicines

Before older people return home from acute care their ability to manage their condition and their medication is assessed and support and monitoring of this is arranged for those who need it after discharge.

Please describe how the NHS board ensures that all older people are enabled to manage their conditions and safely manage their medicines before discharge.

### Questions to consider in your response

- How does the NHS board provide/signpost patients and carers to information and advice about their conditions, managing their conditions and any services that might support them?
- Can the NHS board demonstrate that carers are routinely informed of their right to a Carers Assessment and signposted to support, advice and training in relation to their caring role?
- Can the NHS board evidence that staff members have received education and training about supporting self management?
- Is there an agreed multidisciplinary approach to supporting patients to self manage their conditions and their medicines?
- What rapid feedback systems are used to collect patient experience data within acute care and how is this used to improve the quality of service delivery?
- How does the NHS board use feedback from the Better Together inpatient surveys about how well supported they feel?

### Examples of Evidence Required

- Assessment used to determine older person’s ability to manage their medicines eg. policies on use of medication compliance devices, self medication, use of patient’s own drugs.
- Evidence of liaison with community pharmacy and general practitioner on the continuity of pharmaceutical care.
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<th>No. 6</th>
<th>Self Assessment Question</th>
<th>Examples of Evidence Required</th>
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<tr>
<td></td>
<td><strong>Identifying Vulnerable Patients and Those at Risk of Early Readmission</strong>&lt;br&gt;There are systems to identify vulnerable patients and those at risk of early readmission. Discharge needs are identified and managed in a multidisciplinary/multi agency way.&lt;br&gt;Please describe how hospital staff identify vulnerable older people and those most at risk of early readmission. How do you ensure their discharge is managed with a coordinated multidisciplinary approach involving primary care, social work staff and community services as well as involvement of carers where appropriate?</td>
<td>• Data on 7 and 30 day readmissions for patients 65+ and evidence of Significant Event/Root Cause Analyses.&lt;br&gt;• Joint Discharge/Moving On policy.&lt;br&gt;• The NHS board's Joint Admission, Transfer and Discharge Policy.&lt;br&gt;• Evidence of multi agency discharge planning at ward level.&lt;br&gt;• Information on delayed discharge performance over the past 12 months.&lt;br&gt;• The last audit of the Immediate Discharge Document.</td>
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<td><strong>Working Together to Improve The Quality of Discharge</strong>&lt;br&gt;Please describe how hospital staff identify the discharge needs of older people and their carers and how do they manage these needs in a multidisciplinary way.</td>
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<tr>
<td>Questions to consider in your response</td>
<td>Response</td>
<td>Evidence</td>
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<td>• How are referrals made for a supported discharge?</td>
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<td>• Is there access to, for example, rapid response services, early supported discharge etc and what percentage of older people would access these types of service?</td>
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<td>• Can the NHS board provide good practice examples of the above?</td>
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<td>• How does the NHS board ensure that older people who are vulnerable are identified and made known to Community Services in a pro-active way?</td>
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<td>• Please describe how acute wards identify older people who may benefit from care management, link with case/care managers and with specialist nurses eg. CPN, heart failure nurses, stroke nurses as indicated to minimise risk of readmission?</td>
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<td>• Can the NHS board demonstrate that the Immediate Discharge Summary is of appropriate quality and communicated within appropriate timescales?</td>
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<td>• Can the NHS board demonstrate that at ward level, all appropriate staff have an understanding of discharge planning and the appropriate members of the multidisciplinary/multiagency staff to liaise with to facilitate an effective discharge?</td>
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<td>• How do staff involve carers and older people in discharge planning?</td>
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<td>• How well embedded is carer awareness throughout the hospital and how do hospital staff identify carer support needs?</td>
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<td>• How does the NHS board review the discharge/transfer experience of patients and carers?</td>
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<td>• How does the NHS board ensure that transfer/discharge information is communicated appropriately and timeously to patients and carers and how would this be evidenced?</td>
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### D – Care of Older People with Communication or Cognitive Impairment in Acute Care

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<th>No. 7</th>
<th>Self Assessment Question</th>
<th>Examples of Evidence Required</th>
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<tr>
<td><strong>Standard Statement</strong>&lt;br&gt;2a 3 8</td>
<td><strong>The needs of older people with communication or cognitive impairment are identified and appropriate support given as required.</strong>&lt;br&gt;Please describe the systems in place to allow staff to identify and meet the needs of older people who may require additional support as a result of dementia, delirium or communication impairment and explain how these systems support older people with additional support needs to participate in shared decision making.</td>
<td>• Evidence of how this is monitored and evaluated.</td>
</tr>
</tbody>
</table>

#### Questions to consider in your response

- What systems are in place to request and record key personal information about older people with dementia and ensure that this information is shared with all staff that are in direct contact with them?
- Does each general hospital have access to advice and/or assessment from a liaison service specialising in the diagnosis and care of dementia and delirium?
- Can the NHS board demonstrate that all staff that provide care to acutely unwell older people are given education and training in the care of patients with dementia/delirium and those with additional support needs?
- Can the NHS board demonstrate that staff are familiar with and can recognise the behavioural and psychological symptoms associated with dementia?
- Are systems in place to monitor the number of moves older people with dementia are subject to whilst in hospital?
- Does the NHS board carry out regular audit of the physical environment using the dementia design checklist and ensure that appropriate action is taken to meet any deficits?
- How has the NHS board made the physical environments more accessible for older people with a physical disability?
- Are there suitable facilities for older people with a disability eg. suitable signage for those with visual impairments, assistive listening devices, ‘easy read’ information leaflets? Do you involve people with disabilities in audits of these facilities?
- How does the NHS board provide accessible information for older people with dementia, delirium or communication impairment?
- Does the NHS board have ready access to translation services, advocacy services etc?
- How do staff fully involve carers and in particular utilise their expert knowledge of the person they care for, in the decision making process?
<table>
<thead>
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<th>Response</th>
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<tr>
<th>Evidence</th>
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**E – Practice Development, Leadership and Quality Improvement**

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<thead>
<tr>
<th>No. 8</th>
<th>Self Assessment Question</th>
<th>Examples of Evidence Required</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>A clinical and care governance framework is in place which will underpin the quality improvement agenda and safeguard high standards of care. Staff are aware of relevant legislation, national standards and key strategies which support this framework. Can the NHS board demonstrate that staff are aware of and have an understanding of their responsibilities in relation to the following legislation:</td>
<td>• Details of relevant training programmes for the past 12 months with details of uptake and evaluations.</td>
</tr>
<tr>
<td></td>
<td>• Adults with Incapacity (Scotland) Act 2000</td>
<td>• Evidence of how this training is embedded in induction and in the Knowledge and Skills Framework.</td>
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<td></td>
<td>• Adult Support and Protection (Scotland ) Act 2007</td>
<td>• Evidence from use of clinical improvement tools and techniques applied to care of older people.</td>
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<td></td>
<td>• Equality Act 2010</td>
<td>• Overviews of complaints about care of older people and actions in response to feedback of patient experience reports.</td>
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<td>• Human Rights Act 1998</td>
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<tr>
<td>Questions to consider in your response</td>
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<td>----------------------------------------</td>
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<tr>
<td>• Describe the NHS board’s professional leadership and practice development support to improve the quality of care for older people.</td>
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<tr>
<td>• Provide a brief overview of how the NHS board is implementing ‘Leading Better Care’ and ‘Releasing Time to Care’ to improve quality and efficiency in the delivery of services to older people.</td>
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<tr>
<td>• Please explain how the NHS board uses clinical improvement tools and techniques such as clinical audit, Plan, Do Study, Act, LEAN principles, Patient Stories and Root Cause Analysis to support reflective practice. Please give examples of how this has improved processes and created value for older people that use services.</td>
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<td>• Please describe what action the NHS board has taken or propose to take in relation to Care and Compassion? (Report of the Health Service Ombudsman on ten investigations into NHS care of older people) 2011</td>
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<tr>
<td>• Can the NHS board demonstrate that staff have an awareness and understanding of common clinical conditions such as immobility, impaired cognition, continence problems and how these manifest in acute conditions? Do staff have an understanding of common age related changes such as for example, age related hearing loss?</td>
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<td>• Please describe how the understanding and impact of this training is monitored and evaluated.</td>
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<th>Response</th>
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| Evidence |  |
## Observation Recording Guidance for Inspectors

### Agenda Item 8

**Presented By:** Christine Johnston

<table>
<thead>
<tr>
<th>Step In Inspection Process&lt;sup&gt;1&lt;/sup&gt;</th>
<th>During</th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
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<td>The document provides supplementary guidance to allow trained inspectors to systematically record observations of the quality of interactions between staff and patients using a validated observation tool. Observation data will ensure the experiences of people who are unable to tell us themselves are captured during the inspection process.</td>
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| **Actions for Group**                |        |
| To note the use of the observation tool and the development of the guidance |

| **Comments to**                      |        |
| For noting |

<sup>1</sup> The stages of the inspection process are detailed in the diagram on the next page. This is based on the inspection process that is currently employed by HEI.
Prior to inspection:
- Online self-assessment framework finalised and issued
- NHS board undertakes self-assessment exercise and submits outcomes to HEI
- HEI reviews self-assessment submission to inform and prepare onsite inspections

During inspection:
- Arrive at hospital
- Inspections of selected wards and departments
- Individual discussions with senior staff and/or operational staff and patients
- Group discussions with NHS board and senior hospital staff
- Feedback with NHS board and senior hospital staff
- Further inspection of hospital if areas of significant concern identified

After inspection:
- Report and improvement action plan published
- Follow-up activity to ensure improvement actions are completed
Inspection of services for older people in acute hospitals in NHSScotland

Observation recording guidance for inspectors

Person Centred Care:

Care which demonstrates compassion, dignity, privacy, clear communication and shared decision making
Introduction

About this Guidance

This guidance has been created in support of the Programme of Inspections of Older People’s Care in Acute Hospital Settings in Scotland.

The guidance will help you to use an observation tool called The Quality of Interaction (QUIS) once you have completed QUIS training.

The Quality of Interaction Schedule (QUIS)

The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions without becoming involved (non-participant observation). It is a technique that was first developed for use in long term mental health settings, but has since undergone many refinements and has been adapted for general use in care homes and hospital settings. The tool described in this guide has been designed to help inform evaluations of the type and quality of interaction that takes place between staff and older people and their visitors in an acute hospital setting.

Using Observation during Inspection Visits

During inspection visits the views and experiences of people who use services are central to helping us make a judgement. A number of different tools will be used to allow patients and visitors to share their views and experiences with us without fear of reprisal. These tools include patient and visitor questionnaires, face to face interviews and walk rounds together with existing sources of feedback.

We know that, irrespective of the condition that brought older people into the acute hospital setting, more than half will have a long or short term mental health disorder such as dementia, depression, delirium or cognitive impairment. We also know that interviews and questionnaires are unlikely to capture the experiences of cognitively frail older people. Observation is a practical and proven method that can help us to build up a picture of the care experiences of older people in a given care setting, including people who are unable to tell us themselves and who are most likely to have the greatest care needs.

All observations will be carried out in pairs.

The Limitations of Observation

Person centred care is care which demonstrates compassion, dignity, privacy, clear communication and shared decision making. Not all aspects of person centred care can be observed and not all observations can be interpreted without additional information.

The focus of the observation is also restricted to the way that staff respect and interact with older patients and their visitors.

Observation data will therefore be used alongside findings from other methods and ‘triangulated’ to provide a more complete picture of the care of older people and to put the observation data in context.
Questions and Considerations

| When should I use observation during the visit? | • There will be a timetable which will ensure that each of the different methods (questionnaires, interviews, walk rounds and observations) are used at the most useful, unobtrusive and appropriate times during the visit

• Observations will generally be carried out at times of day when speaking with patients or handing out questionnaires would be inappropriate or obtrusive |
| --- | --- |
| What do I need to carry out the observation? | To carry out the observation you will need:

• A watch

• Observation Recording Sheets (4 or 5 should be sufficient)

• A pen |
| Where should I carry out the observation? | • You will be allocated a ward or bay as your observation area

• The ward staff will have been given an Information Sheet and asked to ensure that patients and staff know what you are doing

• Speak to ward staff to find a position in the observation area that gives you a clear view, that is unobtrusive and where you will be able to sit and record what you see and hear without interruption

• Ask staff to try to ignore your presence as much as possible

• Tell them to let you know if you are in the way

• Always observe in a communal area

• Do not follow patients, staff or visitors out of the observation area |
| How should I conduct myself during the observation? | • It is important that you observe in an unobtrusive way that preserves people’s dignity and human rights

• If anyone becomes distressed by your presence you should immediately stop observing

• If you see that a person is in danger you should take action as detailed in the Managing Concerns procedure

• Always respond in a person centred and open way to anyone who speaks to you while you are observing, whether it is a member of staff, a patient or a visitor

• If anyone is concerned about confidentiality assure them that this will be respected

• Do not start any interaction with a patient or visitor during the observation period

• Say goodbye and thank you before leaving |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</table>
| How long will the observation last?                          | - Each observation period will last for 20 minutes  
- You should observe continuously during the 20 minute period                                                                                          |
| How many people should I observe?                           | The number of people you can observe will be determined by:  
- the number of older people being cared for in the observation area  
- the layout of the ward or bay  
- your observation position  
- the level of ward activity  
Typically not more than six older patients will be observed. |
| What should I observe?                                      | The focus of the observation is interaction:  
- All staff – patient interactions that take place within the ward during the period of observation should be recorded  
- Any staff – visitor interactions that take place within the ward during the period of observation should be recorded  
- NOTE: Staff – staff, patient - patient and patient – visitor interactions should not usually be recorded. If however you feel there is something significant to record, use the Events column in the Recording Sheet to make a note of the interaction  
- During your observations you may see things that indicate that people’s diversity is or is not promoted and respected. All equality and diversity issues must be noted in the Recording Sheet. |
| How do I rate the quality of interaction?                    | The 3 quality rating categories Positive Social, Basic Care and Negative are described, with examples, in the Quality Rating Prompts sheet. When rating an interaction you should:  
- Rate each observed interaction immediately  
- Be consistent when rating the quality of interaction, bearing in mind your agreed consistency with your colleagues  
- Negative interactions must always be identified, even as part of a ‘better’ whole interaction  
- In all other cases where interactions are of mixed quality, aim to give a fair picture of the overall quality of interaction  
- You can use the Quality Rating Prompts sheet in this guidance to help you decide how to rate the quality of interaction  
- Your rating will be checked with that of your paired observer to ensure consistency and enhance the reliability of the data |
| What if I am concerned about something I observe?            | - If you observe an incident of concern this should be reported in accordance with the standard procedure for managing and escalating concerns: Managing Concerns |
Rating the Quality of Interactions: Person Centred Interactions

You will record a short description of each observed interaction between staff and patients or between staff and visitors during the observation period, including verbal and non-verbal interactions. You will also rate the quality of interaction using one of three categories: Positive Social Interaction; Basic Care or Neutral Interaction or Negative Interaction.

Before thinking about the three rating categories, it is important that you have a clear understanding of what “person centred care” entails. The following questions are provided to prompt you to think about the kind of interactions that capture the essence of person centred care.

They are examples of positive social interactions that might be observed in any acute hospital.

The prompts are not a checklist. They are simply suggestions that you might take into consideration when rating the quality of the interactions that you observe during inspection.

As many cognitively frail older patients may be unable to respond verbally, references to ‘having a say’ or ‘conversations’ should not be interpreted literally.

<table>
<thead>
<tr>
<th>Do staff try to actively engage with people as they go about their work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Having caring ‘conversations’ (even if the person is unable to respond verbally)</td>
</tr>
<tr>
<td>• Taking an interest in the patient as a person, rather than just another admission</td>
</tr>
<tr>
<td>• Smiling or laughing together</td>
</tr>
<tr>
<td>• Checking with people to see how they are and if they need anything</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do staff treat people with respect?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Addressing patients and visitors respectfully</td>
</tr>
<tr>
<td>• Giving timely assistance in meeting comfort needs, e.g. toileting and pain relief</td>
</tr>
<tr>
<td>• Explaining why if unable to do something right away</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Do staff respect people’s privacy and dignity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Speaking quietly with people about private matters</td>
</tr>
<tr>
<td>• Not talking about an individual’s care in front of others</td>
</tr>
<tr>
<td>• Making appropriate use of curtains or screens and checking before entering a screened area</td>
</tr>
<tr>
<td>• Respecting personal space and property</td>
</tr>
<tr>
<td>• Carrying out personal care with discretion</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>How are tasks carried out?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• With encouragement and accompanying ‘conversation’</td>
</tr>
<tr>
<td>• With enjoyment, warmth and enthusiasm</td>
</tr>
<tr>
<td>• At a pace that matches the older person’s needs and abilities</td>
</tr>
<tr>
<td>• Caring about rather simply caring for the person</td>
</tr>
<tr>
<td>How is information about care and treatment communicated to people who use services?</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>• Considerate language used, simplicity of language / non-verbal if appropriate</td>
</tr>
<tr>
<td>• Tone of voice</td>
</tr>
<tr>
<td>• Explanations provided, such as advising what will happen next</td>
</tr>
<tr>
<td>• Communication tailored to the individual / checking understanding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What opportunities are given to people to make choices and have ‘a say’ in how their care or treatment is delivered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offering choices or seeking preferences at mealtimes, around personal care</td>
</tr>
<tr>
<td>• Offering choices of where, when and with whom to have care and treatment</td>
</tr>
<tr>
<td>• Respecting / acting on choices made</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are adjustments made, where appropriate, to enable people to be involved in decision-making about their care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supporting explanations provided</td>
</tr>
<tr>
<td>• Involving family, friends or other advocates as appropriate in discussions</td>
</tr>
<tr>
<td>• Communication tailored to the individual, use of communication supports, pace of presenting information</td>
</tr>
<tr>
<td>• Offering opportunities to experience or learn about options before deciding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do staff promote people’s autonomy and independence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supporting or encouraging people to do things for themselves, but providing assistance where needed</td>
</tr>
<tr>
<td>• Supporting people’s preferences and choices</td>
</tr>
<tr>
<td>• Recognising and acknowledging people’s achievements</td>
</tr>
</tbody>
</table>
### Positive Social Interactions (PS)

These interactions:
- Show warmth, are respectful and enabling
- Provide people with a feeling of safety and significance
- Are sensitive and assist individuals to make choices and be in control

**Examples:**
- Giving encouragement during care tasks and recognising achievements
- Giving options and respecting choice
- Actively seeking engagement and participation – giving the opportunity to ask questions
- Explaining and tailoring information to the individual, checking their understanding
- Checking proactively to see if anything is needed (and responding accordingly)
- Smiling, laughing together – the human touch
- Showing interest in and knowledge of the patient as a person
- Having caring ‘conversations’
- Welcoming visitors into the ward
- Recognising and responding to patient and visitor emotions
- Responding warmly to visitors’ questions

### Basic Care or Neutral Interactions (BC)

These interactions:
- Neither undermine nor enhance people
- Are either part of carrying out care tasks adequately in order to get the job done or
- Involve a request, suggestion or information exchange without any of the features of positive social interactions

**Examples:**
- Perfunctory completion of a care tasks such as checking readings, filling in charts without any verbal or non-verbal contact
- Offering brief verbal explanations and some encouragement, but only that necessary to complete the care task
- Speaking to someone in a manner that lacks empathy but is not necessarily rude or disrespectful
- Telling someone what is going to happen without offering choice or the opportunity to ask questions
- Not showing any interest in what the patient or visitor is saying
- Actively avoiding conversation
- Treating visitors with indifference
- Indifference to patient and visitor emotions
- Giving minimal responses to visitor questions
**Quality of Interaction Schedule (QUIS): Rating Prompts**

<table>
<thead>
<tr>
<th>Negative Interactions (N)</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>These interactions:</td>
<td>Patient: patient, staff: staff or patient: visitor interactions should not be usually be recorded unless you consider them significant.</td>
</tr>
<tr>
<td>• Lack warmth or respect</td>
<td></td>
</tr>
<tr>
<td>• Undermine feelings of safety and significance</td>
<td></td>
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<tr>
<td>• Are insensitive and can be disempowering</td>
<td></td>
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<tr>
<td><strong>Examples:</strong></td>
<td><strong>Examples:</strong></td>
</tr>
<tr>
<td>• Ignoring or talking over a person during conversations</td>
<td>• Staff talking about a patient or visitor in a rude or disrespectful manner</td>
</tr>
<tr>
<td>• Telling someone to wait for something without any explanation or comfort</td>
<td>• Staff engaging in caring conversations about each other or enhancing care on the ward</td>
</tr>
<tr>
<td>• Telling someone they can’t have something without good reason or explanation</td>
<td>• One patient bothering another patient</td>
</tr>
<tr>
<td>• Telling or instructing a person to do something without discussion or offering assistance</td>
<td>• One patient helping or providing comfort to another</td>
</tr>
<tr>
<td>• Treating a person in a child like or disapproving way</td>
<td>You may also observe events which are critical to the overall quality of care, but which do not necessarily involve a direct interaction.</td>
</tr>
<tr>
<td>• Using child like language or ‘elder speak’</td>
<td><strong>Examples:</strong></td>
</tr>
<tr>
<td>• Not allowing a person to use their abilities or make choices (even if said with ‘kindness’)</td>
<td>• A patient calling for attention without response</td>
</tr>
<tr>
<td>• Seeking choice but then ignoring or over ruling it</td>
<td>• A patient left inadequately clothed</td>
</tr>
<tr>
<td>• Being rude, short or unfriendly to patients or visitors</td>
<td>• A visibly upset patient or visitor being ignored</td>
</tr>
<tr>
<td>• Being angry with or scolding patients</td>
<td>• An uneaten meal removed without attempts to encourage the patient to try it</td>
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</tbody>
</table>
## Quality of Interaction Schedule (QUIS): Observation Recording Sheet

<table>
<thead>
<tr>
<th>Time</th>
<th>Interaction Description</th>
<th>Code</th>
<th>Verbal / Non-Verbal</th>
<th>Between</th>
<th>Event</th>
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Quality of Interactions Schedule (QUIS) Developed by Dean, R., Proudfoot, R. & Lindesay, J. 1993
 References


QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University. Available at: http://www.staff.city.ac.uk/~jacky/dignity/resource.htm

10.5

NHS LOTHIAN

Board Meeting
23 November 2011

Director of Public Health & Health Policy (Executive Lead)

ALCOHOL (MINIMUM PRICING) (SCOTLAND) BILL SUBMISSION

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the submission to the call for evidence on the Alcohol (Minimum Pricing) (Scotland) Bill from the Health and Sport Committee of the Scottish Parliament. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

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

2 Recommendations

The Board is recommended to agree:

2.1 That there is a clear and longstanding relationship between the affordability of alcohol and levels of consumption and both Scotland and Lothian have a significant alcohol problem.

2.2 That other methods of affecting price have a variety of disadvantages.

2.3 That a minimum price per unit of alcohol is a proportionate and pragmatic way of reducing the consumption of alcohol by people drinking at harmful levels.

2.4 The submission from NHS Lothian to the call for evidence on the Alcohol (Minimum Pricing) (Scotland) Bill.

3 Discussion of Key Issues

3.1 NHS Lothian has been invited to submit its views on the provisions of the Alcohol (Minimum Pricing) (Scotland) Bill to the Health and Sport Committee of the Scottish Parliament. The draft response for approval is attached at Appendix 1. This response is based on a submission to the Alcohol etc (Scotland) Bill, which initially included a minimum pricing section that was not in the final Act as passed in the previous session of the Scottish Parliament. This previous submission was discussed at the Executive Management Team on 3/2/2010 and submitted by the
Director of Public Health and Health Policy. This previous response has been amended and subjected to a rapid email consultation within NHS Lothian among clinicians involved in areas particularly affected by alcohol use and misuse.

3.2 The Alcohol (Minimum Pricing) (Scotland) Bill seeks to help reduce alcohol consumption in Scotland and reduce the impact that alcohol misuse and over-consumption has on public health, public services, productivity and the economy as a whole. The demand for alcohol is very price sensitive and this measure is directly targeted at the price of alcohol. It complements the wider strategic approach to tackling alcohol misuse, as set out in Changing Scotland’s Relationship with Alcohol: A Framework for Action, and the licensing and other issues included in the Alcohol etc (Scotland) Act 2010.

3.3 The Alcohol (Minimum Pricing) (Scotland) Bill gives Scottish Ministers the power to set a price per unit below which alcohol cannot legally be sold. The consultation response at Appendix 1 explains the various options and the potential effect of this proposal.

4 Key Risks

4.1 Without action on the price of alcohol, consumption is likely to remain at high levels in the population in Lothian and continue to contribute to preventable ill-health and death.

5 Risk Register

5.1 There are no new implications for NHS Lothian’s Risk Register.

6 Impact on Health Inequalities

6.1 As a response to proposed legislation, this does not need to be subject to an Equality Diversity Impact Assessment.

7 Impact on Inequalities

7.1 As a response to proposed legislation, this consultation response has not been subject to an impact assessment. However, the impact on inequalities will have been considered as part of the process.

8 Involving People

8.1 This response has been subject to a rapid email consultation with clinicians involved in areas particularly affected by alcohol use and misuse. It is contributing to an open consultation by the Health and Sport Committee of the Scottish Parliament.
9 Resource Implications

9.1 There are no new resource implications for NHS Lothian, other than the continued burden of preventable alcohol-related ill health and death the NHS already deals with and which might be reduced as a result of the introduction of a minimum price per unit of alcohol.

Jim Sherval
Specialist in Public Health
14 November 2011
Jim.sherval@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Draft response from NHS Lothian to consultation on Alcohol (Minimum Pricing) (Scotland) Bill
APPENDIX 1:
Call for written evidence on the Alcohol (Minimum Pricing) (Scotland) Bill by the Health and Sport Committee, Scottish Parliament

Response from NHS Lothian

Approved by Lothian NHS Board on 23rd November 2011

Introduction

Tackling alcohol misuse and its consequences are key issues for the NHS in Scotland in general and NHS Lothian in particular. NHS Lothian welcomes the introduction of the Alcohol (Minimum Pricing) (Scotland) Bill as it is an evidence-based policy that will directly address problematic drinking.

There is clear evidence that Scotland has a significant problem with alcohol: between 1998 and 2004, 15 of the 20 local authority areas in the UK with the highest alcohol-related death rates were in Scotland. This included Edinburgh and West Lothian, for both men and women. Between 1998 and 2002 there was a 52% increase in alcoholic liver disease in Scotland and we now have one of the highest death rates from liver cirrhosis in Western Europe.

Alcohol contributes disproportionally to deaths in Scotland occur under the age of 65 which are generally classified as premature deaths. Alcoholic liver disease is the third most common cause of death under 65 and accounted for more than 6% of all premature deaths between 2007 and 2009 (more than 700 per year on average). Mental and behavioural disorders due to alcohol caused another 2.3% of deaths in the under 65s during the same time period.

A review of the literature for the Home Office in England published in January 2011 found that “Overall the research literature supports an established association between alcohol consumption and many negative health outcomes and the balance of research finds that increases in alcohol prices are linked to decreases in these health harms.”

Changing Scotland’s Relationship with Alcohol: a Framework for Action sets out the need for change and draws on a variety of reports that chart the costs and impact of alcohol in Scotland. We welcomed this Framework as it clearly took a population and evidence-based approach. This issue is not just about young binge drinkers and dependent street drinkers: as the Framework acknowledges, we all need to drink less.

As with many issues, we need to take action across a range of areas. For instance, NHS Lothian has had considerable success in training over 80% of Lothian GPs and antenatal staff in screening and delivering Alcohol Brief Interventions (ABIs). NHS Lothian was given a HEAT target of delivering 23,594 ABIs between 2008-2011 and achieved 127% of the target (29,884). Work is now underway to establish this approach in other areas such as smoking cessation, sexual health clinics, acute mental health, and pharmacy. NHS Lothian is also extending the training to promote the delivery of ABIs into community and voluntary and other statutory organisations such as the police, prisons, youth workers, and the fire and rescue service. However, action by the NHS alone will not solve this problem.
Consultation questions and response

- The advantages and disadvantages of establishing a minimum alcohol sales price based on a unit of alcohol;
- The level at which such a proposed minimum price should be set and the justification for that level;
- Any other aspects of the Bill.

Response to Questions

There is a clear and long standing relationship between the affordability of alcohol and levels of consumption. This has been established across many countries over time. In the UK, alcohol is now 69% more affordable than in 1980, with consumption increasing by around 20% over the same period. The World Health Organisation considers that tackling the affordability of alcohol is a key component of an effective alcohol strategy. To implement the rest of the Framework and ignore the price of alcohol would not make sense.

There are a number of ways in which governments might seek to affect the price at which alcohol is sold:

**Taxation:** Excise duty is not within the gift of the Scottish Parliament to change but it is an important lever for change. Excise duty currently varies according to beverage type. Beer and spirits are taxed in relation to their alcohol strength. Duty on wine, cider and perry is fixed by volume and takes no account of alcohol strength. In the UK wine between 5.5% ABV and 15% ABV has the same rate of duty. This area is governed by EU Council Directive (92/83/EEC) but it has been argued that the UK Government would have scope to increase taxes on higher strength alcoholic drinks and lower duty on lower strength alcohol on the grounds of public health. This differential has been introduced in Australia, where around 40% of the beer market by value consists of drinks with lower alcohol content than 3.8%. Since 1980 alcohol consumption in Australia has decreased by 24%. Cider is in a particularly anomalous position. Under the current duty regime a litre of beer at 5% ABV has 65p duty added, while the equivalent litre of cider has 26p of duty levied. While this difference has roots in an attempt to preserve rural traditions, over 50% of cider made in the UK is by one multi-national company.

**Prevent sales at below tax and duty:** One potential difficulty with taxes is that there is no guarantee that increases are passed on to the consumer. UK retailers have in the past marketed on the basis that ‘we pay the tax for you’ and so it might be anticipated that without other action (such as a ban on selling below cost price or a minimum price) the effect of taxation would be undermined. The issue here is that the effect would be limited under the current duty regime – probably creating a minimum price of around 20p per unit – and therefore have little impact on consumption and concomitant harm.

**Ban on discounts:** Discounts – such a ‘buy one get one free’ or ‘3 for £10’ - are probably the most conspicuous price reduction mechanisms used in off-sales. This is an important measure introduced by the Alcohol etc (Scotland) Act 2010 and one that balances the ban on promotions in on-sale premises in the Alcohol Licensing (Scotland) Act 2005.
However, if discounts are tackled without also establishing a minimum price then it is arguable that retailers will simply adjust their marketing model to reduce the price of an individual bottle or can.

**Minimum pricing:** Introducing a minimum price would create a price below which a unit of alcohol could not be sold. Minimum pricing would apply to all alcoholic drinks but it would not result in an increase in the cost of all drinks, only those which are currently sold below the level set. It would primarily affect low cost, high alcohol products such as ciders and own-label vodka and would impact most on harmful drinkers. On this, the modelling work by the University of Sheffield is very persuasive.

For example, if a 40p minimum price was introduced, a moderate (i.e. those drinking within sensible weekly limits of 21 units for men and 14 for women) drinker’s spend on alcohol would go up by just £11 per year (21p per week), but that of a harmful drinker, who tends to buy more and cheaper alcohol, would go up by £137. A study conducted in two Edinburgh Hospitals compared alcohol purchasing and consumption by ill drinkers in Edinburgh with wider alcohol sales in Scotland. The study looked at last weeks or typical weekly consumption of alcohol by type, brand, units, purchase place and price. Patients consumed a mean of 198 UK units per week. The mean price paid per unit was 43p (lowest 9p per unit) which is below the 72p mean unit price paid in Scotland in 2007. Of units consumed, 70% were sold at or below 40p/unit and 83% at or below 50p per unit.

There is a surprisingly short time-lag in the strong correlation between affordability of alcohol and deaths from liver cirrhosis. Based on the available evidence, the Chief Medical Officer’s assessment is that – like the smoking ban – minimum pricing would save lives within a year. The Sheffield study supports this: their model suggests a 40p minimum price would save about 70 lives in year one, rising to 365 lives per year by year ten.

There is near universal support among the medical profession for the introduction of a minimum price for alcohol. Minimum pricing is has been supported by the UK’s other Chief Medical Officers and by the Scottish Directors of Public Health Group.

Any minimum price needs to be set at a level which will have an impact on consumption and ultimately alcohol related diseases and deaths. While most attention has been paid to a minimum price of 40p it should be noted that this should be in tandem with a ban on promotions. Together these produce an additive effect. The Sheffield study found that at higher minimum prices the additive effect of a promotions ban lessened until at 60p there was little additional effect. In the end this is a political judgment and is the reason that the Bill seeks to give Ministers the right to set the price rather than, for instance, it being fixed to the retail price index. Put starkly, it is a choice between how many deaths might be prevented and what might be a publicly acceptable level for the minimum price.

Enforcement of a minimum price is also much easier than other measures as it is easy to calculate using the formula MPU x S x V x 100 where MPU is the minimum price per unit, S is the strength of the alcohol, and V is the volume of the alcohol in litres.

**Conclusion**

In tandem with previous legislation on off-sales discounts and promotions, minimum pricing does appear to be a proportionate and pragmatic approach that is within the gift of
the Scotland Parliament to implement. This would not put up the price of every drink, only those which are sold at an unacceptably low price such as cheap spirits and cider. It would also be much clearer to enforce.

Clearly, the area of drugs misuse is benefitting from a political consensus around the recovery agenda. NHS Lothian would be keen for a similar consensus around alcohol to emerge that includes action on the affordability of alcohol. From the evidence presented to NHS Lothian, minimum pricing has a substantial part to play in Scotland’s response to this challenge along with the previous legislative, policy and service elements introduced over the last few years.

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5. Marmot M et al. Calling Time: the nation’s drinking as a major health issue, Academy of Medical Sciences, 2004
7. Chick J, Gill J, Black H. Alcohol units consumed and price paid per alcohol unit by patients seen by the Edinburgh Alcohol Problems Services, with a comparison to wider alcohol sales in Scotland. Addiction, 2011
NHS LOTHIAN CONTRIBUTION TO SEAT WORK

1 Purpose of the Report

1.1 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 this report is based on the outcomes of the last meeting of SEAT 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 streams by exception and relevance to the Board.

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. Work is continuing in relation to repatriate NSH Borders activity from NHS Lothian and to direct agreed activity from East Lothian to Borders.

3.2 The Director of Public Health and Health Policy is leading the work on performance standards and minimising variation. 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. Work has been done around high cost/low volume procedures, procedures of limited clinical value, more efficient use of hospital beds and prescribing. There has been a request for worked up examples the next meeting on the 25th November.

3.4 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 but the work is lead by the Chief Executive of NHS Borders with the support of the Learning Disabilities MCN. The work has now progressed to look at an agreed approach to commissioning services across the SEAT region as well as looking at how services/beds are fully utilised across the Board areas.

3.5 Technology and radiology. 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 particularly in relation to plain film reporting.

3.6 Corporate Shared Services is the fifth work stream and Board level functions such as HR and Public Health have been benchmarked across the region, identifying variations between Boards. Further work is underway to identify actual options to be progressed.

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 but we have now recruited the Consultant post. Timescales for the Unit being open and taking patients is now early January 2012.

3.8 SEAT agreed to fund recurringly the work around the regional MCN for Child Sexual Abuse. Dr Helen Hammond a Consultant Paediatrician in Lothian is the lead clinician for the MCN. This service will provide day time and emergency out of hour’s service for those children deemed to have been at risk of sexual abuse.

3.9 The SEAT regional cancer advisory group also agreed to support a joint piece of work between the Boards in the EAST and the West in relation to the development of a seventh facility to accommodate a machine to provide radiotherapy to people in the central belt as this is where the greatest population growth is expected to be. This work is now moving forward.

3.10 Severe weather – a draft Severe Winter Weather policy and procedure based upon the current PIN guidelines was agreed in principle and is now going through relevant governance processes across Boards with partnership support.
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 SEAT 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
10 November 2011
Alex.mcmahon@nhslothian.scot.nhs.uk
COMMITTEE MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree revised membership of the Staff Governance Committee following the amendment to the Terms of Reference at the September Board meeting.

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

2 Recommendations

The Board is recommended to agree:

2.1 To confirm the appointment of Iain Whyte as the Community Health Partnership/Community Health & Care Partnership member of the Staff Governance Committee.

3 Discussion of Key Issues

3.1 Following the approval of amended Terms of Reference at the September Board meeting reducing the number of Community Health Partnership/Community Health & Care Partnership Chairs on the Staff Governance Committee from all the Chairs to one, the Community Health Partnership/Community Health & Care Partnership Chairs have agreed that Iain Whyte should be the Community Health Partnership/Community Health & Care Partnership member of the Staff Governance Committee.

4 Key Risks

4.1 Failure to regularise the membership of the Staff Governance Committee could lead to decisions being challenged.

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 ratio 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
25 October 2011
peter.reith@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>Reference</th>
<th>Description</th>
<th>Date</th>
<th>Signatories</th>
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<tbody>
<tr>
<td>1</td>
<td>PCA(M)(2011)013</td>
<td>Primary medical services (Directed enhanced services) (Scotland) (No2) Directions 2011</td>
<td>26/09/11</td>
<td>DOF, DPHHP, GMPCC</td>
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<td>2</td>
<td>PCA(P)(2011)012</td>
<td>Pharmaceutical Services: Amendment to Annex A discount clawback scale for proprietary drugs</td>
<td>05/10/11</td>
<td>DOF, GMPCC</td>
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<td>3</td>
<td>PCA(P)(2011)011</td>
<td>Pharmaceutical services: Drug tariff amendments – transitional &amp; shadow fee payment restructuring – 2011-2012 electronic claim training payment.</td>
<td>05/10/11</td>
<td>DOF, DPHHP, GMPCC</td>
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<td>4</td>
<td>PCA(M)(2011)014</td>
<td>Influenza and pneumococcal directed enhanced services – amended.</td>
<td>23/9/11</td>
<td>DOF, DPHHP, GMPCC</td>
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<td>5</td>
<td>CEL(2011)023</td>
<td>Guidance on reimbursement of ‘out of pocket’ expenses for volunteers within NHSScotland</td>
<td>05/10/11</td>
<td>ND</td>
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<td>6</td>
<td>JD(2011)001</td>
<td>The criminal Justice and Licensing (Scotland) Act 2010 (commencement no.9, transitional and savings provisions) order 2011.</td>
<td>07/10/11</td>
<td>DSP</td>
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<td>7</td>
<td>PCA(P)(2011)013</td>
<td>Pharmaceutical Services: Amendment to Annex A: Discount clawback scale for proprietary drugs</td>
<td>13/10/11</td>
<td>DOF, GMPCC</td>
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<td>8</td>
<td>PCA(M)(2011)016</td>
<td>General medical services statement of financial entitlements for 2011/12</td>
<td>26/10/11</td>
<td>DSP, GMPCC</td>
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<td>9</td>
<td>CEL(2011)024</td>
<td>General Dental Services, primary medical services, general ophthalmic services pharmaceutical services, payment verification procedures</td>
<td>28/10/11</td>
<td>DOF, GMPCC</td>
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<td>10</td>
<td>PCA(M)(2011)015</td>
<td>Health Board direct provision of primary medical services (Scotland)(No2) directions 2011(the direct provision direction).</td>
<td>31/10/11</td>
<td>DSP, GMPCC</td>
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<td>11</td>
<td>CEL(2011)025</td>
<td>Safeguarding the confidentiality of personal data processed by third party contractors</td>
<td>11/11/11</td>
<td>MD, GMPCC</td>
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12 DES(2011)012 2011/12 allocation for directed enhanced services (DES) for extended hours access for GP practices, nursing provision for extended hours access, palliative care and osteoporosis 11/11/11 DSP, GMPCC

13 SPPA(2011)008 Premature retirement on redundancy, organisational change or in the efficiency of the service – payment of employer costs. 11/11/11 DHR & OD

Douglas Weir
Corporate Services Manager
14 November 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