NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 25 JANUARY 2012

TIME: 9:30 A.M. (PRESENTATIONS) 10:15 A.M. (BOARD MEETING)

VENUE: “SPACE 3”, HOWDEN PARK CENTRE, HOWDEN, LIVINGSTON, WEST LOTHIAN EH54 6AE

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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<td>9:30 a.m. West Lothian Community Health &amp; Care Partnership Presentation</td>
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<td>1. Minutes of the Previous Meeting of Lothian NHS Board held on 23 November 2011</td>
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<td>2. Matters Arising</td>
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<td>2.1. Older Peoples Inspections</td>
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<td>3. Committee Minutes for Adoption (Indicative Timing 10:30 - 10:45 a.m.)</td>
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<td>3.1. Area Clinical Forum - Minutes of the Meeting held on 17 November 2011</td>
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* = paper attached  
# = to be tabled  
v = verbal report  
p = presentation

For further information please contact Peter Reith, ☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
3.3. Healthcare Governance & Risk Management Committee - Minutes of the Meeting held on 15 December 2011

3.4. Mutuality and Equality Governance Committee - Minutes of the Meetings held on 14 October & 13 December 2011

3.5. Service Redesign Committee - Minutes of the Meeting held on 19 December 2011

3.6. Staff Governance Committee - Minutes of the Meeting held on 22 November 2011

3.7. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 28 October 2011

3.8. Edinburgh Community Health Partnership Sub-Committee Minutes of the Meeting held on 7 December 2011

3.9. Midlothian Community Health Partnership Sub-Committee Minutes of the Meeting held on 24 November 2011

3.10. West Lothian Community Health & Care Partnership Sub-Committee Minutes of the Meeting held on 13 October and 24 November 2011

3.11. West Lothian Community Health & Care Partnership Board Minutes of the Meetings held on 27 September and 8 November 2011

4. Chairman’s Report

5. Chief Executive's Report

6. Governance (Indicative Timing 11:00 - 11:30 a.m.)

6.1. Quality Report

7. Performance Management (Indicative Timing 11:30 a.m. - 12:30 p.m.)

7.1. Financial Position to 30 November 2011

7.2. Delivering Waiting Times

7.3. Tackling Delayed Discharge

7.4. Healthcare Associated Infection Update

LUNCH 12:30 p.m.

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

8.1. Annual Review 2011

8.2. NHS Lothian Health and Safety Policy

8.3. NHS Lothian Contribution to SEAT Work

9. Presentation - Scottish Patient Safety Programme - Dr Nikki Maran, Consultant Anaesthetist, Royal Infirmary of Edinburgh

10. Communications Received
11. Date, Time and Venue of Next Meeting: Wednesday 28 March 2012 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

12. Resolution to take items in closed session

Dates of Meetings in 2012:

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* Special meeting to consider the Annual Accounts

# Trustees Meeting preceding Board Development Day
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 23 November 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); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Mrs M Hornett (Nurse Director); Dr A K McCallum (Director of Public Health and Health Policy); Professor A McMahon (Acting Director of Strategic Planning and Modernisation) 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; Mr E Egan (Vice-Chair); Professor J Iredale; Mrs J McDowell; Councillor P McLennan; Professor P Murray; Professor M Prowse; Mr S G Renwick; Mr G Walker; Mr I Whyte and Dr R Williams.

**In Attendance:** Ms K Leach (Shadowing Mr Boyter); Ms C A Knox (Shadowing Mr Egan (Vice-Chair); Mr M Pearson (Shadowing Mrs Sansbury); Mr D Weir and Mr S Wilson.

Apologies for absence were received from Councillor P Johnston and Mr B Peacock.

**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.

**78. Welcome and Introduction**

78.1 The Chair welcomed members of the public and the press to the meeting. He also welcomed Ms Leach who was shadowing Mr Boyter, Ms Knox who was shadowing the Vice-Chair and Mr Pearson who was shadowing Mrs Sansbury.

78.1.1 The Chair, on behalf of the Board, wished Mr Peacock a speedy recovery.
79. Minutes of the Previous Meeting of Lothian NHS Board held on 28 September 2011

79.1 The Minutes were approved as a correct record, subject to the following amendments:

- Minute 62.5 – “medical” to read “medication”
- Minute 74.8 – “used equipment to read” “paraphernalia”

80. Committee Minutes for Adoption

80.1 Audit Committee – Minutes of the Meeting held on 11 October 2011 – the Board adopted the Minutes. Mr Renwick advised useful debate had been held around the Royal Hospital for Sick Children/ Department of Clinical Neurosciences (RHSC/DCN) Business Case with a view to synthesising the audit risk and this would dovetail with further Finance and Performance Review Committee and Board work.

80.1.1 Mr Renwick commented on recent publicity that the NHS in Scotland Counter Fraud Service had saved £43m on fraud avoidance. He noted that Lothian was recognised as the most proactive Board in Scotland regarding fraud awareness, which highlighted the benefit of the Board and Audit Committee having adopted a strong zero tolerance policy.

80.2 Finance and Performance Review Committee – Minutes of the Meetings held on 13 September and 12 October 2011 – the Board adopted the Minutes.

80.2.1 Mr Walker commented a further meeting of the Finance and Performance Review Committee would be held on 14 December 2011. This would be a key meeting to discuss the RHSC/DCN Business Case and he reminded all Board members they were invited to attend the meeting, commenting it would be important to have as many people as possible in attendance.

80.2.2 Mrs Sansbury commented in response to a question from Mrs Douglas that the full range of options was being considered in respect of the advertisement for specialty doctors in the Paediatric service at St John’s Hospital.

80.3 Healthcare Governance and Risk Management Committee – Minutes of the Meeting held on 4 October 2011 – the Board adopted the Minutes.

80.4 Service Redesign Committee – Minutes of the Meetings held on 12 September and 17 October 2011 – the Board adopted the Minutes.

80.4.1 Mr Renwick noted in the Service Redesign Committee Minutes an action for Professor McMahon to feed back to the Ambulance Service. He noted that the NHS Lothian Transport and Access Committee had senior Ambulance Service representatives serving on the Committee and was keen to present a coherent and corporate single message to the Scottish Ambulance Service.
80.4.2 Professor McMahon commented the Scottish Ambulance Service, University Hospitals Division and representatives from Lothian Health met regularly and specialist transport proposals were being discussed. Mr Renwick commented it would be important the analysis and outcomes of these discussions were reported through the Transport and Access Committee.

80.5 Staff Governance Committee – Minutes of the Meetings held on 29 June and 31 August 2011 – the Board adopted the Minutes.

80.5.1 The Vice-Chair commented despite investment in road traffic improvements significant problems were still being experienced and staff were meeting with aggression from drivers being asked to move vehicles, which had resulted in a miscreant being charged by the Police.

80.5.2 The Vice-Chair commented over the previous three weeks there had been no rogue items sent to the Laundry and he encouraged the continuation of this positive progress.

80.5.3 The Vice-Chair commented in respect of sickness and absence, NHS Lothian was reporting the lowest figure by some distance and this was evidence of positive partnership working, which should be commended.

80.6 East Lothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 25 August 2011 – the Board adopted the Minutes.

80.7 Edinburgh Community Health Partnership Sub-Committee – Minutes of the Meeting held on 5 October 2011 – the Board adopted the Minutes.

80.7.1 Mr Anderson commented a positive presentation had been received on the Willow Project, which was delivering good results. He advised a finance workshop had also been established to look at savings plans for the next financial year.

80.8 Midlothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 29 September 2011 – the Board adopted the Minutes.

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

80.9.1 Mrs Douglas commented the presentation on the Royal Hospital for Sick Children/ Department of Clinical Neurosciences had been well received.

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

80.10.1 The Vice-Chair referred to the discussion on joint commissioning plans and expressed concern that these were occurring in the absence of any governance from NHS Lothian. Mrs Douglas advised there had been discussions about governance aspects for both organisations and the CHCP Director was looking at this in further detail.
80.10.2 The Vice-Chair commented he was not aware the CHCP was in a position to “commission” and he was concerned about creating a postcode lottery effect through such an exercise. Mrs Douglas advised these concerns had been part of the debate and the Director of the CHCP would address this as part of his further deliberations.

80.10.3 The Chief Executive reminded colleagues the current political administration had, as part of its manifesto flagged the need for better integration between health and social care, and he had discussed this with colleagues. He commented in respect of the points made by the Vice-Chair that language was important as commissioning was the language of the previous internal market with Scotland having set its face against the market for healthcare purposes.

80.10.4 Councillor Edie commented different approaches to the market were being used in social services. He reminded colleagues that European procurement legislation required any contract over £250,000 to be tendered.

81. Chairman’s Report

81.1 The Board noted the Chair’s report detailing internal and external events that had taken place since the previous Board meeting.

82. Annual Review Update

82.1 The Chair advised the NHS Lothian annual review session held on 27 October 2011 had been the first time the event had taken place without the Cabinet Secretary chairing the event. He advised the proposal was that the Cabinet Secretary would only attend annual reviews on alternative years. There was, however, still a requirement to subject the system to the same degree of rigorous scrutiny whilst encouraging as much direct dialogue and accountability as possible between local communities and the Health Board.

82.2 The Chair advised the draft annual review letter had been received from the Scottish Government in which it concluded by thanking NHS Lothian for conducting a constructive and informative annual review. The letter made it clear the Board was making significant progress in taking forward a challenging agenda on a number of fronts, including improving access, maintaining tight financial control and driving forward the quality agenda. In the draft letter, the Cabinet Secretary had also commented she was assured NHS Lothian was not complacent and recognised that there remained much to do.

82.3 The Board congratulated Executive colleagues on the high level of performance displayed at the annual review meeting.
83. Chief Executive’s Report

83.1 The Chief Executive thanked colleagues for attending the Celebrating Success event, which had been reported upon separately in the Connections newsletter, and thanked sponsors for their ongoing support. He commented it was of huge value to see staff recognised in external awards and provided details of a wide range of award winners amongst NHS Lothian staff at such prestigious events as the National eHealth awards; the Society of Radiographers; the National British Lung Foundation; the Institute of Health Management; the Civilian Health Partnership awards and the Daily Record Scottish Health awards. The Chief Executive commented the level of success in awards ceremonies was demonstrating a positive return on the investment made in staff through ongoing development and training.

83.2 The Chief Executive provided the Board with details of a visit to the Royal Infirmary of Edinburgh and Clinical Research Imaging Centre that he had undertaken with the Chief Operating Officer on September 30. He had met colleagues from the renal ward and those active in outpatient dialysis, as well as a number of patients. Of particular interest was NHS Lothian’s work in counselling elderly people who may be faced with the need to undergo dialysis.

83.3 The Chief Executive commented he had also toured the Clinical Research Imaging Centre with University colleagues, including the University Chair of Radiology. The Chief Executive advised the Centre was at the cutting edge of clinical research using state of the art equipment, which benefitted patients, both diagnostically and in respect of future applications of the services.

83.4 The Chief Executive advised he had been delighted to be invited to present the Healthy Working Lives awards to representatives of some thirty-four organisations on November 8. He commented these were very important awards, since they demonstrated how employers across the Lothian area were securing better health outcomes for staff through actively promoting health and well-being in the workplace. The Chief Executive advised he was delighted NHS Lothian had 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 the Western General Hospital.

84. Quality Report

84.1 Dr Farquharson advised the purpose of the quality report for this month was to present clinical effectiveness measures to assess the quality of stroke and surgical care in Lothian. Dr Farquharson commented the stroke effectiveness measures demonstrated Lothian had a lower mortality rate from stroke than the rest of Scotland and a similar level for premature mortality. He commented with the exception of thrombolysis of acute ischaemic stroke, Lothian did not meet the NHS Health Improvement Scotland (HIS) standard and this was similar to the position across Scotland as a whole. Dr Farquharson detailed the
measures being put in place to address this position, which had included a 5x5x5 project and a major Lean workstream as part of the older people’s pathway work.

84.2 Dr Farquharson advised the latest unpublished data indicated there was an improvement in Lothian’s performance across the HIS standard. He advised the standard in relation to stroke unit admissions on the day of admission, or the day following presentation at hospital had now become a HEAT target. He commented there was confidence within the stroke pathway management team that not only would this target be met but outcomes for patients would be improved and their recovery would be speedier. Dr Farquharson commented in respect of surgical effectiveness measures, the data demonstrated a high quality of surgical care in NHS Lothian. Nonetheless, in areas where Lothian’s hospitals appeared to be doing less well, plans to investigate this further had been developed and submitted as requested to HIS. Dr Farquharson advised these plans were also reviewed by the Healthcare Governance and Risk Management Committee.

84.3 Dr Farquharson advised for all surgical specialties, the mortality rates for elective patients was below the Scottish mean for all three Lothian hospitals. He commented the Royal Infirmary of Edinburgh was an outlier in respect of deep vein thrombosis and this needed investigated and might simply be an issue about the number of cases being diagnosed. He commented the rate of emergency re-admission following admission was being investigated.

84.4 Dr Farquharson commented for elective general surgery, the mortality rate in Lothian was better than across Scotland as a whole at both the Western General Hospital and the Royal Infirmary of Edinburgh.

84.5 Professor Iredale questioned what was causing the delays in patients receiving thrombolysis. Dr Farquharson commented the availability of good data would be key to identifying the reasons, as would examination of different case mixes.

84.6 Professor Prowse commented the integration of services and the urgency of treating patients quickly was important with the Ambulance Service and NHS 24 being key players in this area. Dr Farquharson concurred advising appropriate linkages were in place.

84.7 Mr Renwick commented he had concerns about the accessibility of the report and he did not fully understand it from an academic viewpoint. He felt there would be benefit in making it more user-friendly for lay readers. An example of this lay in table 1 where, in one area, the HIS standard was 80% with NHS Lothian achieving just 18.5% and he questioned what the risk to patients was in respect of this and how these issues were addressed. He commented in respect of a proper audit trail, this should be evidenced through the paper by additional narrative and not through the Board Minutes. Dr Farquharson agreed to follow-up this specific issue and brief Mr Renwick directly.

84.8 Dr Farquharson commented he had changed the format of the paper to make it more clinically relevant. He had provided data available at the time the Board papers had issued and had only provided a verbal update to demonstrate
progress made through the Lean and 5x5x5 processes, which had had a positive effect on patient care.

84.9 The Chair felt there was scope within the structure of the paper to provide more narrative that would be meaningful to lay readers. Dr Farquharson undertook to review for future meetings.

84.11 The Chair commented it was important the quality reports provided by Dr Farquharson covered areas of good performance and areas where performance was behind target. He commented, however, there was a need for more focus to be paid to the risk register aspects of the paper, particularly in respect of areas where performance was behind trajectory. Mrs Sansbury commented the risk register within the University Hospitals Division contained reference to stroke services and thrombolysis.

84.12 The Chair advised in response to a question from Mrs McDowell that the system had been working for 2-3 years to achieve HIS standards.

84.13 Mr Walker and Mrs McDowell welcomed the detailed reports. Dr Farquharson noted the desire to expand on the actions which were currently being taken and that further details of actions and timescales for achieving these would be insightful. The Chair reminded colleagues detailed progress was tracked at the Healthcare Governance and Risk Management Committee.

84.14 Mr Burley commented on the provenance of HIS and questioned whether there were lessons that could be learned from elsewhere. Mrs Sansbury advised Professor Dennis and other stroke colleagues utilised the Stroke Managed Clinical Network (MCN) in order to keep in touch with good practice. She advised a Lean workout was looking at the operational challenges of achieving targets and this work would be shared across Scotland.

84.15 Mr Whyte commented performance monitoring at the Healthcare Governance and Risk Management Committee included international comparators and he felt the key issue was to identify the desired performance level, which might exceed HIS levels. Dr Farquharson commented currently there was not much international data against which to benchmark.

84.16 Dr Williams commented it was important not to lose sight of the fact that there were success stories both within the primary care and secondary care sectors in Lothian where performance was ahead of the Scottish targets.

84.17 The Chair questioned the role of the Quality Alliance Board in respect of the report before the Board. Dr Farquharson advised the report would feed into some of the figures which he would be seeking to provide to the Quality Alliance Board. The Chair commented it was important to continue to challenge HIS targets and to consider whether there were other aspects to be measured.

84.18 The Board noted the Quality Impact report and the performance being made in stroke and surgical care.
85. **NHS Lothian: Report on the 2010/11 Audit**

85.1 Mrs Goldsmith advised the circulated paper provided the Board with the external auditors’ report on NHS Lothian for 2010/11 as completed by Audit Scotland. She commented the work of the external auditors was primarily concerned with arriving at an opinion on the annual financial statements. However, Audit Scotland’s responsibilities and remit also extended to providing a view on overall organisational performance, regularity and use of resources. Mrs Goldsmith provided the Board with details of the key messages from the report. She advised the report was also considered by the Audit Committee and was subject to detailed scrutiny.

85.2 Mrs Goldsmith commented the circulated report was a positive validation of a system which continued to face challenges in respect of its NRAC (National Resource Allocation Committee) allocation and the outcome of the report would feed into the national review process.

85.3 Mr Renwick commented although the language in the report was somewhat stilted, he did agree this was a positive report. He felt the two main issues of relevance raised within the report were in respect of equal pay liability and the potential future requirement to consolidate Endowment Funds into Exchequer funds. The Chair commented the latter point was a UK Treasury initiative and would be difficult to resist.

85.4 Mr Anderson questioned whether there was any progress in obtaining outstanding income from neighbouring Health Boards who were disputing their level of liability. Mrs Goldsmith advised in respect of Fife and Borders, a solution had been reached and they had accepted the East coast costing model. In respect of Ayrshire and Arran and Grampian, she had raised issues with the Scottish Government Health Department through the formal dispute process and had met with colleagues from the Health Department. The Chair commented it was right and proper for Mr Anderson to raise this as the current position was not helpful in terms of securing the income due to NHS Lothian.

85.5 Mrs Goldsmith reminded colleagues initially the East coast costing model had been agreed by the South East and Tayside Planning Group (SEAT) and had been validated by senior finance staff within Scotland. Both she and the Chief Executive would continue to pursue this matter.

85.6 The Board received the NHS Lothian: Report on the 2010/11 Audit.

86. **NHS Lothian Falls Prevention and Bone Health Strategy**

86.1 Mrs Hornett commented the primary aim of the Falls Prevention and Bone Health Strategy was to reduce the number and harm arising from falls across Lothian by 30% per annum from 2014 following implementation, and improve bone health in the population. She commented the Strategy set out the vision for NHS Lothian for 2011-2016 for service provision to those individuals who were at risk of falling or suffering bone fragility fractures, and/or have had a fall.
86.2 Mrs Hornett commented the Strategy was also about bone health and preventing people from falling in the first instance. She commented both the Board and Board Committees had discussed the impact of falls over recent months and advised this equated to 74,000 incidents across NHS Lothian in a year.

86.3 Mrs Hornett commented the Strategy had been developed through identifying good practice, both locally and internationally. She advised wide consultation including with the public had been undertaken.

86.4 Mrs Hornett advised a falls “bundle” of actions had been developed to reduce the risk of people falling in hospital and this had been rolled out across eighteen wards with slight reductions over the previous three months having been evident. She advised focussed work would continue, particularly in respect of prevention through multi-agency working. Mrs Hornett advised ongoing progress in respect of the aims of the Strategy would be reported through the Healthcare Governance and Risk Management Committee.

86.5 Dr McCallum in response to the Chair commented services provided in the community were integrated with the Falls Prevention Strategy and an example of the work undertaken was in respect of brief alcohol interventions.

86.6 Mrs Douglas welcomed the generic approach and commented, given the changes in demographics, this was an area which would require continuous awareness. Mrs Hornett commented she would be happy to share the details of local work with Mrs Douglas from a CHCP perspective.

86.7 Mr Anderson commented Scotland had recently suffered two severe winters and questioned whether there was any details around the impact on the number of falls in the community and whether there was anything local authorities could do to mitigate falls during adverse winter weather.

86.8 Mrs Sansbury commented there had been a large increase in the number of falls in the previous winters, which had led to the introduction of a “slippy day policy”, which meant orthopaedic clinics changed to reflect the different case mix.

86.9 Mrs Hornett commented, as discussed at the previous Board meeting, discussions were ongoing with local authority colleagues via the Falls Co-ordinator and these positive discussions would continue throughout the life of the Strategy.

86.10 The Chair commented the newly appointed Garrison Commander had advised he was keen for the military to assist communities during the winter period. Professor McMahon commented the change fund paper, which would be discussed later on the agenda provided good examples of where an emergency response team had been established and hospital admittance avoided by early interventions.
Mrs McDowell commented two Board meetings previously discussion had been held in respect of the high numbers of falls in hospitals with the point having been made this was a good quality indicator. She questioned whether the Healthcare Governance and Risk Management Committee would be monitoring the level of falls in hospitals through a simple dashboard indicator. Professor Murray and Mrs Hornett confirmed this would be the case.

Councillor McLennan welcomed the success of the emergency response team in East Lothian and commented local authorities had a key role in falls prevention within the community. He felt people could avoid being admitted to hospital by utilising a process of short-term intensive care and it would be important to monitor progress in this area moving forward. Mrs Hornett commented the detail of this approach was contained within the Strategy document.

Councillor Edie questioned if discussions had been held with the Edinburgh Community Safety Care Partnership. Mrs Hornett advised she would check this position and refer back to Councillor Edie outwith the meeting.

The Vice-Chair commented the detail of the Strategy was to be welcomed as the consequences of falls to people’s personal independence was catastrophic. He commented it would be important to remind citizens they had responsibilities to help ameliorate this position and this could be done through simple aspects like clearing snow and ice from pavements during periods of bad weather.

The Board approved the NHS Lothian Falls Prevention and Bone Health Strategy.

87. Refreshing the Human Resources and Organisational Development (HR/OD) Strategy

Mr Boyter commented it was with some pride and pleasure that he presented the HR/OD Strategy to the Board. He commented the previous Strategy had been approved three years previously.

Mr Boyter commented appendix 1 to the Strategy set out what had been achieved in terms of the actions that arose from the original Strategy. He advised this should contain no surprises for the Board, as there had been three interim and two full annual reports on progress provided in public session over the three years of the Strategy.

Mr Boyter commented in moving forward and developing the refreshed Strategy, he had consulted many people, including the Lothian Partnership Forum, the Service Redesign Committee and the Public Partnership Forum. A theme that emerged was continuity and, whilst there was recognition that economically the world was a different place now from when the HR/OD Strategy had first been agreed in 2008, the fundamental principles of living values, engaging leadership and delivering quality should be maintained.
87.4 Mr Boyter commented as the current Strategy came to an end there was a need to refresh the approach to the management of people. He advised it was a tremendous privilege to be involved in helping NHS Lothian staff to realise their talent, as people were the organisation's greatest asset. Mr Boyter commented he would continue with the existing philosophy and encourage staff to consistently deliver a quality standard of excellence and to turn the organisation's back on mediocrity.

87.5 Mr Boyter commented whilst he recognised tangible fixed assets were important to delivering healthcare, it was the skill and motivation of staff that drove service quality.

87.6 Mr Boyter commented in the refreshed Strategy, the organisation would set out, in partnership, on a course covering socially responsible recruitment, staffing engagement, leadership, managing change and workforce modernisation. He advised interventions would be designed to produce consistently high performance from staff as NHS Lothian strove to be at the level of Scotland's best and in the top 25 in the world's largest healthcare organisations. He advised the Strategy set out how NHS Lothian would invest in its people. Mr Boyter detailed the highlights contained in the Strategy.

87.7 Professor Prowse commented the Strategy was commendable and ambitious. In terms of demographics she commented the system’s own staff were sometimes not the fittest or healthiest and resilience in the workforce was important and it would be up to NHS Lothian as the employer and the workforce itself to deliver this outcome. She further commented this step change would send a powerful psychological message to members of the public. Mr Boyter commented the Occupational Health Service counselling service was available to staff as was the staff physiotherapy service and recently through the Health and Safety Committee, it had been agreed to implement a Safe and Well Policy at Work. He advised progress on this would be monitored through the Staff Governance Committee and the Health and Safety Committee.

87.8 Mr Renwick commented the Strategy was sensible and, in general, the themes were positive. He commented, however, the Audit Committee and the Staff Governance Committee had, in the past, raised concerns about the release of staff for mandatory training with this also having been raised by Audit Scotland. He also questioned the Strategy’s position in the respect of succession planning.

87.9 Mr Boyter commented in respect of mandatory training, a full debate had been held at the Staff Governance Committee the previous day. He advised Mr David Lee, prior to leaving the service, had looked at mandatory training and its frequency. A further report would be taken to the Staff Governance Committee in February in respect of mandatory training and attendance to identify areas where further focus was required. Mr Boyter commented ongoing performance would be thoroughly reported through the Staff Governance Committee with a six monthly report coming forward to the Board.
87.10 Mr Boyter commented in respect of succession planning that the workforce planning and development section of the Strategy would address this issue and the proposals were supported by both the Lothian Partnership Forum and the Executive Management Team.

87.11 Mr Burley reported he was supportive of the themes contained within the Strategy and commented socially responsible recruitment was very positive, particularly if focussed around youth employment. Mr Burley commented it would be useful for the Board, not only to look at recruitment but also aspects of using its influence in other areas, particularly in conjunction with the voluntary sector. Mr Burley commented the mediation approach was only referred to in respect of a narrow focus and he felt opportunities were being missed. He commented there would be benefits in training staff to use the powers of influence as he felt this would lead to a more effective organisation as he felt the mediation approach could be cross cutting across the whole Strategy.

87.12 Mr Boyter advised the Scottish Government was interested in what NHS Lothian were doing in respect of socially responsible recruitment and discussions were ongoing with civil servants. In terms of mediation, he apologised if the impression given in the Strategy was that this was limited to industrial relations as this was not the intention. He advised the intention was to progress this on a planned and co-ordinated basis across all work and to build on existing in-house expertise.

87.13 Mrs Allan commented the case for socially responsible recruitment was strong and was to be welcomed. She advised she would welcome details of longer-term job prospects available to people as a consequence of the recruitment process. Mr Boyter advised NHS Lothian supported eleven different projects, including an approach to modern apprenticeships with the City of Edinburgh Council, which had arisen following a suggestion by the Chief Executive of NHS Lothian. He advised the Healthcare Academy approach had a particular focus on socially excluded people and enabled them to obtain the skill sets to apply for work within NHS Lothian, including work placements with there being a high correlation between work placements and permanent employment. Mr Boyter advised the eleven programmes would be regularly reviewed in order to allow NHS Lothian to touch more people and he would bring back more detailed plans around this to the Staff Governance Committee and the Lothian Partnership Forum.

87.14 Mr Walker questioned how the Board would know whether or not the Strategy was successful. Mr Boyter commented key issues would be discussed through the Staff Governance Committee and the Lothian Partnership Forum. Thereafter, consideration would be given on how best to report progress back to the Board in terms of the more high-level strategy. He advised any financial implications associated with the Strategy would require to go through the normal financial process undertaken under the auspices of the Finance and Performance Review Committee.
87.15 The Chair commented the Staff Governance Committee could focus on the key issues and report progress to the Board through its Minutes.

87.16 The Vice-Chair commented, in his capacity as Employee Director, that he personally strongly supported the Strategy and reminded colleagues that in his view NHS Lothian was already the best Board in Scotland in terms of partnership working. He reminded colleagues through partnership working the workforce had been reduced significantly and year-on-year financial targets had been met. The Vice-Chair reminded the Board a national day of action was forthcoming and, in full partnership, agreement had been reached with Mr Boyter to ensure patient safety was maintained through this period of industrial action.

87.17 The Vice-Chair commented staff surveys were positive in that they demonstrated gradual improvement was being made, although many staff within NHS Lothian were looking for leadership around areas such as staff sickness and he was pleased to see the Strategy built on work already started in this area.

87.18 The Board approved the Human Resources and Organisational Development Strategy.

88. **Financial Position to 30 September 2011**

88.1 Mrs Goldsmith advised the paper issued with the agenda related to the financial position to 30 September 2011, although she would also provide a verbal update on the October position.

88.2 Mrs Goldsmith commented as at the end of September, the financial position had improved from August with no further non-recurrent support being required because of improved Local Reinvestment Plan (LRP) delivery in the University Hospitals Division and within corporate areas. The October position was reporting a £2.8m overspend, mainly in relation to prescribing with some slippage on LRP schemes.

88.3 Mrs Goldsmith advised the outcome of the mid-year review would accompany the month 7 results and she assured the Board there was sufficient non-recurrent support in the system to cover any overspends and to meet financial delivery targets, although it was important to remember the use of non-recurrent support came with an opportunity cost in providing head room moving into the next financial year.

88.4 Mrs Goldsmith commented that currently the three main areas of risk in terms of financial performance were around prescribing costs, LRP delivery and UNPACS.

88.5 Mrs Goldsmith commented in respect of the prescribing position there had been no change in the forecast out-turn, although a lot of work was underway with action plans being developed, although these would take time to deliver results. Mrs Goldsmith commented the Scottish Government Health Department
response to correspondence around the prescribing pricing issues had been to state Information Services Division ISD were undertaking modelling and this might result in budget changes, although it would be important not to anticipate any additional allocation. In that regard, the system still required to work hard to address the prescribing overspend. Mrs Goldsmith advised she was looking at a process of productive modelling.

88.6 Mrs Goldsmith advised progress on LRP was good, although there was still further work to be undertaken to make schemes recurrent. She commented the mid-year review outcomes were suggesting an increased need for non-recurrent support, which would need to be ameliorated. She advised in respect of UNPACS, plans were being developed, although it was unlikely there would be significant benefit in the current year, as capital investment was required to move the position forward. Mrs Goldsmith advised there were no significant issues around capital.

88.7 The Board noted the financial position of NHS Lothian to 30 September and 30 October respectively and Mrs Goldsmith’s confirmation that financial break even would be achieved for 2011/12.

89. Delivering Waiting Times

89.1 Professor McMahon commented NHS Lothian was posting strong performance around cancer targets. He advised the 18-week referral to treatment (RTT) target was still sustaining strong performance and the system was on trajectory to meet the end of December target.

89.2 Professor McMahon commented performance on drug and alcohol issues was positive with it being anticipated the target would be met by the strong partnership of the Area Drug and Alcohol Partnership, as well as a Kaizen event. The Board were advised by Professor McMahon that areas requiring further focus were around the outpatient 12-week standard and the inpatient 9-week standard. Ophthalmology and ENT work was also ongoing with a view to ensuring performance moved back on to target. The position in respect of diagnostics was back to a 6-week standard and this had Scottish Government Health Department agreement. He advised the position in respect of audiology was improving and it was hoped momentum would continue with the appointment of a new head of service.

89.3 Professor McMahon advised NHS Lothian had narrowly missed its 98% access target in respect of accident and emergency, although NHS Lothian still remained the fourth best performing Board in Scotland. He advised the Scottish Government Health Department had set its sights on access targets on a full system approach.

89.4 Professor McMahon advised Mrs Sansbury was looking at areas where more activity could be generated, both internally and via other Boards and sources. He advised from October patients would no longer be offered treatment in England and the Medical Director had undertaken a high-level review of waiting times management to ensure compliance moving forward with the New Ways
89.5 The Board noted the progress being made by NHS Lothian in delivering waiting times targets.

90. **Tackling Delayed Discharge**

90.1 Professor McMahon advised performance had marginally improved since the previous census date, although the system was still seeing pressure in Edinburgh as a consequence of the Elsie Inglis nursing home closure. He commented other partnership areas were demonstrating good progress with there being zero delays over six weeks. He advised the average length of stay had reduced significantly and the three longest delayed patients now had dates set for January for moving into the new Midlothian facility. Professor McMahon advised a future report would focus on the fifteen longest delays and their impact on the average length of stay.

90.2 Professor McMahon advised the Board the Scottish Government Health Department were looking for systems to achieve a 4-week standard in 2013 and a 2-week standard in 2015 on the back of the change fund. He and colleagues were looking at what partnerships would need to do to achieve these enhanced targets.

90.3 Professor McMahon commented that over the previous 2 weeks there had been press coverage about the care home sector. He advised the position in respect of Southern Cross was now resolved with new owners in place. He commented Argus had gone into administration and there were issues around Guardian, which had one 25-bedded home in Midlothian with Mr Small and his colleagues supporting the ongoing provision of services within that facility. Professor McMahon commented there was also speculation about Four Seasons and commented NHS Lothian had over 400 beds provided by them and work was in progress with Councils and national contingency planning in the event of a deterioration in the position. Professor McMahon commented the key focus was to ensure patient safety remained paramount.

90.4 The Chief Executive commented in respect of the A&E target that achieving this would be a function of a whole variety of issues and would involve partnership working with CHPs and local authorities. He reported as part of his routine site visits, he had visited a ward in the Royal Infirmary of Edinburgh where a consultant had shared her frustration about the lack of local social worker engagement in the discharge planning process, which he reminded colleagues should start at the point of admission. The Chief Executive reminded the Board the 66 in-month target had been set deliberately at a level which the system could sustain to allow it to work in equilibrium and it had been on that basis the number of beds in the Royal Infirmary of Edinburgh had been predicated.
90.5 The Chief Executive advised the 66 target was not routinely being met and this position needed to change. He had met with the Chief Executive of the City of Edinburgh Council and the Joint Director of Health and Social Care and stressed the need for better engagement of social work colleagues in multi-disciplinary team working, in order to improve the flow of patients through the system. The Chief Executive commented the pressures being experienced in the acute sector during the current week were not compatible with activity the Scottish Government required regarding A&E performance.

90.6 Councillor Aitchison thanked Professor McMahon for his comments around the opening of the Midlothian facility and commented a large house had been purchased with a view to delivering targets. Councillor Aitchison advised the Guardian home in Midlothian was not in financial jeopardy and the tenure of the residents was not under threat.

90.7 Mrs Allan commented in respect of the nursing home market that it would be important to avoid confusion amongst patients and to ensure they and their families were adequately involved in any decision-making processes. Professor McMahon agreed it was important proper engagement was undertaken on an individual basis and reminded colleagues the adoption of the Moving On policy supported that process. Professor McMahon undertook to cross-refer the current situation to the risk register.

90.8 Councillor Edie commented in respect of Professor McMahon’s opening remarks about issues still remaining with the City of Edinburgh Council partnership that the delayed discharge position in Midlothian had actually increased by 50%. He advised he had recently taken part in a sod cutting ceremony for the Drum Brae care home which would represent the third additional facility in Edinburgh.

90.9 Councillor Edie advised work had been undertaken to resolve issues around home care capacity with new contracts having been let. He stressed, however, there were long term issues around capacity as a consequence of demographic changes and this would need to be carefully addressed. He referred back to the previous debate about commissioning and commented if proper value for money was not achieved for all services, then insufficient resources would be available for future service delivery. Councillor Edie commented despite significant investments by the City of Edinburgh Council, the position remained difficult and he was concerned about the ability to deliver care if difficult decisions were not taken.

90.10 The Board noted the position in respect of achieving the delayed discharge target.

91. **Quality and Outcomes Framework (QOF) 2010/11**

91.1 Professor McMahon commented the circulated paper represented a good news story with NHS Lothian having moved from sixth to fourth position across NHS Scotland. He advised the main driver was anticipatory care and performance in
the current year was around 98% across all GPs which was just short of the best performance level.

91.2 The Chair commented for future reports it would be useful to have more information about QOF targets in Section 17(c) Practices. Professor McMahon would progress and advised the availability of local enhanced services allowed the system to undertake things differently. The Chief Executive commented Professor McMahon’s further work in this area should focus on solutions relevant to specific issues that could be impacted upon at local level.

91.3 Dr Williams commended the report to the Board and commented it reflected the high standard of care provided by General Practitioners who were doing more activity with less resource as a consequence of reduced QOF payments. However, it was important to recognise some aspects of the report would lead to increased costs as a consequence of prescribing in primary care.

91.4 Mr Anderson questioned whether there were any proposals to encourage a higher update of the flu vaccination, particularly to those groups who were known to be at risk. Professor McMahon commented this was not currently covered by the QOF process. Dr Williams advised the provision of flu vaccines to the elderly and those at risk in Lothian was above the Scottish average performance, although it was proving more difficult to encourage uptake amongst younger patients at risk.

91.5 The Chair commented the risk section of this report and other reports coming before the Board needed to be properly completed and commented, in general, all changes or actions in some way or another impacted on the risk status of the organisation.

91.6 The Board noted the achievement of the Lothian GP practices in the 2010/11 Quality and Outcomes Framework (QOF).

92. **NHS Lothian Corporate Objectives 2011/12**

92.1 Professor McMahon advised the content of the NHS Lothian corporate objectives 2011/12 had been produced and agreed in collaboration with Executive Director colleagues and had been formally signed off by the Board at its May 2011 meeting. He advised the HEAT targets agreed with the Scottish Government as part of the Local Delivery Plan were also included as part of the organisation’s overall corporate objectives.

92.2 The Board noted the positive actions being taken to ensure delivery of the corporate objectives by March 2012.

93. **Healthcare Associated Infection (HAI) Update**

93.1 Dr McCallum commented since the beginning of the year, NHS Lothian had been on trajectory to meet the 2013 targets in respect of staphylococcus aureus bacteraemia and clostridium difficile and the position was monitored on
a weekly basis. She advised there had been 26 episodes of staphylococcus aureus bacteraemia recorded in October 2011 (5 meticillin resistant staphylococcus aureus and 21 meticillin sensitive staphylococcus aureus), compared to 27 in September 2011 (3 meticillin staphylococcus aureus and 24 meticillin sensitive staphylococcus aureus). In respect of clostridium difficile infection there had been 24 episodes of clostridium difficile infection in patients aged 65 or over in October 2011, compared to 27 in September 2011. Dr McCallum advised although there was a slight variation on the previous month, NHS Lothian was on trajectory to achieve the Health Efficiency Access Treatment target.

93.2 Dr McCallum commented in respect of the meticillin resistant staphylococcus national screening progress, to date the screening programme had covered more than 2,500 patients. She advised NHS Lothian was 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 perineal screens. Dr McCallum advised compliance with perineal screening had been lower due to the number of patients refusing this screen, primarily medicine for the elderly patients. However, all of this group had been appropriately screened using the alternative nose and throat swabs. She advised roll out of the new policy was on track for completion by December.

93.3 Dr McCallum advised hand hygiene continued to improve with all staff groups achieving the hand hygiene compliance rate of 94% to 97% as evidenced through the most recent audit period. Ongoing work continued to focus on improving and sustaining hand hygiene compliance amongst medical staff and areas of non-compliance.

93.4 Dr McCallum commented it was testament to all staff across the system that antibiotic expenditure had reduced by 23% for 2010/11, which in itself had been a reduction from the 2009/10 position.

93.5 The Chair commended to other Board Directors the thoroughness of the completion of the risk section in the HAI report.

93.6 The Vice-Chair commented in respect of areas of non-compliance, the report was silent around sinks and wash hand basins, particularly in the risk register section despite this having been an issue discussed at the Healthcare Governance and Risk Management Committee. He also noted the position in respect of only 50% compliance with perineal screening.

93.7 Dr McCallum advised international evidence supported the fact that perineal screening was something which should be provided to elderly people. However, where elderly patients refused this opportunity the next best approach was to provide other screening. She advised issues around this position had been fed back to colleagues at the Scottish Government Health Department.

93.8 Dr McCallum, at the suggestion of the Chair, undertook to update the Healthcare Governance and Risk Management Committee at a meeting in the New Year on the position in respect of sinks and hand basins.
The Board noted the progress being made to reduce healthcare associated infection in Lothian hospitals and other facilities.

**Change Fund: Financial Arrangements**

Professor McMahon commented £9.7m had been allocated to Lothian for the change fund process, which was intended to support older people to stay in communities and to avoid and speed up the admission process. Professor McMahon advised the Scottish Government Health Department had been provided with a progress report and had noted partnerships were experiencing slippage, particularly around recruitment. He commented within Lothian, work was underway to ensure a clear metrics was available to demonstrate how money had been spent and what the actions were in terms of betterment to the population. Professor McMahon advised significant resource was being played into community capacity planning with involvement from local communities. He commented moving forward there would be a need for robust scrutiny around spend and slippages with community partnerships.

The Chair commented it would be important to ensure project deliverables were properly measured and, where appropriate, outcomes mainstreamed. He advised appropriate linkages should be made with local authorities and voluntary organisations. Professor McMahon advised the process for the following year would take account of these issues in the same way as in the current year’s exercise. He advised the process for the next financial year would commence with the submission of proposals to the Scottish Government Health Department on 17 February 2012, which would include strong GP engagement. Professor McMahon commented in respect of mainstreaming, it would important to remember funding was provided for a maximum of 4 years.

Mr Whyte commented discussions had been held within the East Lothian CHP about the need to performance manage the change fund process and how to ensure progress remained on trajectory. He commented part of this process would be to look at trends and performance targets and map these against expectations. Professor McMahon commented in respect of the performance metrics, this would be refined to make it more meaningful as the process developed. He advised it would be important to agree core measures moving forward and he was keen in the current year to look at what was available as invest to save schemes, which would free up capacity in areas such as orthopaedics.

Mr Whyte commented, in his experience, significant progress was being made in East Lothian through voluntary and community groups to sustain people to lead healthy lives in the community and commented on the success of the partnership development of a day facility centre in East Lothian. Councillor McLennan advised he had met with colleagues from the care home who had expressed a real desire to work with the NHS and local authorities. He agreed with Mr Whyte’s comments around the success of the day centre facility and he was keen to move to do more in this particular area.
The Vice-Chair commented the change fund monies were top-sliced from health and, whilst good progress was being demonstrated, he noted not all staff had yet been recruited. He questioned where the governance lay in terms of slippage arrangements and subsequent financial flexibility. Professor McMahon commented finance, CHP and local authority colleagues had discussed slippage and the proposals would require, as per the mandate for receiving funds from the Scottish Government Health Department, to be discussed and approved by community planning partnerships and CHPs. Professor McMahon stressed, however, in overall terms the Board had ultimate governance responsibility for change fund monies and slippage arrangements. Mrs Goldsmith confirmed she would be responsible for signing off on any slippage proposals under the extant scheme of delegation.

Councillor Edie suggested for a future iteration of the paper, it would be useful to tease out a strand related to carers and to have their needs quantified. Professor McMahon would progress.

The Board noted the update position on change fund projected spend in each of the four Lothian partnerships, along with the committed spend by the year-end and the arrangements for payment and management of any slippage.

### Single Outcome Agreements 2010/11

Professor McMahon commented the paper described significant achievements in terms of progress in delivering strategic priorities. It also demonstrated the robust governance process in place.

Professor McMahon commented in the current year, it was proposed to use the independent resource framework model as the basis for agreeing indicators to prioritise with partners. He advised there were clear links with the Clinical Strategy and he would meet with community planning partnerships as part of the overall process. He commented the Scottish Government Health Department had not yet issued definitive guidance in respect of the Single Outcome Agreement process moving forward.

The Chair commented for future versions of the paper, it would be useful to identify annual aspirations and to link these closely with the risk section of the paper. Professor McMahon advised he would reflect this request in future papers.

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

The Board approved the response to the Scottish Government consultation on the revised specific duties of the Equality Act 2010, and noted the comments made by the Mutuality and Equality Governance Committee had been incorporated in the proposed response.
97. Healthcare Environment Inspectorate: Care of Older People in Acute Settings

97.1 Mrs Hornett reminded the Board they would be familiar with the Healthcare Environment Inspections and she reminded them of the announcement from the Cabinet Secretary in the summer to combine the Environment Inspections with inspections of the care of older people in the acute care and implementation of the dementia standard.

97.2 Mrs Hornett commented Board members would also recall that in June 2011 she had set out NHS Lothian’s work in terms of delivering better care to improve the provision of essential care to all patients. She advised this built on a number of previous reports and projects and was in line with the Quality Strategy to provide safe, effective person-centred care for all, as well as the aspiration to be at Scotland’s best and a top 25 world health performer.

97.3 Mrs Hornett advised since the summer work had also been in progress nationally to establish the format and infrastructure to deliver the inspections. Two pilot inspections had taken place in NHS Borders and NHS Greater Glasgow and Clyde. Mrs Hornett advised the programme would commence with announced inspections in three Boards starting with Greater Glasgow and Clyde in the current week, NHS Lothian on 8/9 December and Tayside on 12/13 December. NHS Lothian had been informed the initial inspection would focus on Liberton Hospital and, as required, self-assessment and supplementary evidence had been submitted to the inspection team.

97.4 Mrs Hornett advised the inspection would involve observation of care delivery, discussions with patient carers and staff and a review of documentation and inspection of the environment. She commented issues had yet to be fully resolved around access to patient documentation and the legal right of inspectors with an opinion being awaited from the Central Legal Office. She commented there were also issues in respect of how intrusive the inspection might be in terms of patient care, particularly given the fact the inspection approach was untried.

97.5 The Chair commented discussion had been held around the inspection process at the national Chairs’ meeting where it had been advised inspectors would only be observing and not going through records. He commented, therefore, he would be interested to learn the view from the Central Legal Office. It was also his understanding there was no role in the inspection process for people to pass comment on clinical decisions. Mrs Hornett advised from feedback from the pilot project, she was not sure this was entirely the case and issues would have to be dealt with on an ad hoc basis as the inspection progressed.

Councillor Edie left the meeting.

97.6 The Vice-Chair commented he had concerns about the provision of access to patient records and commented it was important this was resolved as soon as possible. Health systems should not be dependent upon adopting a mystery shopper approach and people needed to be comfortable about raising issues at
the time of the inspection process. He commented following the previous Healthcare Environment visits, the adversarial nature of the process and negative feedback needed to be managed.

97.7 The Chief Executive commented this issue and the preparation arrangements for the inspections had been discussed extensively at the Executive Management Team where the view had been taken that the inspection process should be seen by NHS Lothian as a positive validation of the good services already provided within national frameworks. He advised it was important the Board was aware of the ramifications of the inspection process to include the fact the review of clinical observation would focus on individual's responsibility and any individual failure would have to be addressed as such. The Chief Executive commented there would be a requirement for any inspector involved in making comment about professional standards to make themselves available, if required, to present evidence as part of the Board’s Employee Relations Policy. The Chief Executive commented this was a fundamentally different position from inspection regimes in the past.

97.8 Mr Walker commented the inspection process should be embraced and questioned whether any thought had been given to undertaking a self-assessment process more widely across Lothian, particularly if it was felt to be a useful tool. Mrs Hornett advised the assessment had been completed on a pan-Lothian basis and had taken two weeks to produce and reflected all of the areas where older people services were provided. She commented it was useful to take the tool out into the system and use it locally at ward level, as this would be helpful in identifying issues for further focus. Mrs Hornett commented the current focus on the inspection process had been successful in ensuring everyone was extremely focused on the needs of older people. In that regard, it was a positive process at clinical level.

97.9 Mrs Allan commented the inspection process should be positive, particularly as it was focussed on a vulnerable group but she was also concerned given the vulnerability of the patients that they might not be aware of the process happening around them. She questioned what thought had been given by the Scottish Government Health Department to this and also what would happen if issues around individual patient care were uncovered. She also questioned the degree of experience the inspectors would have, given this was a new process.

97.10 Mrs Hornett commented the inspectors had been recruited over the summer period and trained. Clinical nurses had also been recruited. Mrs Hornett commented not all of the inspectors would have a clinical background.

97.11 Professor Iredale commented there was potential through the inspection process for negative publicity even if the system was performing well and it would be important positive engagement was encouraged. He had concerns about the experience of people undertaking the inspection process. Mrs Hornett commented this issue had been discussed with the inspectorate who advised that members of Health Board staff were not supposed to accompany inspectors onto the ward, although it had been made clear to the inspection team that NHS Lothian senior staff would be present during the inspection process.
97.12 Mr Renwick commented there were two issues of legal compliance that had to be addressed. The first was around whether the outcomes of the inspection process would be Freedom of Information accessible and also issues around data protection, especially vis the role of the Caldicott Guardian, which would require to be addressed. Dr McCallum commented in terms of the technical aspects of confidentiality, assurance had been given that areas of the NHS Scotland Act would allow the process to take place but she had concerns about how this would compare and contrast with the well established Mental Health Commission process. Dr McCallum commented she was also unsure about the arrangements in respect of how data was collected and used.

97.13 Dr McCallum commented her second area of concern was around potential non-compliance with internationally agreed standards of ethics in respect of non-participative engagement. She advised the number of people able to undertake this process properly was extremely limited and required many years of proper training and experience. She was concerned inexperienced staff were being used for this type of exercise.

97.14 Mrs Hornett advised in respect of the Freedom of Information aspects, assurance had been given that individuals would not be able to be identified from non-participant observation. It would be important to see and learn from the outcomes of the three scheduled inspections.

97.15 The Board noted the expansion of the Healthcare Environment Inspectorate inspections to include care of older people in acute settings and the national dementia standards and the preparation underway within NHS Lothian.

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

98.1 Dr McCallum advised she was inviting 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.

98.2 Dr McCallum commented there was a clear and long standing relationship between affordability of alcohol and levels of consumption with both Scotland and Lothian having significant problems associated with alcohol consumption. Dr McCallum commented a minimum price per unit of alcohol was a proportionate and pragmatic way of reducing the consumption of people drinking at harmful levels.

98.3 Councillor Aitchison commented whilst he supported the proposed submission, it was important in respect of harmful drinkers to do more than just increase the price of alcohol as, in many instances, this would only increase the poverty problem. He felt there needed to be reference to ways in which NHS Lothian supported people with harmful drinking problems. Dr McCallum advised for serious drinkers a small increase in the unit cost would have a significant impact. She reminded the Board that NHS Lothian provided a number of interventions to problem drinkers.
98.4 Professor Iredale stressed the importance of not under-estimating the problems associated with harmful drinking. He would provide Dr McCallum with suggested minor amendments to the response outwith the meeting. Professor Iredale advised education needed to go hand-in-hand with minimum pricing. He felt there was also a need to re-visit licensing arrangements as these made alcohol more available in some instances.

98.5 Mr Whyte commented the most easterly aspects of NHS Lothian’s boundary was only around 20 miles from the nearest English-based supermarket and, therefore, the proposals around minimum pricing would not not have a universal affect across the population of NHS Lothian. He also had concerns about some of the evidence base and, in his opinion, the establishment of a minimum price level was an issue for professionals and not politicians. Mr Whyte advised issues also had to be considered in respect of Treasury receipts and flow back into the public sector as a consequence of increased tax revenue.

98.6 Dr McCallum advised there was no evidence to suggest the availability of cross-border trade had a negative impact when minimum pricing was introduced. She commented in respect of setting the minimum price per unit of alcohol, work had been done in conjunction with the Scottish Government to support the level of 50p per unit of alcohol.

98.7 Dr McCallum reported in other countries when the price of alcohol fell, the number of deaths increased with the converse being true when the cost of alcohol was increased. She advised discussions had been held with the Scottish Government about how funds from revised alcohol pricing might be captured, although the outcome in terms of flow back into the public sector was not yet known.

98.8 The Chair commented the introduction of minimum alcohol pricing would ultimately be a political decision, which would no doubt take into account how the price level was established, as well as considering unintended consequences.

98.9 The Board supported the submission to the call for evidence on the Alcohol (Minimum Pricing) (Scotland) Bill subject to the comments made at the Board meeting being incorporated into the final version.

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

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

99.2 Professor McMahon commented a further meeting of SEAT would held later in the week and provided the Board with an update in respect of progress being made around the Eating Disorders Unit, Managed Clinical Network for Child Sexual Abuse and radiotherapy.
Professor McMahon advised, as previously discussed, plans were in place in order to maximise the use of the workforce across NHS boundaries in the event of severe winter weather.

Mr Boyter in response to a question from Mr Renwick advised paediatric medical cover remained a key focus on the SEAT agenda.

Mrs Douglas commented the ongoing work in respect of learning disabilities was extremely important and would be of wide benefit. Professor McMahon advised Managed Clinical Network colleagues would provide feedback and an update to the SEAT meeting later in the week.

Committee Memberships

The Board confirmed the appointment of Mr I Whyte as the Community Health Partnerships/Community Health and Care Partnership member of the Staff Government Committee. It also approved the appointment of Mr R Y Anderson as an additional Non-Executive member on the Healthcare Governance and Risk Management Committee and that the terms of reference be amended accordingly.

Presentation – Community Mental Health – Dr Peter Lefevre, Associate Divisional Medical Director, Community Mental Health

The Chair advised Dr Tim Wheeldon, who had been initially scheduled to provide the clinical presentation was unavailable and the presentation would now be provided by Dr Peter Lefevre.

Dr Lefevre provide the Board with an informative presentation covering many aspects of community mental health, including details of potential patient pathways.

Councillor McLennan commented the engagement of local authorities working to develop services in future would be an important way forward and there would be a need to focus on good quality outcome indicators.

Mr Renwick commented the correlation between the cost of peaks and troughs was important and he sought advice on how the service ensured people were reviewed at the appropriate level within the care spectrum. Dr Lefevre commented in general terms people escalated up through treatment levels prior to receiving the most intense treatment, although it was possible to fast track patients if this was necessary. He advised review in the community was different, with the focus being on encouraging General Practitioners to review patients after a few weeks as in some instances symptoms disappeared within that timeframe.

Mr Burley commented at the lower levels of intervention, social factors as well as physical interventions would be important. He stressed the importance of
the built environment advising he had chaired a group looking at the healthy built environment, which had worked in conjunction with the Planning Department at the City of Edinburgh Council. He commented if this work could be replicated, it would be possible to develop mentally flourishing areas within the built environment.

101.6 Dr Williams reminded the Board the presentation had outlined the improvements in mental health care in Lothian and the shift from acute care provision into the primary care and community setting. He advised this provided General Practitioners with more scope when treating patients. He felt, however, the two areas requiring further prioritisation were around accessibility to the primary care team and compulsory admission, which was a distressing process for all parties concerned.

101.7 Dr Lefevre agreed compulsory admission was a distressing process and the tripartite emergency plan was reviewed regularly. He advised work was underway with the Scottish Ambulance Service to make the process as smooth as possible. He commented consideration was also being given on how to provide more services to General Practitioners, as the waiting times for psychological therapies was variable. Dr Lefevre stressed, however, the number of emergency detentions had reduced.

101.8 The Chair thanked Dr Lefevre for his informative presentation.

102. Communications Received

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

103. Resolution to Take Items in Closed Session

103.1 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 issues of patient and commercial confidentiality not appropriate at a meeting in public.

104. Date and Time of Next meeting

104.1 The next meeting of Lothian NHS Board would be held on Wednesday, 25 January 2012 at 9.00am in Space 3, Howden Park Centre, Howden, Livingston, West Lothian, EH54 6AE.
### Action Checklist from Meeting held on Thursday 17 November 2011

<table>
<thead>
<tr>
<th>Item</th>
<th>Action to be taken</th>
<th>By whom</th>
<th>Completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Performance Standards and Minimising Variation - Dr McCallum would bring updates to the Forum as appropriate.</td>
<td>AKM</td>
<td>ongoing</td>
</tr>
<tr>
<td>3</td>
<td>Pharmaceutical Care Services Plan - Mr Bell offered to look over the document from a lay person’s point of view to help out with any wording that may be overly technical.</td>
<td>CG</td>
<td>22/11/11</td>
</tr>
<tr>
<td>7.1</td>
<td>ACF Chairs’ Group Output from September Session – noted. The Chair reported that there was to be an Infrastructure Delivery Group and she would circulate the papers for it and feedback on the meeting at the next Forum.</td>
<td>PM</td>
<td>21/11/11</td>
</tr>
<tr>
<td>7.2</td>
<td>MHRA Consultation on the Project to Consolidate UK Medicines Legislation - Members were asked to forward any comments on the consultation to the Chair ahead of the 17 January deadline for feedback.</td>
<td>ALL</td>
<td>17/01/12</td>
</tr>
<tr>
<td>9.1.1</td>
<td>LADC – Ms Roebuck agreed to check with the DDE to see if DDE minutes could be circulated with LADC minutes.</td>
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<td>9.1.2</td>
<td>LAHSC: Life Sciences Review - Mr Gow reported on the Life Sciences Review. It was noted that the LAHSC had not been engaged with the Review and Mr Gow had written to the Medical Director to raise concerns over the accuracy of workforce data being used for the Review. Dr McCallum agreed to raise the concerns with the Medical Director as they were meeting in the afternoon and would also discuss the workforce issue with the HR&amp;OD Director. Dr McCallum would report back to Mr Gow.</td>
<td>AKM</td>
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The Chair welcomed members to the meeting. The Chair thanked the Area Clinical Forum members and co-ordinator for all their support, effort and contributions towards the recent Annual Accountability Review.

1. Prison Transfer of Healthcare Update

1.1 The Chair welcomed Mr Short to the meeting.

1.2 The Forum noted the prison healthcare paper which outlined changes following the transfer of prison healthcare to the NHS from 1st November 2011. Prison Healthcare for NHS Lothian would be hosted by East Lothian CHP.

1.3 Mr Short outlined the responsibilities that NHS Lothian now had in relation to HMP Edinburgh and HMP Addiewell. The Forum noted that Addiewell’s population is currently 80%-90% from Lanarkshire Courts but it was hoped that Addiewell would soon be taking prisoners from West Lothian Courts. Mr Short added that all clinical and non-clinical healthcare staff had been transferred over to NHS Lothian. A new
IM&T infrastructure had also been required to allow the implementation of the ‘Vision’ system from April 2012. The Forum noted that there would be one GP practice for HMP Edinburgh and one for HMP Addiewell using the ‘Vision’ system.

1.4 There was discussion on continuity of care, medication management, equity of care and the health role in liberation planning. Dr McCallum added that there was work ongoing with prison leavers and short term offenders to engage them during the periods shortly before and after prison to help them when they are going back to previous environments. It was noted that drugs and alcohol were a big part of the revolving door issue and Dr Fiona Watson was leading on this work. Dr McCallum also stated that staff from the Access Practice were providing General Practice. The issue of GP deregistration when someone goes into prison was mentioned. Mr Short stated that from April there will be auto registration with the prison practice if someone’s sentence is 6 months or more this would allow access to medical records in the community setting. There were concerns that prisoners will not have a GP when liberated and PSD/ISD is currently working on same day transfers.

1.5 Mr Short informed the Forum of the challenges involved with the transfer of 114 women from HMP Cornton Vale to HMP Edinburgh in July. Women’s Clinics have had to be put in and issues of staff that have never worked with women before have had to be addressed. There was also work needed on prisoner flow in relation to the only dental suite at HMP Edinburgh. Suicide prevention training was also mentioned Mr Short stated that there should be no women in HMP Edinburgh that are a suicide risk as HMP Edinburgh does not currently have anti-ligature cells.

1.6 There was also discussion on governance arrangements, funding levels and resources difference between the two prisons. Mr Short confirmed that the transfer of funding for prison healthcare took into account the additional costs associated with staff transferring onto Agenda for Change from 1 April 2012. There was however areas where NHS Lothian could save in the amount paid for private GP hours.

1.7 Mr Short also explained the process in relation to out of hours care. The Forum noted that there was a temporary arrangement in place until 31 March 2012 then it was hoped that the service would be aligned to the custody suite nursing unit. The Forum also noted that the Forensic Medical Examiner service was currently out to tender.

1.8 It was noted that following the transfer, the NHS Lothian complaints department was experiencing very few complaints coming through. Mr Short stated the previous Scottish Prison Service complaints system had made it too easy to complain. Frontline staff are now being empowered to deal with minor complaints themselves where appropriate and a feedback form had been introduced with timelines – two days verbal; one week written. There is still the mechanism for formal complaints which will be responded to in 20 days. The feedback forms were being collated to look at lessons that can be learnt. Ms Waugh reported that she had been at a recent SPSO conference where Ayrshire and Arran’s good practice for its straightforward complaints policy had been commended as had the State Hospital system which encourages ‘active listening’. It may be worth looking into sharing ideas with these other organisations.
1.9 Prisoner advocacy was discussed. The Forum noted that prisoners do have the right to advocacy and Mr Short stated that work with the Citizen’s Advice Bureau on the logistics of providing advocacy was ongoing.

1.10 The Chair stated to Mr Short that the Area Clinical Forum and NHS Lothian’s Professional Advisory Structure were available for engagement, help and support as appropriate.

1.11 The Chair thanked Mr Short and he left the meeting.

2. Performance Standards and Minimising Variation

2.1 The Committee noted the tabled paper updating on progress made in relation to Performance Standards and Minimising Variation.

2.2 Dr McCallum reported that this work was one of the eight South East and Tayside (SEAT) Planning Group’s ‘improvements in efficiency and effectiveness’ workstreams which had been progressed following workshops undertaken in May 2011. The paper highlighted the potential for cost savings associated with marginal reductions in activity and service redesign.

2.3 The Forum and Dr McCallum discussed the numerous issues detailed in the report including:

- better ways of sharing good practice and translation of good practice from abroad to NHS Lothian
- minimizing DNA rates
- delivering waiting time targets with less funding
- reducing length of stay
- learning from primary care achievements and acute division initiatives
- managing in a way that does not effect quality
- long term medication
- innovation and implementing solid bases of evidence
- pain assessment
- median stay reduction
- optimising procurement
- investing in technology

2.4 The Chair thanked Dr McCallum for the paper which covered interesting new ground. The Chair stated the importance of having the correct process for engagement and the need for systematic review and feedback. Health Economist engagement was also vital. Ms Roebuck added that it was important for the public to understand how this system worked so that it was not viewed as cutting services.

2.5 Dr McCallum thanked the Forum for its input and stated that herself and the medical director would be taking to Clinical Management Teams on this topic and would be happy to talk to Professional Advisory Committees and the Division of Psychiatry as requested. Dr McCallum would bring updates to the Forum as appropriate.
3. Lothian Pharmaceutical Care Services Plan

3.1 The Chair welcomed Ms Aileen Muir to the meeting.

3.2 The Forum noted the report giving an update on the current work to develop a pharmaceutical care services plan for NHS Lothian.

3.3 Ms Muir reported that the Smoking, Health and Social Care (Scotland) Act 2005 contained provisions which, once commenced, would provide for the regulations and directions to cover the new community pharmacy contract. Under those provisions NHS Boards would have a duty to provide or secure the pharmaceutical care services that are required in their respective areas.

3.4 Under these provisions, a formal Pharmaceutical Care Services Plan would be produced by all NHS Boards as a statutory duty. The legislation is not yet in place to enable this. However, PCA(P)(2007)25 commissioned individual NHS Boards to produce a draft Pharmaceutical Care Service Plan (PCSP) by November 2007. This initiative was undertaken on a pilot basis, the results of which were to inform the future introduction of formal PCS planning arrangements. The result was that the Scottish Government Health Department (SGHD) was to consider all the draft pilot plans produced and return with guidance on these plans. In March 2011 PCA(P)7(2011) The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 introduced an annual requirement for Boards to produce an annual Pharmaceutical Care Services Plan from 1st April 2010. As this was not sufficient time to produce an in depth pharmaceutical care services plan that included an analysis of need, agreement was made between Directors of Pharmacy and SGHD that for 2011/12 Boards would be expected to publish extended Pharmaceutical Lists detailing the full range of services available from community pharmacies within the Board area. It was agreed with SGHD that Boards would develop fuller PCSPs for April 2012 and a short life working group would produce additional guidance for this.

3.6 The Chair stated that the mapping at the moment showed that core services were covered and the enhanced services appeared to be in the right place. The Chair also mentioned the 17 October 2011 Scottish Government News Release “Role of the pharmacist to be reviewed”. There was a need to look for and identify gaps; evidence and plan for provision of pharmaceutical care; make best use of resources and effective use of technology such as robotic dispensing and also low level technology such as compliance devices.

3.7 The Forum noted that a Board level document was currently in development and would be circulated widely for comment, including patient involvement. Ms Muir stated that there was a danger that the document may end up being too technical. Mr Bell offered to look over the document from a lay person’s point of view to help out with any wording that may be overly technical. Ms Muir thanked Mr Bell for his generous offer and asked the Co-ordinator to forward contact details to her.

3.8 The Chair thanked Ms Muir and she left the meeting.

4. Minutes of Previous Meeting ~ 18 August 2011 - The circulated minutes of the meeting were approved as an accurate account of that meeting.
5. **Matters Arising [Action Checklist]**

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

5.1 **Patient Rights (Scotland) Act 2011: Consultation on Secondary Legislation** – The Response which Ms Alison Meiklejohn had compiled on behalf of the Forum was noted.

6. **Chair's Business**

6.1 **Annual Accountability Review Feedback** – The Chair reported that the Review had been held on 27 October and had been in the new ‘non-ministerial’ format. The Forum noted that this format would be used biannually. The new format had seen the Board Chair assuming the Minister’s usual role. The Chair stated that the Review had been successful and Dr McCallum added that draft feedback from the Scottish Government suggested this also. It was hoped that the final feedback would provide the ACF with more detail on its performance.

6.2 **Connections Article** - The Chair thanked members for their contributions to the Connections article. The Chair reported that the first draft of the article had not been appropriate and it was currently being re-written ahead of the December Issue of Connections. It was hoped that the article would have an overview of the ACF with a focus on the ACF’s representative patient following his first year in the role. There would also hopefully be short pieces on individual Advisory Committees in subsequent issues of Connections.

7. **Items to Report**

7.1 **ACF Chairs’ Group Output from September Session** – The summary paper was noted. The Chair reported that there was to be an Infrastructure Delivery Group meeting later today and that she would circulate the papers for it and feedback on the meeting at the next Forum.

PM

7.2 **MHRA Consultation on the Project to Consolidate UK Medicines Legislation** - Members were asked to forward any comments on the consultation to the Chair ahead of the 17 January deadline for feedback.

ALL

8. **Board Issues**

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

8.1.1 The Forum noted the minutes of the Board meeting held on 27 July 2011 and the agenda and electronically circulated papers from the 28 September meeting.

8.2 **NHS Lothian Service Redesign Committee**

8.2.1 The Forum noted the minutes of the meeting held on 12 September 2011.
9. **Lothian Professional Advisory Committees Minutes**

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

- Medical Committee 12/10/11; 10/08/11
- Pharmaceutical Committee 06/10/11
- Healthcare Scientists Committee 31/08/11
- Nursing & Midwifery Committee 19/10/11
- Allied Health Professions 30/08/11
- Optical Committee 04/10/11
- Dental Committee 22/09/11

9.1.1 **LADC** – Ms Roebuck stated that in order for the Forum to have a better overall view of dentistry it may be helpful to include the Dental Division Executive (DDE) minutes with LADC minutes. Ms Roebuck agreed to check with the DDE to see if this would be acceptable.

9.1.2 **LAHSC: Life Sciences Review** - Mr Gow reported on the Life Sciences Review. It was noted that the LAHSC had not been engaged with the Review and Mr Gow had written to the Medical Director to raise concerns over the accuracy of workforce data being used for the Review. Dr McCallum agreed to raise the concerns with the Medical Director as they were meeting in the afternoon and would also discuss the workforce issue with the HR&OD Director. Dr McCallum would report back to Mr Gow.

10. **Items for Information**

10.1 No items were raised.

11. **Any Other Competent Business**

11.1 **Treatment of Libyan Civilian Casualties in NHS Lothian** – Mr Gow reported that over the next three weeks around ten casualties would be arriving for prosthetic management in Lothian. The Medical Director was aware of this and Forum members should be aware of any possible impact on other NHS services.

11.2 **Veterans’ Centre of Excellence in Lothian** – Mr Gow informed the Forum of the possibility that a centre of excellence may be site in Lothian, with eight being planned for the UK. The Medical Director and the Board Chairman were involved in the work and Mr Gow would report back on progress as appropriate.

12. **Date of next meeting:** Thursday 2 February 2012, 8.30 – 11.30am, Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG *(Deadline for receipt of papers is 19 January 2012)*
13. 2012 Meeting Dates

- 17 May 2012
- 16 August 2012
- 22 November 2012
## FINANCE & PERFORMANCE REVIEW 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>
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<tbody>
<tr>
<td><strong>Management of Drug Spend</strong> (9 June &amp; 28 October 2010, 13 April, 12 October and 14 December 2011)</td>
<td></td>
<td>30/01/12</td>
<td>Bring outline to Committee in February as part of the Local Reinvestment Plan</td>
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<td><strong>Royal Hospital for Sick Children</strong> (12 October 2011)</td>
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<tr>
<td>• Include a detailed summary of the risks at the different stages in the paper to the Board</td>
<td>SG</td>
<td>30/01/12</td>
<td>A paper on resource requirements for the Project is to be considered by the Project Board OBC on Private Board Agenda for 25 January 2012</td>
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<tr>
<td>• Undertake work to mitigate the identified risks</td>
<td>SG</td>
<td>30/01/12</td>
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<tr>
<td>• Submit Outline Business Case to the Lothian NHS Board for consideration on 25 January 2012 and to the Scottish Government for consideration before the Capital Investment Group on 31 January 2012</td>
<td>JKS/SG</td>
<td>30/01/12</td>
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<td><strong>Financial Position</strong> (9 February &amp; 13 April 2011)</td>
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<tr>
<td>• Include corporate income figures in the next financial update</td>
<td>SG</td>
<td>05/12/11</td>
<td>O/S</td>
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<tr>
<td><strong>Digitisation of Health Records Business Case</strong> (12 October 2011)</td>
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<td>• Circulate the eHealth Strategy to members</td>
<td>DF</td>
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<tr>
<td>• Find out where the electronic records will be stored, provide reassurance about the security of the system and patient records and ascertain whether General Practitioners are following the same digitisation route for their medical records</td>
<td>DF</td>
<td></td>
<td>The scanned materials will be stored within the SCI Store system which is currently hosted within the e-health Data room at WGH. The system is password protected and has a number of security groups to allow the granulation of access where required.</td>
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<td>• Copy response to members</td>
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<td>Action Required</td>
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<td>Property - Asset Management and the Strategic Framework for Developments (13 April 2011)</td>
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<tr>
<td>• Provide regular updates on the strategic direction in asset management and future capital developments</td>
<td>SG</td>
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<td>Work underway through ICIC</td>
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<tr>
<td>Delivery of Local Reinvestment Programmes in 2011/12 (8 June 2011)</td>
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<tr>
<td>• Working towards a set of primary care activity indicators</td>
<td>AMcM</td>
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<td>Work underway – initial paper considered by Primary Care Forward Group in December. Work underway Quality measures have been developed for effectiveness (based on 5 key QOF indicators) and person centeredness (based on Better Together Survey). These will be included in Board Quality Report. Work is underway to develop a patient safety measure. A method of providing fast frequent feedback to GPs on person centeredness is being piloted. A survey of timeliness of discharge summaries and out-patient letters found significant variation and is being used to inform work undertaken by secondary care to improve the quality of discharge letters.</td>
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<td>Performance Management (8 June 2011)</td>
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<tr>
<td>• Include quality indicators/headings and stretch targets if appropriate in future reports</td>
<td>AMcM</td>
<td>05/12/11</td>
<td>We have included metrics on palliative care and are also looking at including ethnicity recording as part of the suite of measures.</td>
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<tr>
<td>• Bring a further report to the Committee identifying areas where specific action is needed</td>
<td>AMcM</td>
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<td>Action Required</td>
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<tr>
<td><strong>Capital Investment Programme 2011/12 to 2015/16</strong></td>
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<tr>
<td>• Change the format of the appendix to quote funding in a more relevant and concise way</td>
<td>SG</td>
<td>05/12/11</td>
<td></td>
<td>Monthly budgets currently being prepared for all Capital projects</td>
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<tr>
<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>
<td>SG</td>
<td>05/12/11</td>
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<td><strong>Shared Services (14 December 2011)</strong></td>
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<td>• Report back on the third seminar to be held in February to the next meeting of the Committee</td>
<td>AB</td>
<td>30/01/12</td>
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<tr>
<td>• Bring back a paper on all five workstreams to the next meeting</td>
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<td><strong>Relocation of the Psychiatry of Old Age Ward from the Royal Victoria Hospital to the Royal Edinburgh Hospital (14 December 2011)</strong></td>
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<td>• Confirm the precise cost to the Executive Management Team</td>
<td>SG</td>
<td>30/01/12</td>
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<td><strong>Replacement of SPECT Dual Head Gamma Camera and Cardiology Catheterisation Laboratory at the Royal Infirmary of Edinburgh (14 December 2011)</strong></td>
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<td>• Bring a report to the Committee on potential savings in the Business Case</td>
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<td><strong>Capital Investment Programme 2011/12 (14 December 2011)</strong></td>
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<td>• provide a paper updating the Committee on the governance arrangements for Hub and Hubco for the next meeting</td>
<td>IG</td>
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<td>Emergency Access – 4-Hour Emergency Access Target (14 December 2011)</td>
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<td>• Consider the subject for discussion at one of the clinical presentation slots of Board meetings</td>
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Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 14 December 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (Chair); Mr R Y Anderson; Professor J J Barbour; Mr A Boyter; Councillor P Edie; Mr E Egan; Mrs S Goldsmith; Professor J Iredale; Mr P Johnston; 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 B Currie; Mr I Graham; Ms S Lloyd; Ms J Long; Ms L McLaughlin; Ms C Potter; Mr P Reekie and Mr P Reith.

Apologies for absence were received from Councillor J Aitchison; Dr D Farquharson 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. Mr Renwick declared an interest in agenda item 3.1 “Shared Services Position Update” as his company had a contract with the City of Edinburgh Council, which was one of the local authorities participating in the discussions on Shared Services.

44. Minutes of the Previous Meeting

44.1 The previously circulated Minutes of the meeting held on 12 October 2011 were approved.

45. Matters Arising

45.1 Management of Drug Spend – Mrs Goldsmith advised the Committee that a workstream had been set up on both general prescribing and primary care prescribing and this would report back as part of the overall financial plan. It was anticipated that an outline would be available in February as part of the Local Reinvestment Plan programme.
45.2 **Royal Hospital for Sick Children and Department of Clinical Neurosciences** – the Committee noted that the Project Board had met on Friday, 9 December 2011 and would be discussing the resource question at its next meeting.

45.3 **Digitisation of Health Records Business Case** – Mrs Goldsmith advised that a response had now been received and this would be sent out to members. **SG**

45.4 **Shared Services** – Mr Boyter advised that two out of the three scoping seminars had taken place and the Transport Department was costing a number of possibilities for shared services. Local authority partners had been impressed with the Laundry services at St John’s Hospital and substantial progress had been made. The third seminar would be held in February and he would report back to the next meeting of the Committee. **AB**

45.4.1 Dr Winstanley commented that the progress made was encouraging and asked if the release of top-sliced funds from the Scottish Ambulance Service, allowing the use of alternative means of patient transfer to be examined, was being pursued.

45.4.2 Mr Boyter confirmed that this was on the agenda and was currently being investigated. He commented that there had been a change of emphasis in the Scottish Ambulance Service and the partnership representative, Alex Joyce was playing a full part in this. The Transport Committee was also being briefed on progress.

45.4.3 Mr Egan welcomed the report and commented that he would welcome some actual shared services even more. He continued to have concerns about the possible privatisation of local authority services as, whilst one area of privatisation had been rejected by the City of Edinburgh Council, decisions still had to be taken on other areas and he would like to see this pursued further. He was also concerned that other Boards within SEAT were not participating.

45.4.4 Mr Boyter advised that further discussions were planned for the City of Edinburgh Council, although he was disappointed at the position being taken by East and Midlothian Councils who had withdrawn from discussions. Mr Boyter undertook to bring back a paper on all five workstreams to the next meeting. **AB**

46. **Royal Hospital for Sick Children/ Department of Clinical Neurosciences Outline Business Case**

46.1 The Committee received a previously circulated confidential Outline Business Case for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France.

46.2 Mrs Goldsmith gave a presentation to the Committee outlining the anticipated timeline, non-profit distributing contract structure, details of the land and access, enabling work, capital costs, non-capital costs charges and risks, together with an overview of the design, the procurement and project delivery.

46.3 The Committee noted that the Royal Hospital for Sick Children was presently a stand-alone hospital for children and young people and that moving to Little
France to integrate onto a wider site including adult services would be a significant change of environment. The ethos and culture of a purpose-built facility for young patients would, however, remain in the development of the new Royal Hospital for Sick Children facilities in their joint build with the Department of Clinical Neurosciences.

46.4 For users of both the Royal Hospital for Sick Children and Department of Clinical Neurosciences, the aim was to provide age-appropriate facilities in a safe, caring and healing environment. This ranged from suitable facilities for young children and adolescent inpatients to separate accommodation for the adult population of the Department of Clinical Neurosciences.

46.5 The design would incorporate clearly identifiable, friendly and secure children’s entrances to their outpatients and ward areas. Recreation space and public facilities outwith the wards would also be segregated as far as was practical.

46.6 The Committee noted that a joint build gave the opportunity to deliver economies of scale in clinical departments with high-tech and high-cost equipment such as radiology and operating theatres. Whilst patient pathways did not cross in these areas, staff pathways were made more efficient by co-location of the Royal Hospital for Sick Children and Department of Clinical Neurosciences components.

46.7 The Committee noted the complexities of such a build on the site of an existing private finance facility and that supplementary agreements with Consort for each works package would be required.

46.8 In terms of the commitment of other NHS Boards for whom the new hospital would provide regional specialist services, it was noted that the costs were close to those already in their respective financial plans.

46.9 Professor Barbour commented that it had taken an enormous amount of work to reach the present position and colleagues had been working above and beyond the call of duty to reach this stage.

46.10 The Committee endorsed Professor Barbour’s comments and recorded a vote of thanks and appreciation to all the staff involved in the project for their hard work.

46.11 Mrs Sansbury advised the Committee that the funding route for the project had been agreed with the Scottish Government and the Chair indicated that the key risks were currently being analysed.

46.12 Mr Currie reminded the Committee that the contract dialogue would take a considerable amount of time and was within a pre-determined structure.

46.13 Mr Egan commented that until formal agreement was reached with Consort on the release of the site, the anticipated completion dates were still hypothetical.

46.14 Mr Reekie reminded the Committee that this was one of Scotland’s most important capital projects and funding had been top-sliced at the Scottish Government budget level. Whilst it was complex, the contract process made the
arrangements more favourable towards NHS Lothian than the earlier private finance initiative. He confirmed that the reference design was standard and he was confident that market would show a good interest in the project.

46.15 Mr Whyte commented that he had seen the competitive dialogue process at work in the past and confirmed that it could take a very long time.

46.16 The Chair queried the point at which NHS Lothian would take on all of the risks associated with the project and Mr Reekie advised that this would vary at different stages for different aspects of risk. Mrs Goldsmith undertook to include a detailed summary of the risks at the different stages in the paper to the Board.

46.17 The Committee received a summary report on the Outline Business Case from the legal advisers MacRoberts LLP giving legal advice to NHS Lothian. Ms Goldsmith explained that this document outlined areas of potential risk and confirmed that work to mitigate these risks would be undertaken.

46.18 Mrs Sansbury emphasised that a number of the issues being dealt with were made more complex due to the PPF process and whilst it was a large undertaking, the individual construction components were no more complex than projects which had been undertaken in the past.

46.19 The Committee agreed to approve the revised programme for submission of the Outline Business Case to the Scottish Government and for the commencement of procurement, noting that this was dependent on securing funder approval for Supplementary Agreement No 6 between Lothian Health Board (NHS Lothian) and Consort Healthcare (Edinburgh Royal Infirmary) Limited (Consort) and an agreed approach to the delivery of the enabling works.

46.20 The Committee agreed to approve the Outline Business Case for submission to Lothian NHS Board for consideration at the Board meeting on 25 January 2012 and to the Scottish Government for consideration before the Capital Investment Group on 31 January 2012.

47. Relocation of the Psychiatry of Old Age Ward from the Royal Victoria Hospital to the Royal Edinburgh Hospital

47.1 Mrs Sansbury introduced a previously circulated report recommending the approval of the Initial Agreement to refurbish facilities at the Royal Edinburgh Hospital to reprovide a 15-bed psychiatry of old age ward transferring from the Royal Victoria Hospital.

47.2 Mrs Sansbury reminded the Committee that this related to the earlier Business Case for the Royal Victoria Hospital agreed in 2004. Whilst the original plan had been to vacate most of the site by 2012, using the Royal Victoria Hospital to support a single ward on the site would be too costly.

47.3 Professor Barbour queried the reference to a revenue gap and Mrs Goldsmith advised that this had arisen because of the asset life of the facility and reminded the Committee that capital schemes had to be funded from revenue. As this was
in the financial plan no additional revenue would be required and the sum involved was not a recurring revenue cost. Mrs Goldsmith undertook to confirm the precise cost to the Executive Management Team.

47.4 Mr Egan questioned whether a 15-bed ward was the best way to deliver services and asked where it fitted in with the Clinical Strategy.

47.5 Mrs Sansbury advised that work was still ongoing on how many beds would be required for elderly psychiatric patients and she was comfortable with the number of beds included in the proposal.

47.6 Professor Iredale reminded the Committee that because of the demographics in respect of the increasing number of older people, the number of beds and need for flexibility of care would inevitably increase.

47.7 Dr Winstanley commented that it would be helpful for the Committee to hear the views of the Service Redesign Committee on the Mental Health Strategy and Professor Iredale advised that this was being discussed at the next meeting of the Service Redesign Committee.

47.8 The Chair commented that there would be a need to review the likelihood of similar pragmatic approaches necessary in the future, and Mrs Goldsmith advised that she would be bringing a paper on property strategy to the Executive Management Team, and this would include reference to contingencies for such strategies.

47.9 Mr Anderson commented that other facilities such as Corstorphine Hospital would also need a pragmatic solution.

47.10 Mr Egan commented on the presentation of the figures and Professor Barbour suggested that these should be presented in a way that showed the optimism bias in a different way.

47.11 The Committee agreed to approve the intention to relocate ward 1 from the Royal Victoria Hospital to the Royal Edinburgh Hospital by July 2012, allowing the Royal Victoria Hospital to be fully decommissioned in preparation for disposal.

47.12 The Committee noted that a “do nothing/minimum” option was not applicable for this project as ward 1 must be relocated to allow the Royal Victoria Hospital to close and agreed to approve the preferred option of the refurbishment of part of the ground floor of the Jardine Clinic at the Royal Edinburgh Hospital to provide appropriate accommodation for the Psychiatry of Old Age ward patients.

47.13 The Committee agreed to approve the Initial Agreement and thus the intention to develop a Standard Business Case where the preferred option would be fully costed through competitive tenders.

48. Replacement of SPECT Dual Head Gamma Camera and Cardiology Catheterisation Laboratory at the Royal Infirmary of Edinburgh
48.1 The Committee received a previously circulated report recommending the replacement of a SPECT Dual Head Gamma Camera and Cardiology Catherisation Laboratory at the Royal Infirmary of Edinburgh. It was noted that these investments had been agreed through the Lothian Medical Equipment Review Group, the Lothian Capital Investment Group and the Senior Management Team of the University Hospitals Division.

48.2 Mrs Sansbury introduced the report and explained that this project sat in the current capital plan and that there was some flexibility to allow certain such projects to be brought forward.

48.3 Mr Egan indicated his strong support for the project emphasising that this would help maintain NHS Lothian’s world leading edge in this field.

48.4 Mr Renwick commented it would be useful to know the priorities in the capital plan and to see an indication of potential savings in the Business Case.

48.5 Mrs Goldsmith undertook to bring a report to the Committee on this.

48.6 Mr Anderson queried why the replacement of such equipment was not carried out until it was no longer functioning properly and Mrs Sansbury advised that in the current financial situation equipment tended to be used as long as possible and that NHS Lothian was doing better than many other NHS Boards. Mrs Sansbury indicated that work was being carried out to identify equipment that would need to be replaced.

48.7 The Committee agreed to approve the expenditure of £714,000 for the SPECT Dual Head Gamma Camera and £624,000 for the Cardiology Catheterisation Laboratory to replace this essential equipment before the financial year-end. The Committee noted that this investment would help maintain NHS Lothian’s world leading edge in this field.

49. Mid-Year Financial Review 2011/12 including Financial Position to 31 October 2011

49.1 The Committee received a previously circulated report giving an overview of the formal mid-year review and the financial position of NHS Lothian for the first seven months of the financial year 2011/12.

49.2 Mrs Goldsmith advised the Committee that NHS Lothian was reporting an overspend of £2,874m for the first seven months of the financial year 2011/12, an adverse movement in the month of £702,000. This reflected the under-delivery of £1.513m against the efficiency target and £1.361m of overspends on other budgets.

49.3 Mrs Goldsmith advised the Committee that whilst the mid-year review confirmed a break-even position remained achievable, this would be extremely challenging and required immediate remedial action. There were inherent uncertainties and associated risks and, in particular, the balance between recurring and non-recurring savings had to be improved. If the next impact of the overspends
across the organisation were not managed, the potential shortfall would be in the region of £8.9m. A key element of this was some £6m overspend on prescribing and work was underway to address this problem.

49.4 The Committee agreed to note the report and the actions set out in the mid-year review to deliver the current year-end break-even revenue forecast for 2011/12.

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

50.1 Mrs Goldsmith introduced a previously circulated report updating the Committee on progress against the agreed capital programme for the current year including the expenditure position to October 2011.

50.2 Dr Winstanley queried the governance arrangements in respect of the Hub and Mrs Goldsmith outlined the governance arrangements, advising that the HubCo Board was a stakeholder Board and all schemes would still go through member Boards.

50.3 Mr Graham undertook to provide a paper updating the Committee on the governance arrangements for Hub and Hubco for the next meeting.

50.4 Mr Whyte advised that it was hoped to move ahead with work on Tranent Health Centre in accordance with the current timescale and Mrs Goldsmith advised that a project request would be submitted to Hubco without commitment and would be considered at the Finance & Performance Review Committee in February. The Committee noted that the Executive Management Team had already agreed to recommend the Business Case.

50.5 The Committee agreed to note the balanced capital position forecast for 2011/12 was dependent on a number of assumptions related to the funding of the programme. These assumptions had been shared with the Scottish Government Health Directorates.

50.6 The Committee agreed to approve the issue of a new project request to South East Scotland Hubco and the proposed extension to Tranent Health Centre and to note expenditure of £38.6m on the agreed capital programme for the first seven months of the financial year.

51. **Performance Management**

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

51.2 Professor McMahon spoke to the report and advised that work on delayed discharges was continuing.
51.3 Professor Barbour commented that local maximum targets for delayed discharges were still not being achieved by local authorities, partly because of insufficient numbers of social workers available to conduct discharge reviews.

51.4 The Committee agreed to note the update and the actions being taken where performance was currently off trajectory or where no data was available. The Committee also noted that from January 2012, it was anticipated that the data reported in the routine performance report would be provided directly by the Health Intelligence Unit.

52. **Workforce Efficiencies within NHS Lothian**

52.1 The Committee received a previously circulated report on progress to date in regard to the planned workforce reductions.

52.2 Mr Boyter advised the Committee that NHS Lothian was on track for similar levels of workforce reductions to 2010/11. Sickness levels currently stood at 3.74% and these had been achieved in full partnership with Trades Union colleagues. This level of sickness absence equated to a saving of approximately £18.2m per annum. Mr Boyter advised the Committee that NHS Lothian was already best in class in terms of sickness absence reduction and work was in progress to reduce sickness absence levels to 3.5%. In addition, overtime and the use of agency and support staff were being reduced. Mr Boyter emphasised that the future of workforce efficiencies in NHS Lothian lay in areas of skill mix rather than continued workforce reductions.

52.3 The Committee agreed to note the reduction of 475.7 whole time equivalent staff in post since 1 April 2011 to 31 October 2011 against the annual target of 734 whole time equivalent, securing 64% of the annual target. The Committee also agreed to note the reduction in sickness absence from April to October 2011 with a year to date average of 3.74% against 4.23% for the same period in 2010.

Mr Boyter left the meeting.

53. **Emergency Access – 4-Hour Emergency Access Target**

53.1 The Committee noted a previously circulated report on progress in improving care for patients attending at emergency attendances within NHS Lothian.

53.2 Mrs Sansbury introduced the report and advised the Committee that in 2004 the Scottish Government had announced a new waiting times target for accident and emergency departments, stating that by the end of 2007 at least 98% of patients should be seen and then admitted, transferred or discharged within 4 hours. The 4-hours target applied to all areas of emergency care such as assessment units, minor injury units, community hospitals, health centres, anywhere where A&E types of activity took place. The 4-hour target was intended to measure how well the whole health and social care system was performing, not just the A&E departments, and required the engagement of all partners involved in unscheduled care.
53.3 Mrs Sansbury outlined the nature of the difficulties being experienced and advised that whilst performance had improved, it was not always being sustained.

53.4 Mr Renwick commented that whilst the Royal College of Nursing had requested that targets be dispensed with in England and there did not seem to be any progress on the achievement of this target in Scotland.

53.5 Dr Winstanley echoed Mrs Sansbury’s concerns over the nature of some of the problems and emphasised the need to actively manage frequent attendees at accident and emergency through General Practitioners.

Mr Whyte and Professor Prowse left the meeting.

53.6 The Chair suggested that this was a subject that would benefit from being discussed at one of the clinical presentation slots of Board meetings.

53.7 The Committee agreed to note the improvement in care for emergency patients, the actions taken to date and the continuing work being undertaken to consolidate this performance.

54. **Date of Next Meeting**

54.1 It was noted that the next meeting of the Finance & Performance Review Committee would be held on Wednesday, 8 February 2012 at 9.00am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh. The meeting closed at 12.10pm.
## Adults with Incapacity (Scotland) Act 2001 – Part 5 (February 2011)

- The Chair also requested an update report in 2012.

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<td>AMcM</td>
<td>February 2012</td>
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## NHS QIS Pre-JAG Endoscopy Assessment Visits (October 2011)

- 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 February 2012.

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## Business Continuity Management (June/October 2011)

- Mr Egan asked about the backlog in maintenance work. He advised the Committee that there were a number of inadequate areas for accommodation across NHS Lothian. The Committee noted that this was a serious issue and affected patient care. Committee members felt that they should have been informed of this earlier and requested more detailed information on the maintenance issues and those that affected patient care – this should include primary and secondary care. It was agreed that a report should be requested from George Curley, Acting Director of Facilities. Mr Curley would also be invited to attend the Committee in February. Members commented that there should be better linkage between Improving Care Investing in Change Strategy (ICIC).

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<td>GC</td>
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## NHS Lothian Public Protection Services Update (August 2011)

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

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## Report of the Triennial UK Confidential Enquiry into Maternal Deaths (August 2011)
• 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.

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<thead>
<tr>
<th>Prison Healthcare Implementation Plan (October 2011)</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>
<td>• Mr Egan referred to the prison update report that had been discussed at the previous meeting and requested more information on governance issues for prison healthcare</td>
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<thead>
<tr>
<th>Review of Governance Arrangements for Anticipatory Care Enhanced Service (October 2011)</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>
<th>NHS Lothian Incident Report (December 2011)</th>
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<tr>
<td>• The Chair asked about the 102 dispensing medication incidents and whether these were linked to one stop dispensing. Dr Farquharson agreed to look into this and feedback to the next meeting.</td>
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<tr>
<td>• Mrs Hornett agreed to report back on the numbers of staff that had not been trained in challenging areas within NHS Lothian. Mr Egan informed the Committee of a recent incident which involved a male patient being restrained by five members of staff. Mrs Hornett would give an update on this to the next meeting in February.</td>
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<tr>
<th>Suicide Review Process in NHS Lothian (December 2011)</th>
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<tr>
<td>• There was a request to include timelines for reviews. A member asked about euthanasia and also requested more information on the method of suicide. It was suggested that there should be references in the report to the Chose Life Campaign and further work should be carried out with people affected by suicides.</td>
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<tr>
<td>Pre JAG Roodlands and Leith Community Treatment Centre (CTC) Healthcare Improvement Scotland Final report (December 2011)</td>
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<td>---------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Dr McCallum agreed to check the implications for the NHS Lothian risk register arising from decontamination issues.</td>
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<tr>
<th>Update on the Findings from the Adverse Events Reviews (December 2011)</th>
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<tr>
<td>It was agreed that this should be highlighted as a success at the next NHS Lothian Board meeting. Dr Farquharson also agreed to amend the title of the report to make reference to the SPSP.</td>
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<tr>
<th>Older People in Acute Care Inspection (December 2011)</th>
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<tr>
<td>Liberton had been inspected on 8-9 December 2011 and would be concluded on 20 December. The initial feedback from this inspection had been positive and more information would be available at the next meeting.</td>
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</table>
Present: Professor Murray (Chair); Mrs S Allan; Professor M Prowse; Dr R Williams and Mr E Egan.

In Attendance: Ms M Anderson; Dr D Farquharson; Mr A Boyter; Dr A McCallum; Mrs I Garden; Mrs E O’Connor (Minutes); Professor A McMahon; Ms M McFarlane; Mrs M Hornett; Dr S Mackenzie; Mrs P Dawson and Mr W Rae.

Apologies for absence were received from Ms L Falconer; Ms Sarah Ballard-Smith; Mr I Whyte; Mr D Forbes and Dr C Winstanley.

CHAIR’S REMARKS

The Chair welcomed members to the meeting and members introduced themselves. The Chair advised that since Professor Tierney had left the Board in September 2011 there was no longer a Vice Chair for the Committee. The Chair suggested that Dr Williams take over as Vice Chair. The Committee agreed.

52. RENAMING OF THE COMMITTEE

52.1 The Committee discussed the possibility of renaming the Committee the Quality Committee. The Committee agreed that the Committee should focus on Quality but there were reservations regarding the governance of the risk management components. The Committee noted that the Audit Committee would also consider aspects of risk but it was felt that clinical risk should still remain a main focus of the Committee. A paper on this would come to the next meeting in February.

DF/PM

53. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF THE PREVIOUS MEETING: 4 OCTOBER 2011

52.1 The minutes of the previous meeting on 4 October 2011 were approved as a correct record subject to the following amendment – item 45.6 and 46.3 should read Dr Nigel Williams. The Committee noted the updates to the October 2011 cumulative action note and the following points were picked up on:

• NHS Lothian Incident Report – Dr Farquharson pointed out that the majority of substance misuse incidents in East and Mid Lothian concerned...
patients with other co-morbidities and were often patients admitted into hospital at the end stage of their disease.

- **NHS Lothian Public Protection Services Update** – Mrs Hornett advised that more information on the risk assessment of public protection would come to the February meeting.

  MH

- **Business Continuity Management - Maintenance Work** – Mr Egan asked about the backlog in maintenance work. He advised the Committee that there were a number of inadequate areas for accommodation across NHS Lothian. The Committee noted that this was a serious issue and affected patient care. Committee members felt that they should have been informed of this earlier and requested more detailed information on the maintenance issues and those that affected patient care – this should include primary and secondary care. It was agreed that a report should be requested from George Curley, Acting Director of Facilities. Mr Curley would also be invited to attend the Committee in February. Members commented that there should be better linkage between Improving Care Investing in Change Strategy (ICIC).

  GC/JKS

- **Prison Healthcare** - Mr Egan referred to the prison update report that had been discussed at the previous meeting and requested more information on governance issues for prison healthcare.

  AMcM

53. **MATTERS ARISING**

53.1 **Decontamination Action Plan for the Royal Infirmary of Edinburgh and the Western General Hospital**

53.1.1 Dr McCallum advised that the Decontamination Action Plan for the Royal Infirmary of Edinburgh and the Western General Hospital would come to the February meeting.

  AKM

54.2 **Business Continuity Management**

54.2.1 Professor McMahon spoke to the business continuity report. He explained that each area had a business continuity champion that had been nominated by the executive director. A number of other staff also had business continuity in their job descriptions. He explained that a business continuity workshop was being arranged to ensure all staff were aware of the processes in place for business continuity management. If there were any issues regarding capacity this would be picked up at the workshop and reported back to the Committee. Mrs Allan asked about reporting arrangements. Professor McMahon reported that there was a regular report on business continuity to the Executive Management Team and to the Healthcare Governance and Risk Management Committee. Members noted that the business continuity eLearning module was not mandatory but work was underway to understand a business case to establish whether this was needed and
would be feasible. Professor Prowse suggested incentivising the business continuity training and including it as part of Agenda for Change and staff professional development.

55. **EMERGING ISSUES**

55.1 There were no emerging issues.

56. **SAFE CARE**

56.1 **Healthcare Associated Infection Update**

56.1.1 Dr McCallum spoke to the circulated Healthcare Associated Infection (HAI) update. She advised that the circulated report had information on the October HAI figures. She gave a brief update on the November HAI figures and reported that the full November report would be available on the NHS Lothian intranet. Mr Egan raised concern regarding an incident within the neonatology unit that had not been addressed in the report. Dr McCallum explained that there had been three cases of staphylococcus aureus bacteraemia within neonatology in the last 3-4 months. Dr McCallum advised that this was not in the report as the incident was not yet concluded and was being investigated. However the broader part of the inclusive nature of the reports to Committee was accepted. The Committee commented that this could be discussed under emerging issues.

56.2 **NHS Lothian Incident Report**

56.2.1 Dr Farquharson presented the NHS Lothian incident report for July 2011 – September 2011. It was noted that there had been 7420 incidents in this period. The main themes continued to be patient falls, violence and aggression and medication incidents. Dr Farquharson highlighted that the falls prevention programme had been initiated and was being tested in areas with the greatest contribution to falls within the University Hospital Division. The Committee noted that the falls rate was stabilising but was not progressing towards to the target. A full update report on the falls prevention programme would come to the Committee in April 2012.

56.2.2 Dr Farquharson drew attention to medication incidents and reported that a pilot prescribing project was being taken forward within NHS Lothian hospitals for undergraduate students. Medical students would be required to complete a prescription and then each prescription should then be countersigned by a doctor, usually an FY1. Mrs Hornett also reported that a target had been set to reduce nursing medication administration errors by 15%. A working group had been set up by Sarah Ballard Smith to implement interventions to sustain the delivery of the target – this included joint working with the Scottish Patient Safety Programme Team. The Chair asked about the 102 dispensing medication incidents and whether these were linked to one stop dispensing. Dr Farquharson agreed to look into this and feedback to the next meeting.
56.2.3 The Committee went on to discuss violence and aggression incidents. It was noted that there had been an increase in the number of violence and aggression incidents in this period. Mr Egan pointed out that there were a number of staff that had not received training in violence and aggression. Mrs Hornett agreed to report back on the numbers of staff that had not been trained in challenging areas within NHS Lothian. Mr Egan informed the Committee of a recent incident which involved a male patient being restrained by five members of staff. Mrs Hornett would give an update on this to the next meeting in February.

MH

56.3 Suicide Review Process in NHS Lothian

56.3.1 Professor McMahon introduced the report. He highlighted that 75% of suicides within NHS Lothian involved people that were not in contact with NHS Lothian mental health services. He advised that it was important to learn from these incidents and to establish the feasibility and scope of reviews. A selection of cases would be reviewed in January 2012. There was also a request to include timelines for reviews. A member asked about euthanasia and also requested more information on the method of suicide. It was noted that this was not a comprehensive report on all aspects of suicide but how they were reviewed to national standards. It was suggested that there should be references in the report to the Choose Life Campaign and further work should be carried out with people affected by suicides.

AMcM

56.4 Pre JAG Roodlands and Leith Community Treatment Centre (CTC) Healthcare Improvement Scotland Final report

56.4.1 Dr Farquharson gave a brief overview of the circulated report. He highlighted the details of the scores achieved by Leith CTC and Roodlands Hospital. It was noted that an update on progress to Healthcare Improvement Scotland (HIS) would be required in March 2012 and an action plan was in place to address recommendations. Committee members noted the low scores for training at Leith CTC. Dr Farquharson explained that closer integration of trainers and trainees at Leith CTC with Lothian wide training had been recommended and this had now been addressed. Dr McCallum agreed to check the implications for the NHS Lothian risk register arising from decontamination issues.

AKM

57. EFFECTIVE CARE

57.1 NHS Lothian Public Protection Services Update

57.1.1 Mrs Hornett spoke to the NHS Lothian Public Protection Services Update. She reported that there had been discussions with ELBEG regarding the structure and function of the Public Protection Partnership (PPP). There would now be one ELBEG Strategic Group with one representative from each partner organisation. The first meeting of the ELBEG Strategic Group would be in early 2012. She referred to the section on child protection and reported that the timeframe between referral and initial child case conference had been reduced from 28 days to 20...
days. The Committee also noted the Framework for Public Protection October 2011.

57.2 NHS Lothian Corporate Risk Register

57.2.1 The Committee reviewed the updated NHS Lothian corporate risk register. Dr Farquharson advised that the Risk Management Procedure had been drafted and was being tested by operational staff during the divisional risk register workshops. The Risk Management Procedure would come to the Committee in February.

57.3 Update on the Findings from the Adverse Events Reviews

57.3.1 Dr Farquharson presented the report to update the Committee on progress to meet a 30% reduction in adverse events which was a key outcome measure of the Scottish Patient Safety Programme (SPSP). The Committee welcomed the report and noted the significant improvement. There had been an overall reduction of 42% in the adverse event rate. It was agreed that this should be highlighted as a success at the next NHS Lothian Board meeting. Dr Farquharson also agreed to amend the title of the report to make reference to the SPSP.

DF

58. PERSON CENTRED CARE

58.1 Learning from Complaints and Incidents

58.1.1 Dr Farquharson advised the Committee of the mechanisms in place to learn from complaints and incidents across NHS Lothian. The Committee noted that it was important to learn from complaints and incidents and to improve internal communications to learn lessons from incidents more widely. Professor Prowse asked about the Compassionate Care Programme. Mrs Hornett explained that work was being taken forward nationally on person centred care which would include work on the Compassionate Care Programme. This would come to a future meeting.

58.2 Older People in Acute Care Inspection

58.2.1 Mrs Hornett went through the paper and explained that the expansion of the Healthcare Environment Inspectorate (HEI) inspections would now include care of older people in acute settings and the national dementia standards. It was noted the following hospitals would be inspected: The Royal Infirmary of Edinburgh, St John’s Hospital, the Royal Victoria Hospital, Liberton Hospital, the Western General Hospital, Roodlands Hospital and the Royal Hospital for Sick Children for HEI core standards. Liberton had been inspected on 8-9 December 2011 and would be concluded on 20 December. The initial feedback from this inspection had been positive and more information would be available at the next meeting. Ms McFarlane was assured that NHS Lothian had in place systems for patients with incapacity, living wills and patients that did not request resuscitation.

MH
58.3 Progress Report on the Implementation of The Quality Improvement Strategy

58.3.1 The Committee noted the progress on the implementation of the strategy. Dr Farquharson reported that this was the first progress report on the Quality Improvement Strategy since it was approved in May 2011.

58.4 Healthcare Improvement Scotland Healthcare Scrutiny Model

58.4.1 The Committee noted the emerging Healthcare Improvement Scotland (HIS) Healthcare Scrutiny Model (HSM) methodology.

59. OTHER MINUTES: EXCEPTION REPORTING ONLY

59.1 The Committee noted the following minutes:

- Minutes of NHS Lothian Health and Safety Committee: 28-08-2011
- Minutes of the Area Drug and Therapeutics Committee: 07-10-2011
- Minutes of the Mutuality and Equality Governance Committee: 14-10-2011

60. EXCEPTION REPORTING ONLY

60.1 The Committee approved the following annual reports:

- Coronary Heart Disease Healthcare Improvement Scotland Final report

61. DATE OF NEXT MEETING 7 February 2012 to be held from 9am – 11am in Meeting Room 7 at Waverley Gate (deadline for papers 26 January 2012)

Other Dates for 2012:

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

All to be held from 9am – 11am in Meeting Room 7 at Waverley Gate
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<tr>
<td>Equality &amp; Human Rights Scheme and impact of New Equality Act</td>
<td>AB/JG</td>
<td>n/a</td>
<td>Awaiting new regulations</td>
<td>Ongoing</td>
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<tr>
<td>(13 October 2010 and 31 May 2011)</td>
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<tr>
<td>• Circulate briefing to Committee</td>
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<tr>
<td><strong>Equality Impact Assessment</strong> (13 October 2010, 6 January, 31 May and 14 October 2011)</td>
<td>AKM/JG</td>
<td>01/09/11</td>
<td>On agenda for 13/12/11</td>
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<td>• Board Paper Template</td>
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<tr>
<td>Caring Together Strategy Update and CIS Funding</td>
<td>MH</td>
<td>01/09/11</td>
<td>Email Circulated 9 November</td>
<td>Complete</td>
</tr>
<tr>
<td>(6 January, 22 February and 31 May 2011)</td>
<td></td>
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<tr>
<td>• Take account of comments made. Clarify £230,000 to be held back</td>
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<tr>
<td>Human Rights in Healthcare: Developing NHS Lothian's Strategic Approach (22 February and 31 May 2011)</td>
<td>JG</td>
<td>31/05/11</td>
<td>Ongoing</td>
<td></td>
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<tr>
<td>• Liaise with The Scottish Commission on Human Rights</td>
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<tr>
<td>Update on Race Discrimination Issues (31 May; 14 October 2011)</td>
<td>MH</td>
<td>01/01/12</td>
<td>Due in January 2012</td>
<td>In Progress</td>
</tr>
<tr>
<td>(31 May; 14 October 2011)</td>
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<tr>
<td>• Full report to be prepared in January 2012 and to go to appropriate meeting thereafter</td>
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<tr>
<td>MEGC Annual Report Timetable (14 October 2011)</td>
<td>AB/JG</td>
<td>31/03/12</td>
<td>Due at 31 March 2012</td>
<td>Ongoing</td>
</tr>
<tr>
<td>(14 October 2011)</td>
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<td>• Plan to produce a more substantive report by the end of the year. It was agreed to produce one report to fulfil the traditional Audit Committee requirement as well as the desire to have a fuller review of the Committee’s activities by the end of the current fiscal year</td>
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<tr>
<td>Discussions with the Archdiocese (14 October 2011)</td>
<td>MH</td>
<td></td>
<td>On agenda for 13/12/11</td>
<td>Ongoing</td>
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<tr>
<td>(14 October 2011)</td>
<td>AB</td>
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<tr>
<td>• To be confirmed if funding had historically come out of endowments</td>
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<td>• Director of Communications to be fully briefed on situation</td>
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<td>Action Required</td>
<td>Lead</td>
<td>Due Date</td>
<td>Action Taken</td>
<td>Outcome</td>
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<tr>
<td><strong>NHS Lothian Equality &amp; Human Rights Scheme Annual Report</strong> (14 October 2011)</td>
<td>AB/JG</td>
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<tr>
<td>• Comments to JG and liaise with AB on amending documents accordingly.</td>
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<tr>
<td><strong>Spirituality &amp; Bereavement Care – Work Plan</strong> (14 October 2011)</td>
<td>JG</td>
<td>09/11 2012</td>
<td>Not due until Sept/Nov 2012</td>
<td>Ongoing</td>
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<tr>
<td>• Theme for either the September or November 2012 meeting.</td>
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<tr>
<td><strong>Equality Act Specific Duty Consultation Response</strong></td>
<td>AB/JG</td>
<td>31/10/11</td>
<td>On agenda for 13/12/11</td>
<td>Ongoing</td>
</tr>
<tr>
<td>• Comments on the consultation to JG by 31/10/11. A revised response to be submitted to the Board for approval.</td>
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<tr>
<td><strong>Ethnicity Monitoring Process</strong></td>
<td>JG</td>
<td>02 2012</td>
<td>Not due until Feb 2012</td>
<td>Ongoing</td>
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<tr>
<td>It was agreed that a further progress report should be brought to the Committee in February 2012.</td>
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NHS LOTHIAN

MUTUALITY & EQUALITY GOVERNANCE COMMITTEE

Minutes of the Meeting of the Mutuality & Equality Governance Committee held at 9.00am on Friday, 14 October 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs J McDowell (Chair); Mr A Boyter; Mr S G Renwick; Mrs S Allan; Mr A Joyce; Mrs M Hornett; Dr A McCallum and Ms N Gormley.

In Attendance: Mr J Glover and Ms J Clearie

Apologies for absence were received from Ms C Garrod.

Declaration of Financial and Non-Financial Interest

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

11. Welcome and Introductory Remarks from the Chair

11.1 The Chair welcomed everyone to the meeting. Two new public representatives, Ms Gormley and Ms Garrod had now been appointed to the Mutuality and Equality Governance Committee. It was noted that Mrs Douglas was no longer a member of the Committee and that Mrs Allan had been appointed to replace her. On behalf of the Committee the chair noted the very valuable contribution that Mrs Douglas had made over recent years towards the work of the Committee and its predecessor. A change to the Partnership Representative was also noted. Mr Egan had now been replaced by Mr Joyce.

12 Minutes of the Previous Meeting of Mutuality and Equality Governance Committee held on 31 May 2011.

12.1 The Minutes of the Mutuality and Equality Governance Committee held on 31 May 2011 were approved as a correct record subject to the following amendments. Para 5.4 – insert following text omitted through a change in formatting:- “..original steering group which oversaw the development of the Scheme will be reconvened. This group, made up of staff side, patient and community representatives, will re-examine the over-arching priorities and ensure that they are still relevant for the coming year.”

12.2 Paragraph 3.4.3 final sentence. Future minutes should be more specific.
13 Matters Arising

13.1 Mutuality and Equality Governance Committee Annual Report Timetable

13.1.1 The Committee discussed the plan to produce a more substantive report by the end of the year. It was agreed that it made more sense to produce one report to fulfil the traditional Audit Committee requirement as well as the desire to have a fuller review of the Committee’s activities by the end of the current fiscal year.

13.2 Board Paper Template Update

13.2.1 Mr Glover provided a verbal update on progress with the agreed template and accompanying instructions for the preparation of Board, Committee and Executive Management Team papers which had now been piloted. The Secretariat is to review the pilot and report to the Board, most likely at its November meeting. Concerns were again highlighted over the lack of clarity of the Impact on Health Inequalities and Impact on Inequalities sections. It was noted that these issues had been mentioned in previous meetings of the Committee, and Mr Glover agreed to feedback all the Committee’s comments on the template and accompanying instructions to the Secretariat.

13.2.2 It was also noted that there would be a further opportunity for Committee members who are members of the Board to articulate their views when the finalised paper on this matter was submitted to the Board for approval in November.

13.3 Discussions with the Archdiocese Update

13.3.1 Mrs Hornett summarised the background to the situation and the moves made to improve the equity of provision of Roman Catholic Chaplaincy. She updated the Committee on the progress of the negotiations to change the funding arrangements for Roman Catholic Chaplaincy Services with the Archdiocese of St. Andrews and Edinburgh. Mr Glover confirmed that a full impact assessment had been completed of potential impacts on equality and diversity. She advised that various proposals had been put forward to the Archdiocese including the phased withdrawal of finances but that so far they had been unwilling to accept any of these. Mrs Hornett confirmed that a firm stance was being taken and she provided reassurance that matters were being adequately addressed. She advised that if no agreement could be reached, governance issues would be considered at the Finance & Performance Review Committee as from April a clear position was needed.

13.3.2 It was noted the funding under discussion amounted to fifty three thousand pounds. Mrs Hornett agreed to confirm whether or not this funding had historically come out of endowments.

13.3.3 Mr Boyter agreed to contact Mr S Wilson, Communications, to ensure they were fully briefed on the situation.
13.4 **Update on Potential Race Discrimination Issues**

13.4.1 Mrs Hornett provided a progress report on developments and in particular on steps taken to eliminate the potential for discrimination from the workplace for nurses. The Committee noted that there had been a significant increase in the uptake of training in Equality and Diversity by nurse managers. The importance of recruitment panels being properly trained to recruit and select was recognised. Issues of practicality and resources related to the need for not just the chair, but all members of an interview panel to have completed appropriate training, were noted. The Committee supported the approach that wherever possible all staff involved in making recruitment and selection decisions should be targeted for training.

13.4.2 Mrs Hornett also highlighted support provided through the mentoring scheme for Black and Minority Ethnic groups. She advised the Committee of plans for the Confidential Contacts Scheme to be refreshed and re-launched.

13.4.3 Mrs Hornett noted the further comments made by the Committee and advised that a full report would be prepared in January 2012 which would be presented to the appropriate meeting of the Committee.

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14 **Mutuality and Equality Governance Committee Annual Report**

14.1 The Committee considered the circulated report inviting the Committee to approve the draft annual report for the Committee’s work during the year 2010/2011. The Committee noted it was required by the Board to produce an annual report of its activities each year, in common with other committees of the Board, as part of the Audit Committee process for reviewing board activity. Mr Glover advised that a standard template was used to ensure that annual reports meet certain standards and include a consistent range of information so as to reassure the Board that the Committee is fulfilling its governance and assurance role. Mr Renwick raised some concerns over the usefulness in this instance of the draft annual report as the deadline for having Audit Committee review of the report had passed. However, Dr McCallum highlighted the benefits of having an approved report as part of the record of Committee work. The Committee approved the annual report for the Committee’s work during the year 2010/2011. The Chair requested that the MEGC work plan be attached as an appendix to the document.

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15 **NHS Lothian Equality & Human Rights Scheme Annual Report**

15.1 Mr Glover introduced the paper to present the revised first annual report on progress with the NHS Lothian Equality & Human Rights Scheme 2010-13 for scrutiny and approval. Mr Glover highlighted where changes and revisions had been made in accordance with suggestions made at the previous meeting that the report should reflect a more balanced view and include more on the challenges to
be faced. In particular discussion focused on pages four and five – and the sections entitled Where We Performed Well and Where We Have More Work To Do.

15.2 Mr Renwick commented on the use of term ‘we’ throughout the report and suggested instead it would be more professional to use the term the Board. Alternatively Mr Boyter suggested the use of the phrase in the Committee’s view. This raised a debate over the nature and purpose of this report. The Chair noted that as this is a report on behalf of the Board it would need to be approved by the Board, although the Committee could recommend its approval. Mr Renwick raised a number of further comments and suggested changes to the wording to the Annual Report 2011 draft and accompanying action plan.

15.3 Discussion then focused on section 6.3 of the action plan relating to the reporting of harassment. The Chair suggested that it might be useful to include a statement in the progress column advising that NHS Lothian are continuing to look at this and are exploring possibilities of developing a baseline indicator that reflects reality and that regardless of this have a raft of measures and interventions in place to address matters.

15.4 It was agreed members should submit all their comments to Mr Glover and that he would then liaise with Mr Boyter on amending the documents accordingly. On this basis the Committee agreed to recommend that the Board approves an appropriately revised draft annual report and accompanying updated action plan for publication. AB/JG

16 MEGC Work plan for 2011/2012

16.1 Mr Boyter introduced the report and invited the Committee to consider the attached draft work plan for the period to November 2010. In the following discussion issues around succession planning were noted. In addition concerns were raised that the topic of Spiritual Care had been omitted from the work plan and it was agreed that this should be added on as a theme to either the September or November 2012 meeting.

16.1 Taking this amendment into account, the Committee approved the draft work plan. AB

17 Equality Act Specific Duty Consultation Response

17.1 Mr Glover introduced this report. The purpose of the report was to recommend that the Committee approved the circulated consultation response in relation to the proposed revisions to the Equality Act specific duties by the Scottish Government, attached to the Scottish Government’s consultation on a revised set of specific equality duties. Mr Glover invited comments and provided clarification on a number or points. It was noted that the Scottish Government had issued revised draft specific duties, with the consultation period for these running from 9 September until 25 November 2011 and Mr Glover in response to a request from the Chair advised that he was happy to circulate these. JG
17.2 Ms Gormley provided some helpful background and comments on the consultation process and circulated consultation response. Several members of the Committee suggested changes to the proposed response. It was agreed that the response should be revised and submitted to an appropriate body for subsequent approval. There was some discussion on the need to obtain clarification from the Chairman of the Board on MEGC Terms of Reference and in particular the extent to which the Board delegated authority to MEGC with regard to approving such consultation responses. It was noted that in this instance there was still time within the Equality Act Specific Duty consultation response deadline for the matter to be considered at a future Board meeting.

17.3 Dr. McCallum expressed the view that the draft response circulated for consideration was a corporate response and that stronger views on particular points could be submitted as individual professional responses.

17.4 It was agreed that Committee members should forward any comments on the circulated consultation response to Mr Glover before the end of October to allow time for inclusion of these and then for a revised response to be submitted to the Board for approval.

18 Spirituality & Bereavement Care in NHS Lothian

18.1 Mrs Hornett introduced this report and invited the Committee to consider the draft NHS Lothian Framework for Spiritual Care and Bereavement Services and associated Action Plans and Care Continuum. Mrs Hornett invited comments and provided clarification on a number of points. The Chair asked for clarification on the Care Continuum Model and in particular asked if there was any training for staff on how and when to make referrals to the Spiritual Care Team.

18.2 Mr Renwick commented that overall he felt it was a good report, both helpful and encouraging and he commended the work done in this area. He asked for some clarification on the lack of reporting on TRAK and asked if faith was being properly recorded. Mr Glover advised that around half of all patients now have their religion or belief on their records.

18.3 A number of minor points of detail were highlighted in the NHS Lothian Framework for Spiritual Care and Bereavement Services and Associated Plans and Care Continuum. Mrs Hornett noted these points and agreed to amend the document to reflect the comments made.

18.4 The Committee agreed to note the circulated NHS Lothian Framework for Spiritual Care and Bereavement Services and associated Action Plans and Care Continuum and that it provided reassurance on management. An update on the NHS Lothian Framework for Spiritual Care and Bereavement Services would be provided at next September or December meeting.
19 Participation Standard Report Paper

19.1 Mrs Hornett introduced this report to inform the Committee of NHS Lothian’s performance in respect of the Participation Standard 2010-2011.

19.2 The Committee noted the assessment of NHS Lothian’s performance for 2010-2011 was very good and the Committee commended the work done in this area. It was particularly welcome to note the levels that NHS Lothian had obtained in respect of the three standards in this first year, bearing in mind the challenges faced by all Boards regarding standard 1. The Committee noted the requirements for 2011-2012.

20 Developing Equity in Board and Committee Meeting Arrangements and Representation

20.1 Report from impact assessment of Board and Committee Meeting Arrangements

20.1.1 Mr Glover introduced this report recommending that the Committee acknowledge the range of work ongoing to improve the way that Board and Committee meetings engage with patients and the public and are accessible to all with an interest in their business.

20.1.2 The Chair asked for clarification over exactly whose recommendations were listed in Appendix 1 Report from impact assessment of Board and Committee meeting arrangements held on 5 May 2011. Mr Glover explained that these recommendations were ones to be raised with Secretariat. Mrs Allan spoke about a need to ensure these were carried forward appropriately, particularly in relation to what patients were saying.

20.1.3 The Committee agreed to acknowledge and support the work outlined in the paper, and the contents of Appendix 1

20.2 Report from Impact Assessment of Lay Representative Recruitment Process

20.2.1 Mrs Hornett introduced this report to inform the Committee of the outcome of the equality and diversity impact assessment of the recruitment process of patient/public representatives to committees.

20.2.2 A number of minor points of detail or inaccuracies were highlighted by Ms Allan in particular in relation to 3.4 and 3.5 e.g. Edinburgh Volunteer Centre should read Volunteers Edinburgh. The importance of chairs of committees / support leads for respective committees to meet with new members at the first meeting or as soon as possible thereafter to answer questions and give some advice on the work of the committee was recognised. Mr Boyter offered to meet with Ms Gormley after MEGC as this was her first meeting. It was noted that the Chair had already met with Ms Gormley prior to the meeting.

20.2.3 Mrs Hornett noted these points and agreed to amend the document to reflect the comments made.
20.2.4. The Committee agreed to note the report.

21 **Update on Ethnicity Monitoring Process**

21.1 Mr Glover introduced this report to recommend that improved performance of services across NHS Lothian in monitoring the ethnicity of patients be noted. He invited comments and provided clarification on a number of points. It was noted that establishing ethnicity was now a mandatory field on TRAK. The Chair asked for clarification over the number of people trained to ask these questions and Mr Glover confirmed it was in the region of several thousand. Mr Renwick suggested other areas which might benefit from being made a mandatory field on TRAK e.g. faith. Dr McCallum explained why this was not possible at present and it was agreed to take this forward out with the meeting.

21.2 It was noted that some of the text from paragraph 3.7 of the report was missing.

21.3 The Committee noted the much improved levels of performance across NHS Lothian in relation to monitoring the ethnicity of patients on their first outpatient’s appointment and on discharge from hospital, against a target of 90% by April 2012.

21.3 The Committee noted that at 80% at the end of September for inpatients and 64% for outpatients are currently ahead of our trajectory of 50% by the end of September 2011.

21.4 It was agreed that a further progress report should be brought to the Committee in February 2012.

22 **Volunteering in NHS Lothian: Consultation on Framework and Action Plan**

22.1 Mrs Hornett introduced this report to present the refreshed Volunteering in NHS Lothian Framework and Action Plan (2011-2016)

22.2 Mr Renwick highlighted a recent Operational Audit Committee report concerning volunteer and patient expenses and suggested it come to MEGC for their information.

22.3 The Committee agreed to endorse the framework and action plan for implementation.

23 **Any Other Business**

23.1 **Spiritual Care Event**

23.1.1 The Committee noted a flyer for a Spiritual Care and Health: Improving Outcome and Enhancing Wellbeing, International Conference to be held in the Beardmore Conference Centre, Glasgow on the 13 and 14 March 2012.
Date of next meeting: Tuesday 13 December 2011 2-5pm in Meeting Room 5, 2nd Floor, Waverley Gate. 2-4 Waterloo Place, Edinburgh EH1 3EG.
MUTUALITY & EQUALITY GOVERNANCE COMMITTEE

Minutes of the Meeting of the Mutuality & Equality Governance Committee held at 2:00pm on Tuesday 13 December 2011 in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:
Mrs J McDowell (Chair); Mrs S Allan; Mr S G Renwick; Mr A Boyter; Mrs M Hornett; Dr A McCallum; Ms C Garrod and Ms N Gormley.

In Attendance: Mr J Glover and Mr C Graham

Apologies for absence were received from Mr A Joyce.

Declaration of Financial and Non-Financial Interest

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

25. Welcome and Introductory Remarks from the Chair

25.1 The Chair welcomed everyone to the meeting. The Chair welcomed Ms Garrod to her first meeting. Ms Garrod described for the Committee her role with the Lothian Centre for Inclusive Living, her work on the NHS Lothian Disability Equality Scheme and policy work on human rights and independent living.

25.2 The Chair advised members that it would be the intention to have papers circulated at least one week before the meeting in future and that the Committee Administrator and Mr Glover would work on refining the system to ensure this.

26. Minutes of the Previous Meeting held on 14 October 2011.

26.1 The Minutes of the Mutuality and Equality Governance Committee held on 14 October 2011 were approved as a correct record subject to the following amendments:

- Paragraph 22.2 to be reworded to read “Mr Renwick highlighted a recent Operational Audit Committee report concerning volunteer and patient expenses and suggested it come to MEGC for their information.”
Matters Arising [Running Action Note]

Board Paper Template Update - Mrs Hornett reported that the template was due to be revised early in the New Year.

Update on discussions with the Archdiocese - Mrs Hornett informed the Committee that there had not been many developments to update on in relation to this item. Negotiations remained ongoing and Mrs Hornett assured the Committee that there were no gaps currently in the service and the necessary religious care can be provided if required. Mr Renwick suggested that it may be worthwhile taking this issue to the Executive Management Team to discuss instead of waiting until the meeting of the Finance & Performance Review in April 2012.

NHS Lothian Equality & Human Rights Scheme Annual Report – Mr Glover reported that the report had not yet been circulated to the Board for approval as previously planned. The Board Chairman had considered the report and decided that as it had been through MEGC it could now be circulated to the rest of the Board. It had been agreed that the report be circulated to Board members with a covering letter before wider publication. Mr Boyter stated that the report would be circulated very shortly.

Workforce Diversity Annual Report 2010-11

Mr Glover reported that the report had already been to the Staff Governance Committee but without the covering paper. The report itself is based on data up to March 2011. There was discussion on diversity data which is missed unless people are newly appointed or current staff going for promotion. There was also discussion around the issue of under disclosure in relation to ethnicity, disability and sexual orientation. Mr Glover added that in relation to religion there was a significant minority which had reported ‘no religion’. It was noted that as an organisation NHS Lothian aspires that its workforce should reflect the community it serves.

Ms Garrod stated that it was interesting to see the diverse make up of the workforce but under-disclosure was a concern especially if reporting was anonymous. Mr Glover confirmed that data provided through the recruitment and selection route was anonymous; however data on disability disclosure was often linked to individual employees through occupational health. Mr Boyter added that following a Data Protection breach in England, Trade Unions in Scotland have not been supportive of staff providing any information or indeed the information being gathered. It was noted that this makes it a challenge to obtain a baseline to judge against.

There was discussion on the definition of disability which the Board has adopted and also the notion that the workforce should reflect the community it serves. Mr Glover stated that once sufficient detail on the workforce had been gathered then this can be analysed in a number of ways and divided e.g. by gender, pay rate. This would then give a picture of where particular areas of underrepresentation lay and the reason for this could be explored. Positive discrimination was also discussed.
28.4 Mr Renwick asked whether the data was nice to have or if there was a statutory requirement to have it. Mr Glover informed the Committee that the specific statutory duties were still awaited and were expected in April 2012. It was likely that there will be a requirement to continue to collect and develop monitoring in relation to this data.

28.5 Mr Boyter stated that it was planned to improve the data collected and that through recruitment there was an opportunity to improve the data on a year on year basis. The Committee noted that Mr Boyter and the Communications Director would be taking a paper on internal communications to the next Executive Management Team meeting. It was hoped that provision of data would improve if staff were better engaged as to why they are being asked for information and what it was being used to do.

28.6 Whilst the data is still not robust enough to use to make decisions, it was acknowledged that the levels of those declining to provide information had reduced over the last 2 – 3 years and this should progress to assure that structural and cultural issues are addressed.


29.1 Mr Boyter gave a brief presentation providing an overview of the Strategy. The presentation covered the fundamental principles – living values, engaging leadership and delivering quality. The Committee noted the ongoing work in relation to provision of work for disadvantaged young people; the opportunities for those socially excluded from communities and also the development of new career structures and opportunities for those underrepresented in the workforce.

29.2 The Chair asked how the implementation of the Strategy would be monitored. Mr Boyter stated that over the festive period the Action Plan would be developed with colleagues. The Action Plan will cover 39 months so as to fit in with the Board’s planning cycle. There will be an Annual Report to the Board with 6 monthly updates and the report will also go to the Healthcare Governance and Risk Management Committee; Staff Governance Committee and Partnership Forum. The full Action Plan including specific MEGC issues will come to the next MEGC.

29.3 There was discussion on ongoing work with other partners including central government and local authorities e.g. the Edinburgh Guarantee. Reduction in sickness absence rates was also mentioned. The Committee noted that the 3.5% target was very challenging but the rate was currently at 3.7%. Family friendly terms and conditions of employment were also discussed.

29.4 Training of staff in equality and diversity was discussed as was the statement in the Strategy relating to being “aware of the ethnicity of a minimum of 90% of our patients to ensure services are designed in a culturally competent manner.”

29.5 Mr Boyter informed the Committee that the original three year Strategy had a section on equality and diversity whereas the intention with this version of the Strategy was to have these themes woven throughout the document.

30.1 The Chair highlighted an amendment to paragraph 3.1 of the report, which should state that the MEGC ‘noted’ the report in February 2011, it did not “approve” it.

30.2 Mr Glover reported that this was the next step on from the discussions at the February meeting with more focus on how NHS Lothian works as a service provider and employer. There had been ongoing work with key organisations including the University of Warwick to produce the attached Action Plan. NHS Lothian would be the first NHS Board to use the University of Warwick model. The Committee noted the four main outcomes from the Action Plan:

- Staff are aware of their responsibilities in relation to Human Rights as appropriate to their role
- There is a good understanding of the key Human Rights issues facing NHS Lothian and measures are in place to address these
- The Human Rights impacts of health inequalities for key disadvantaged groups are identified
- NHS Lothian has built Human Rights into its long term goals

30.3 In response to a question from Ms Garrod, it was noted that there had been around 740 efficiency plans last year, all of which had been impact assessed, with none having a negative impact on patients. There was discussion about the learning and development of staff on equality and diversity. Mr Glover reported that all existing staff training had been reviewed for their coverage of Human Rights issues, including corporate induction, mandatory refresher training and bespoke training for key priority groups. There was also an appetite amongst the Nurse Managers for such training.

30.4 The Committee approved the Action Plan and main outcomes as detailed above.

31. Developing a Performance Monitoring “Dashboard” for MEGC

31.1 The Committee noted the paper and the progress being made to develop equity indicators. There was discussion on the differences between equity and equality. Mr Glover stated that equality is a particularly British term whereas equity translates better and is used when benchmarking internationally. It was agreed that whatever term is used, this should be consistent and well defined. Ms Gormley noted that Scottish government has considered the two terms and decided to use equality.

31.2 The Chair asked Dr McCallum to consult with Ms Gormley and to provide a paper on the definitions for the next meeting. AKM/NG

31.3 It was also agreed that the proposed equity indicators be added to the indicators that are going to be developed to monitor implementation of the Human Resources & Organisational Development Strategy 2011 – 14 Action Plan (Item 29 above) and be brought as a joint package to the next meeting. AKM/AB
32. Equality & Diversity staffing roles and responsibilities in NHS Lothian

32.1 The Committee noted the report summarising the roles and management structure for staff with key equality and diversity duties. Mr Renwick asked if the structure had adequate resourcing. Mr Boyter replied that on one level the resourcing is never sufficient however the important factor is that the resources are deployed in the right way. It is hoped that once the monitoring dashboard is in place then over time it will be possible to tell if progress is being made and the resources are adequate and appropriately deployed.

32.2 Ms Hornett advised that the diagram in Appendix 1 required updating and that she would work on this with Mr Glover out with the meeting. The revised structure would come back to the next MEGC to be shared for information. JG/MH

33. Items for Information

32.1 The Committee noted the following items for information:
  • Volunteers and patients travel expenses internal audit report

33. Any Other Business

33.1 There was none.

34. Date of next meeting: Tuesday 21 February 2012 2-5pm in Meeting Room 8, 2nd Floor, Waverley Gate. 2-4 Waterloo Place, Edinburgh EH1 3EG.

35. 2012 Meeting Dates

  • 29 May 2012
  • 25 September 2012
  • 27 November 2012
Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday, 19 December 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Professor J Iredale; Ms J Anderson; Mr R Burley; Mrs L D’Arcy; Dr D Farquharson; Mr D Forbes; Mr J Forrest; Mrs S Goldsmith; Mrs M Hornett; Dr S Mackenzie; Dr A K McCallum; Professor A McMahon; Dr J Steyn and Ms L Tait.

In Attendance: Professor A Bundy; Dr K Burnie; Ms L Irvine; Dr B McKinstry; Ms F Mitchell; Mr P Reith and Mr J Sturgeon.

Apologies for absence were received from Dr B Agrawal; Mr A Boyter; Professor J J Barbour; Councillor P Edie; Dr J Hopton; Professor P Murray 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.

39. Minutes of the Previous Meeting

39.1 The Minutes of the Service Redesign Committee meeting held on 17 October 2011 were approved.

40. Matters Arising from these Minutes

40.1 Quality Assurance Kite Mark Proposals – the Chair introduced the previously circulated paper listing key issues that had been identified as the template for service redesign proposals to the Committee to explicitly address. Responses on these key issues would require to be incorporated in any proposals submitted to the Committee. The Committee agreed to the adoption of this template.

40.2 Lanfine Unit – the Committee noted that a report on the Lanfine Unit would be brought back to the February meeting.

40.2.1 The Chair advised that the running action note would be updated for the February meeting.
41. Update on Health Literacy Options

41.1 Dr McCallum spoke to a previously circulated report detailing the impact of health literacy on health outcomes.

41.2 The Committee noted that health literacy was a relatively new concept within Scotland and did not have a commonly agreed definition.

41.3 Dr McCallum advised that several studies had demonstrated that using a targeted approach to improve health literacy had a positive impact on self-management and related health outcomes. Within NHS Lothian, there were a number of interventions which had been developed to improve health literacy, such as Teach Back and shared decision-making, as well as health literacy awareness and partnership working.

41.4 The Committee agreed to recognise the impact of health literacy on health outcomes and health inequalities, note the establishment of the national health literacy group and support the programme of interventions to improve health literacy in Lothian.

41.5 The Chair suggested it would be useful for the Committee to hear about progress in this matter and Dr McCallum undertook to provide updates.

42. New Technologies to Improve Health Outcomes

42.1 The Chair welcomed Professor Alan Bundy to the meeting.

42.2 Professor Bundy explained the role of the Scottish Science Advisory Council and, in particular, its project on telehealth care, which aimed to promote collaboration between all stakeholders.

42.3 The circulated report “Telehealth Care: Time for Action” and its executive summary articulating a vision for telehealth care in Scotland was received. The Scottish Centre for Telehealth and Telecare was established in 2011 to develop a single integrated strategy for telehealth and telecare over the course of 2011/12 for adoption by NHS 24 and the Scottish Government.

42.4 Professor Bundy advised the Committee that inter-operability would reduce costs, promote competition and enhance functionality. In particular, it was intended to answer questions about how telehealth could improve services for patients. The Committee noted the intention for Scotland, as a small country with a mix of rural and urban populations and an excellent track record in engineering and science, to become a test bed to stimulate Scottish industry. Professor Bundy emphasised that the status quo was not an option and in the current economic climate, new technologies were the way forward for developing services to patients.
42.5 Mr Burley advised that although he had investigated some of the wider bridges in trying to link to digital change in entertainment, he was not aware of much work being carried out on integrating these in healthcare.

42.6 Mrs Hornett advised that NHS 24 would be launching a TV channel “Living Local” which, whilst basic at first, would establish a link with patients. Other areas for development included mobile phone technology.

42.7 Mr Forrest commented that NHS Lothian was already part of the Dallas project and was looking at a number of areas including developing relationships with industry providers. There was a need for interoperability and co-ordination to help avoid having to re-invent the wheel.

42.8 Mrs Hornett advised that improved means of communication with patients and the public were currently being examined and suggested it would be helpful to have an input from the community.

42.9 Dr McKinstry advised that within NHS Lothian, the use of telehealth care in pilot work had already led to a dramatic drop in patients reporting high blood pressure and the telehealth equipment had proved very popular. It was proving very empowering for people to learn more about their health and the benefit from the investment being put into telehealth was clear.

42.10 Mrs Goldsmith commented that this appeared to be a classic case of invest to save and suggested that appropriate business cases might be forthcoming.

42.11 Professor Bundy advised that telehealth care proposals might not necessarily save money, although it was possible that they could radically improve the health of the population.

42.12 Mr Burley commented that production costs of much of the equipment would reduce once its adoption had been rolled out.

42.13 Dr Mackenzie advised that patients would need to be looked at as individuals and the use of such technology should be appropriately driven by patients rather than the technology itself.

42.14 The Committee noted that telehealth care was a rapidly developing field, which had the potential to facilitate the move of the NHS in Lothian into the 21st century and invited Professor Bundy to keep the Committee appraised of developments in this area.

43. 5x5x5 Project Updates

43.1 The Committee noted a previously circulated report summarising the five 5x5x5 projects currently underway. These were: demand management – improving ambulatory care pathways; clinical quality – effective prescribing – a whole system approach; cost versus quality – acute receiving - variation and cost;
patient experience – improving the patient experience by improving staff attitude and communication; health inequalities – organisational and social justice.

43.2 Ms Tait advised that the improving patient experience project was working to identify deliverable actions, which would improve the quality of staff interactions with patients, recognising that these were the second most common cause for formal complaints. It was noted that whilst this project would not deliver financial savings, it would improve the patient experience. Already the need for clearer statements about the value of the organisation had been identified, along with the need to fully explain and publicise to staff existing policies such as the Lothian Way.

43.3 The Chair commented that the main challenge would be in the implementation and development of such improvement and Professor McMahon suggested that this work would underpin much of the Clinical Strategy.

43.4 Ms Mitchell gave a brief report on the project to explore changes to the model of care in medicine, which was intended to see whether there were scope to reduce the use of inpatient beds in acute hospitals by providing more investigations, assessments and diagnostic procedures on an ambulatory basis. The focus was on non-elective admissions and whether these could be prevented or length of stay reduced, by ease of access to rapid diagnostics/ investigations. Ms Mitchell commented that one of the main challenges was in developing means of incentivising teams to change working practices and implement ambulatory care policies.

43.5 Ms Irvine spoke about the project on addressing health inequalities through building communities’ capacity advising that there was some cross-over with the improving the patient experience project.

43.6 The Committee noted the progress being made in each of the 5x5x5 projects and the Chair thanked Ms Mitchell and Ms Irvine for attending to assist the Committee in its discussions.

43.7 The Committee agreed to note the progress being made in the 5x5x5 projects.

44. Capital Funding

44.1 Mrs Goldsmith gave a presentation to the meeting advising that the NHS Lothian “estate” now included 96 owned properties, 108 leased properties and 100 GP owned properties for which NHS Lothian had a maintenance and legislative compliance role. The current major issue was a cumulative backlog maintenance requirement amounting to £188m.

44.2 Mrs Goldsmith explained that NHS Lothian was aiming to develop a property asset management strategy in conjunction with the capital budget as there was a significant amount of pressure on capital. NHS Lothian had a significant revenue commitment to supporting the capital infrastructure and the Scottish Futures Trust would have a major role in asset management strategy.
44.3 Mrs Goldsmith emphasised that there were a number of sources of funds with new funding streams, such as Hubco entering the equation.

44.4 Mrs Goldsmith emphasised the need for careful thought about the way in which business cases were presented.

44.5 Mr Forbes raised the knowledge gained from the private finance initiative for the Royal Infirmary of Edinburgh and emphasised that the Board needed to be aware of exactly what it was signing up to based on previous experience.

44.6 Mrs Goldsmith advised that Mr Forbes’ concerns were being taken cognisance of and commented that it was recognised that NHS Lothian required to enhance its in-house Public-Private Partnership experience. The Scottish Futures Trust had been established to co-ordinate non-profit distribution schemes and was also providing expert advice on Public-Private Partnership.

44.7 The Chair commented on the use of fundraising in the healthcare profession in countries such as the United States of America where substantial sums could be raised.

44.8 Mrs Goldsmith indicated that such fundraising was under active consideration and it was possible that NHS Lothian might be able to “sell” its experience in larger projects such as the Royal Hospital for Sick Children and Department of Clinical Neurosciences to foreign projects.

44.9 Mr Burley commented that the Board’s Endowment Fund, now rebranded as the Edinburgh and Lothians Health Foundation, could be proactive rather than reactive and would be examining its strategy in order to raise additional funds.

44.10 The Chair commented that it was difficult for the National Health Service, even when it could recruit from the private sector, to maximise private donations as NHS structures did not lend themselves to this end. The University of Edinburgh had been successful in raising funds in this way.

44.11 Mrs D’Arcy advised that she was concerned about the level of backlog maintenance and suggested that adequate maintenance of NHS assets should be a priority.

44.12 The Chair thanked Mrs Goldsmith for her presentation.

45. Improving Care, Investing in Change Update and Review of Remaining Programmes

45.1 The Committee noted a previously circulated report outlining the progress in the implementation of the Improving Care, Investing in Change programme since April 2011.

45.2 The Committee noted the summary of progress and changes of status for the projects which were outstanding and accepted the assurance arrangements in
relation to the capital workstreams via the Finance & Performance Review Committee to avoid duplication of reporting.

45.3 The Committee recognised that the Clinical Strategy development was likely to lead to a new set of service redesign workstreams of which the Committee would wish to provide governance oversight.

45.4 The Chair suggested that the issue of continued sign-off of Improving Care, Investing in Change matters be dealt with at the next meeting as a Matter Arising, after which only exception reporting would be required.

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

46.1 The Committee received for information the previously circulated Minutes of the NHS Lothian Transport and Access Committee held on 17 November 2011.

46.2 The Chair commented that the new Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France would have a significant impact on transport in Lothian.

47. **Date of Next Meeting**

47.1 It was noted that the next meeting of the Committee would be held on Monday, 20 February 2012 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the Meeting of the Staff Governance Committee held at 2.00pm on Tuesday, 22 November 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr E Egan (Chair); Councillor J Aitchison; Mr R Burley; Mr A Boyter; Councillor J Cochrane; Ms L Falconer; Mrs J McDowell and Mr I Whyte.

In Attendance: Mr G Curley; Ms J Harnes; Dr C Kalman; Mrs R Kelly; Mr P Reith and Mr S Wilson.

Apologies for absence were received from Ms J Brown, Dr D Farquharson, Mrs L Khindria 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.

30. Minutes of the Previous Meeting

30.1 The Minutes of the previous meeting of the Staff Governance Committee held on 31 August, 2011 were approved as a correct record.

31. Matters Arising

31.1 Retirement Awards – Mr Boyter advised the Committee that the Office of the Scottish Charities Regulator had no objection, in principle, to charitable funds being held for the benefit of staff and detailed proposals for such a fund were being put together. The Chair expressed delight at the progress being made and the meeting noted the position.

31.2 Prison Healthcare – Mrs Kelly advised the Committee that prison healthcare staff had transferred to the National Health Service with effect from 1 November, 2011. The transfer had gone smoothly and the staff concerned would be offered an Agenda for Change grading, which they had the option of accepting or of continuing on their current effective grade. Ms Falconer advised the necessary IT was up and running and infection control was working on harmonising policies with those of NHS Lothian. Councillor Cochrane
questioned how well embedded NHS Lothian was in Addiewell Prison and Ms Falconer advised that far better terms of service were being offered, and the staff had been more welcoming to the transfer than the MH Prison service. The Chair commented the transfer offered a significant opportunity for improvements in the social conditions of the patients and the Committee agreed to receive an update at the May meeting.

31.3 Health and Safety Annual Report 2010/11 and Health and Safety Policy – Ms Kelly advised the Committee that significant progress had been made moving from one system to another and the analysis of this would be brought to the next meeting. The Chair commented that he was keen to see this analysis and Mr Boyter advised that he was reminding management colleagues of the need for training to be undertaken. Mrs Kelly advised that she was looking at compliance along with Mr Boyter and Mr Payne. The problem was not lack of policy. It was agreed that Ms Kelly should bring forward a paper to the Staff Governance Committee detailing progress in this matter and Mr Boyter undertook to make this an agenda item at the next Committee meeting.

32. Workforce Efficiencies Report

32.1 A previously circulated report providing an update on the progress to date in regards to the planned workforce reductions was received.

32.2 The Committee noted the reduction of 475.6 whole time equivalent staff (wte) in posts since 1 April 2011 to 30 September 2011 against the annual target of 734 wte staff, and that progress was ahead of trajectory.

32.3 The Committee also noted the position in regard to reduced overtime payments and that comprehensive workforce information would now be available monthly for CH(C)P and the University Hospitals Division and could be accessed via the NHS Lothian intranet.

32.4 Mr Boyter confirmed to the Committee that the average absence rate was 3.67%. Bank and agency usage was reducing and the NHS Lothian position of 3.67% was the best in class in Scotland.

32.5 Ms Falconer emphasised the importance of ensuring that staff numbers, particularly in nursing, were not reduced below a manageable level and Mr Boyter commented that the national workforce planning tools were applied and Chief Nurses were responsible for ensuring safe staffing levels.

32.6 The Chair commented that he was pleased at the positive news and reiterated that continuing the same levels of staff reduction beyond the two planned years would not be sustainable in the long term.

32.7 The Committee agreed to note the position.
33. **NHS Lothian Safe Traffic and Vehicle Management Programme**

33.1 The Committee received a previously circulated report providing an update on the progress to date on implementing the traffic management programme of improvements, as well as the position relating to the risk associated with NHS Lothian’s use of vehicles.

33.2 The Chair welcomed Mr Curley to the meeting and agreed to endorse the work undertaken to date relating to vehicle risk management and to approve the recommendations relating to this. The Committee noted that upon completion of the programme of works for 2011/12, it was proposed that a review of site safety in terms of traffic management was undertaken by the Traffic Management Groups on each of the larger sites. This would be followed by an independent review to ensure no further risk has been identified.

33.3 The Committee agreed to endorse the Traffic Management Groups continuing to monitor and update the action plans on a regular basis.

33.4 The Committee noted the proposed letter to be sent to all employees and changes to the policy on reversing manoeuvres were operational matters and that this would require to be considered by the appropriate Executive Directors.

33.5 The Committee agreed to endorse the work undertaken and agreed that there should be a zero tolerance in respect of staff abusing traffic control staff and that this matter should be referred to the Royal Edinburgh and Associated Hospital’s Partnership Forum. The Committee felt that describing the behaviour of members of staff who abused traffic control staff as inappropriate understated the case, as parking in violation of NHS Lothian policy and the Health and Safety at Work Etc. Act 1974 were serious matters requiring rapid resolution.

34. **Investors in People Accreditation – Progress Update**

34.1 A previously circulated report giving an update on progress against the plans for achieving Investors of People accreditation was received.

34.2 Mr Boyter advised the Committee that 19 out of 24 Investors in People business units had achieved the standard and each of the remaining 5 areas yet to satisfy the standard had an action plan to bring them up to the required standards by 31 March 2012. Mr Boyter commented that a significant effort had been involved in this work, which should be concluded by March 2012 after which date the standards achieved would require to be sustained. Mr Curley commented that the staff were working hard and learning as they went.

34.3 The Chair suggested being on Band 1, positive publicity about the achievements of the traffic management staff and the substantial work carried out would be beneficial to morale.
34.4 Mr Burley commented that he had some experience taking a Housing Association through Investors in People and concurred that it could have a very positive effect on an organisation.

34.5 Councillor Cochrane sought confirmation that the resources being spent on this effort were worth it and Mr Boyter confirmed that the accreditation process was merely an external evaluation of those things that the organisation should be doing anyway and was a necessary step towards becoming one of the top 25 healthcare providers in the world. The Committee agreed to note the position.

35. **Equality and Diversity Monitoring Report**

35.1 Mrs Kelly introduced a previously circulated equality and diversity monitoring report for 2010/11 and the Committee noted that 55% of staff had responded to the questionnaire with 45% declining.

35.2 Mrs McDowell questioned the use and purpose of the report and Mrs Kelly advised that NHS Lothian had a legal obligation to monitor equality and diversity in the workforce.

35.3 The Committee agreed to note the position.

36. **eESS Human Resources System Update**

36.1 The Committee received a previously circulated report giving a further update on the implementation of the new national Human Resources system (eESS) highlighting some of the potential governance issues associated with the move to its national system rather than remain with the existing local Empower system.

36.2 Mrs Kelly advised the Committee that the implementation date had been moved from 1 November 2011 to 6 February 2012 and NHS Lothian would be phasing in the system. A 6-month extension with the Empower system had been purchased and Government funding for this would be provided.

36.3 Mrs Kelly advised that progress on the inclusion of a number important areas and features had been made and although the training module had not yet been received, the system should be in full use by 1 April 2012.

36.4 The Committee thanked Mrs Kelly and her team for their work in this matter.

37. **Human Resources Policy Update**

37.1 Mrs Kelly introduced a previously circulated report giving an update on policies approved by the Lothian Partnership Forum and issued, as well as policies under review.
37.2 The Committee agreed to note the position and Mrs Kelly undertook to check if there were any more policies to be updated or whether all remaining policies had now been reviewed.  

     RK

     Mr Whyte left the meeting.

38. Industrial Action

38.1 Mr Boyter advised the Committee that some Trades Unions had balloted their members on industrial action in respect of United Kingdom Government proposals to change public sector pensions. This had resulted in a vote in favour of industrial action which would be held on 30 November 2011.

38.2 Mr Boyter advised the Committee that discussions with the Trades Unions had led to an agreement that a minimum Sunday service would be provided with a full emergency service.

38.3 The Committee noted that the dispute was with the Government and not NHS Lothian as the employer and that agreement had been reached that courses of treatment would not be affected for cancer patients, renal dialysis, etc.

38.4 It was noted that comprehensive arrangements were in place to ensure the business continuity of services to patients.

38.5 The Committee noted the position.

39. NHS Scotland Financial Capability Project

39.1 Mrs Kelly advised the Committee that the NHS Scotland financial capability project was being rolled out throughout NHS Lothian and an update would be provided at the February meeting.

39.2 The Committee noted the position.

40. Health and Safety Committee

40.1 The Committee received the previously circulated Minutes of the meeting of the Health and Safety Committee held on 23 August 2011.

40.2 Dr Kalman advised the Committee that an Improvement Notice had been served by the Health and Safety Executive on NHS Lothian in respect of potential skin allergens and in spite of NHS Lothian having experienced very few problems with skins sensitivities amongst staff, the current questionnaire protocol had been deemed inadequate by the Health and Safety Executive and skin checks of a substantial number of NHS Lothian would now be introduced.

40.3 The Chair thanked Dr Kalman for his report.
41. **Date of Next Meeting**

41.1 It was noted that the next meeting of the Committee would be held on Wednesday, 29 February 2012 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Friday 28th October 2011 at 9 a.m. in the Quay Complex, Musselburgh.

Present: Iain Whyte, Chair of the CHP  
David Small, General Manager (DS)  
Dr Graham Alexander, GP Representative (GA)  
Cllr Paul McLennan, East Lothian Councillor (PM)  
Ann McCarthy, PPF Representative (AM)  
Gill Colston, PPF Representative (GC)  
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)  
David King, Head of Finance (DK)  
Fiona Mitchell, Acute Sector (FM)  
Dr Jane Hopton, Assistant General Manager (JH)  
Thomas Miller, Staff Representative (TM)  
David Heaney, East Lothian Council (DH)

In Attendance: Duncan Miller, General Manager PCCO – Minute Item 45.1  
Ginnie Moreton, Health Promotions – Minute Item 52.2  
Drew McErlean, Minutes (DMcE) – Minutes

Apologies: Dr Ian Johnston, Medical Director (IJ)

45. Welcome and Apologies

Apologies were noted as above.

Cllr Paul McLennan, Elected Representative of East Lothian Council was welcomed to his first meeting of the CHP Sub Committee.

45.1 DOPC Action Plan - Feedback

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 attended the meeting to note the key issues and the context within which this piece of work was being done.

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

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. The range of issues demonstrates how much work is being done by the CHP.

The Chair asked what differences would be visible locally as a consequence of this work. Duncan Miller noted that each CHP has its own action plan and has responsibility for identifying the key local issues that need to be progressed and highlighted.
Dr Jane Hopton commented that nationally, a lot of work had been done in the area of quality standards for out of hours service and this is being referenced in Lothian Unscheduled Care Service (LUCS).

Murray Leys noted the importance of links to the Single Outcome Agreement and for coordination between these pieces of work. David Small, Duncan Miller and Murray Leys will meet to coordinate this work.

**Decisions**

The recommendations in the report were agreed.

### 45.2 Primary Care Activity

The Sub Committee considered a report which had been circulated in advance of the meeting. The key issues from the paper were noted by Dr Graham Alexander.

The paper set out the key results from an audit of Section 17C practices in 2009 – 2010. There had been an estimated 5.4 million General Practice contacts across Lothian. There were low levels of referrals by the GP Practices to Accident and Emergency.

The Chair noted that the report provided a very positive view of General Practices. Duncan Miller felt the report emphasised the need for more Primary Care data sets to be established.

Ann McCarthy commented that she felt an area not being addressed was minor injuries. David Small noted that minor injuries services were part of Accident & Emergency at the Royal Infirmary of Edinburgh and St John’s Hospitals and a stand alone service at the Western General Hospital. A lot of the work is still being done at GP surgeries.

David Small added that a minor injuries clinic had been included in the original scope for the East Lothian Community Hospital.

**Decisions**

The report was noted.

### 46. Minutes of the Previous Meeting Held 25th August 2011

46.1. The decisions made at the previous meeting were homologated.

Dr Graham Alexander noted he had intimated apologies for the meeting.

Item 40.1. (Carers Forum).

It was noted that there had also been a decision to ask for a report on how the £230k funding had been allocated with an explanation of the process used to reach the decisions and the implications of these across Lothian.

The minutes were otherwise agreed as being a true and accurate record of the meeting.
47. Matters Arising / Action Note

47.1. Matters Arising

47.1.1. (20.6) Audit Scotland: Audit of Community Health Partnerships – from the minutes of the meeting held on 29th June 2011.

David Small advised that he had attended a meeting of the East Lothian GP Reps Sub Group and his impression was that there was some dis-engagement between the CHP and the GPs. David Small will prepare a document on the issues on which GPs need to be engaged and he will work on this with Murray Leys.

It was agreed that the Chair of the Sub Committee would attend a future meeting of the GP Reps Sub Group to further improve the level of engagement and consultation. David Small will advise the Chair of the dates of these meetings.

47.1.2. (34.3) Care Homes

Murray Leys advised that HCI will be taking over 2 Care Homes previously operated by Southern Cross.

Ann McCarthy asked if the new organisation would be accepting patients at local authority rates. Murray Leys noted that everything is being done to encourage them to adopt the National Care Homes contract rates but that cannot be enforced and there is very high demand for places both locally and nationally.

Liz Cregan advised that work is underway to look at what the Nursing capacity issues would be if extra resource is required to support these care homes. David Small, Liz Cregan and Murray Leys will meet to quantify what the resource impacts have been across the system as a whole in relation to the recent Care Home issues.

Murray Leys noted there has been significant investment by East Lothian Council in Care Homes Improvement and this work is linking to national discussions on the re-negotiation of the Care Homes contract.

47.2. Action Note

The Action Note was reviewed and will be updated.

47.3. Prison Healthcare

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

The report noted that on 1st November 2011 NHS Lothian takes on responsibility for Prison Healthcare for Edinburgh and Addiewell Prisons as part of a national transfer of responsibility from the Scottish Prisons Service to Health Boards.
East Lothian CHP will take on responsibility for hosting this service. Operational responsibility for the service will be with the CHP Allied Health Professions Manager who will report to the General Manager. Professional Nursing advice and leadership will be from the CHP Chief Nurse and professional medical advice and leadership from the Clinical Director.

The paper set out the management and governance arrangements that will apply.

A separate risk register has been created with the most significant risks being a potential increase in the number of complaints and ensuring that a sustainable in and out of hour’s medical service is in place.

The Chair noted that he felt there may be a risk of the budget not being sufficient to address currently unmet needs. David Small will add this to the Risk Register.

Morag Barrow commented that the model of service delivery has been traditional and there are opportunities to introduce improvements and efficiencies.

Ann McCarthy asked why East Lothian was hosting this service as neither of the two prisons involved are based in East Lothian and noted concerns about the management time that would be required.

The Chair noted that there was a good fit with some of the other hosted services managed by East Lothian and Midlothian CHPs – e.g. addiction services and out of hours services and that since the prisons serviced a population broader than Lothian responsibility could naturally fit with any Community Health Partnership.

Dr Graham Alexander questioned if the CHP had sufficient resource to manage and support this service. David Small noted that each Prison Health Centre has its own Manager who deals with day to day issues and the Access Practice in Edinburgh will manage day to day medical resourcing issues. Dr Graham Alexander noted that he still felt that the resources for managing the service could become an on-going issue.

Fiona Mitchell noted that she felt the clinical governance issues may be challenging and there may be quite significant demands in bringing together two healthcare teams. This is a good move overall but the change management issues must not be under-estimated.

**Decisions**

The CHP Sub Committee agreed the proposed solutions and it was agreed that a progress report together with the Prison Healthcare Risk Register will be tabled at the December meeting of the Sub Committee.

It was agreed that the AHP Manager will produce reports on an on-going basis to update the CHP Sub Committee on any integration or resourcing issues that arise.
The Sub-Committee considered a report which had been circulated in advance of the meeting.

The report noted the background to inspection visits that are conducted by the Healthcare Environment Inspectorate (HEI). Prior notice of the exact timing of such visits is not normally provided. These inspections are now also part of the Older People in Acute Care Inspections by Healthcare Improvement Scotland (HIS).

A recent communication from the HEI showed that Roodlands Hospital will be one of the hospitals in Lothian that can expect to be inspected.

A planned programme of mock multi professional audit visits is currently underway across all four hospital sites in East Lothian. These have identified that the interior of the majority of buildings require substantial improvement and change of use in several areas. In addition a range of equipment needs to be replaced. It should be noted that East Lothian Hospitals have a very low infection rate despite this.

David Small advised that a meeting has been arranged with Estates for 2nd November to consider the issues and quantify the cost impact across Lothian as a whole.

The Chair asked if it was feasible to do all of the work required and whether this would alter any plans in relation to future service delivery. David Small noted that the CHP cannot provide single bed wards in all situations and that bed spacing is a significant issue.

Liz Cregan noted that to get the work done there will be some decanting of patients but this will be kept to a minimum.

Murray Leys noted that he felt staff should be commended for the quality of care they provide in less than ideal physical environments and noted that capacity should be retained in East Lothian wherever possible as local placement of patients is very important.

Fiona Mitchell noted that the Acute Sector experience of HEI visits is that the behaviours and attitude of staff are regarded as very important issues by the Inspectorate Teams – e.g. hand hygiene adherence and the way staff interact with patients. Liz Cregan noted that the CHP Team has been liaising with the Acute sector to ensure lessons learned there from audits are applied in the CHP Managed hospitals.

Ronnie Hill noted how potential audits can result in a focus on what changes are required and he feels that in the longer term the possibility of unannounced visits will actually bring about improved standards.

Decisions

The Report was noted.
Older Peoples Mental Health Services

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

The paper sought agreement on a new model of care for East Lothian and Midlothian Mental Health Service for older people and also sought agreement to proposed nursing management arrangements for adult and older people’s community mental health services.

David Small noted the strategic background to the proposals, highlighting the issues of ageing population, the increased number of people with dementia, increased demand for services, the need to shift the balance of care to community services and the need to improve the physical environment for patient care.

The paper noted specific issues in relation to how the service would be delivered and what the specific impacts would be for sites where the service is currently delivered. The paper also set out the risks in relation to the proposals.

David Small noted the plans that had been put in place to provide patient and visitor transport to the Midlothian Community Hospital using Haddington as a hub.

Ann McCarthy noted that the transport solution needs to be refined to ensure that the bus to the Midlothian Community Hospital does not depart until connecting buses from other parts of East Lothian arrive in Haddington.

Ann McCarthy commented that she felt many of the findings referenced in the report did not fit with the conclusions or recommendations and questioned if the report accurately represented all of the detailed feedback that had been provided from patient group representatives.

Ann McCarthy noted there is expected to be a significant growth in the ageing population in East Lothian but a move to service delivery outside of East Lothian was being proposed and this did not seem logical.

Issues of potential increase on the length of stay in hospital, issues for carers and relatives visiting patients in hospital and the time / expense of such travel were raised by Ann McCarthy and Tony Segall.

Tony Segall noted that in the development of the model some changes have been made following feedback from Carers but Carers do not feel they have been sufficiently consulted and cannot as yet be convinced on the benefits of the proposed changes.

Carers are also concerned as to whether there will be sufficient capacity in Midlothian Community Hospital.

Tony Segall noted risks that exist in relation to patients with Challenging Behaviours, which will remain unless additional investment is made in that service. Part of that needs to be an investment in Carer support.
Tony Segall commented that he felt hospital discharge issues were not sufficiently detailed in the paper.

David Small commented that he felt there was a danger of creating a situation where these points created a bias in favour of the status quo and that is not acceptable due to the patient environment issues in East Lothian hospital sites. David Small said that he felt those responsible for Services had a duty to seek improvement in quality and safety and improvement of resources.

David Small noted that he did not feel there was any evidence to suggest that length of patient stay would increase as a consequence of the proposals and East Lothian’s length of stay was already lower than that required for reasonable occupancy of the ward at Midlothian Community Hospital.

David Small noted that he is confident there will be sufficient capacity and referenced the specific proposals for prioritising East Lothian patients within the ward at the Midlothian Community Hospital.

David Small noted that he is happy to arrange a meeting to discuss how the longer term support issues for Carers can be addressed.

David Small noted that he is committed to building in a system of continuous review as the changes are introduced to identify and address any specific issues that arise in as short a timeframe as possible. There have been a number of lessons learned about the consultation and involvement process both for NHS Lothian and East Lothian Council.

Cllr Paul McLennan noted that the review process needs to include looking at further integration of services.

Dr Graham Alexander noted that the proposed changes in relation to the Day Hospital will mean increased demand at the Day Centres and questioned if there was sufficient capacity. Murray Leys commented that the Day Centre funding will be reviewed and this will include the option of providing new Day Centres. Any short term gaps will be addressed by allocating funding from the Change Fund monies that are scheduled to be released.

Murray Leys noted that a key issue in the short term is to ensure that there is strong operational management support until longer term issues are addressed.

Cllr Paul McLennan noted that he feels this project may provide an example of how opportunities to consult with the PPF, Carers and other groups can be improved in future service change proposals.

Dr Graham Alexander noted concerns over whether groups of staff being given management and clinical responsibility would have the appropriate levels of knowledge and experience.
Liz Cregan noted that in other areas the structure proposed had been very successful but this issue will be included as part of the on-going review process to ensure that any risks or potential issues are addressed promptly. Liz Cregan and David Small noted that the staff in place have very strong levels of clinical skills and this has given the confidence to put forward the proposals.

**Decisions**

The Sub Committee supported the recommendations subject to there being a progress report tabled at the meeting of the CHP Sub Committee in December 2011 and on-going half yearly reports which will focus on any issues identified by the review process.

Ann McCarthy and Tony Segall noted their dissent to the decision to support the report recommendations.

47.6. **Quality and Outcomes Framework**

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

The report identified a very small deterioration in the level of performance achieved in some practices. The Chair noted that the report still reflected a very strong overall performance.

**Decisions**

The report was noted.

48. **General Managers Report**

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

**Delayed Discharges**

The September validated figure for East Lothian showed 10 East Lothian residents delayed with none breaching the national standard of over 6 weeks in post acute care and over 2 days in acute care. This represents an excellent performance.

The challenge in the future of having to achieve tighter timescales was noted. Ann McCarthy noted concerns that the focus on timescales may result in proper assessments of patients needs not being done.

**Capital Projects**

Musselburgh Primary Care Centre remains on track for completion in Spring 2012.

An update on the Gullane Medical Practice Building was not possible due to on-going work to review cost estimates received.
The first phase of moves of services from the Edenhall site to Herdmanflat site has been completed with the refurbishment of Garleton Unit at Herdmanflat to accommodate a single East Lothian day service for older people with mental health problems.

Work is progressing on the detailed development of plans for the extension to Tranent Health Centre.

It has been agreed that the CHP will be re-assessed for Investors in People accreditation on 5th and 6th December 2011. A lot of work has been done in preparation for the re-assessment.

Decisions

The report was noted.

48.2. 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 1st July to 30th September 2011 was 1.7% (annualised rate of 6.75%).

The sickness absence rate for September 2011 was 5.14% (2.7% long term absence and 2.44% short term). This is a change from the recent downward trend and renewed focus will be brought to this issue.

Decisions

The report was noted.

48.3. Finance Report

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

The CHP is reporting an overspend of £646k in the first 6 months of the year with £411k of this relating to Prescribing.

The Prescribing overspend is being driven by higher prices and volumes than had been estimated and a shortfall on LRP. A significant amount of work is being done across the system to identify efficiencies, but the prescribing overspend would require the Community Health Partnership to identify further efficiencies in order to breakeven.

David Small noted the initiatives being undertaken locally to address the prescribing issues that are within the control of the CHP. It was suggested that there may be an option to bundle together some of these initiatives to form a locally enhanced service initiative for GPs.

Decisions

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

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

The report noted,

- The overnight rota at Roodlands continues to work well

- The closure of the mortuary at Roodlands due to health and safety reasons and a critical internal audit report. This will create logistical problems for junior and senior Doctors in relation to cremation procedures. An interim arrangement has been made with a local undertaker until a longer term solution is identified.

- The resignation of Dr. Bindhu Abraham from her post of Intensive Home Therapy Team attached staff grade Doctor with effect from 11 November 2011.

- That the first General Practitioner meeting regarding the QIP (Quality, Innovation, and Productivity) QOF (Quality and outcomes Framework) had run extremely well and was well received.

- The Care Commission has again closed Drumhor Nursing Home to new admissions partly in response to concerns raised by a local GP. Adult Protection issues apply which are being addressed. CHP and East Lothian Council are working closely together to address the issues identified.

**Decisions**

The report was noted.

49.2. **Prescribing Budget Plan.**

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

**Decisions**

The report was noted.

50. **Chief Nurse Report**

50.1. 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**

There were 63 children recorded on the Child Protection Register in East Lothian as of 30th September 2011.
The Chid Protection Quality Assurance Sub Committee has developed the East Lothian draft multi-agency improvement plan. An East Lothian and Midlothian multi-disciplinary health group is progressing the required actions relating to health.

**Adult Protection**

Co-location of East Lothian and Midlothian Lead Officers for Child Protection and the administrative staff is planned for end October 2011.

The report provided updates in relation to the key issues for Community Nursing and the Community Mental Health Services.

**HAI**

A series of mock HEI Inspectorate audits at Herdmanflat Hospital have now been completed. Cleanliness issues identified are now being addressed. Nursing support and leadership has been increased to ensure improved cleanliness is maintained. Audits will continue to ensure improvements are sustained. Environmental issues which have been identified are being addressed by the CHP and estates.

**Decisions**

The report was noted.

### 51. AHP Manager’s Report

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

The report noted the creation of a new post for a period of 3 years for a Community Health and Activity Officer, funded by a Health Improvement Fund grant and by Long Term Conditions Funding.

The report provided an update on the East Lothian Physical Activity Referral Scheme noting the recruitment of a new, temporary, Community Health and Activity Officer post to provide a physical activity referral service for adults in East Lothian suffering from a variety of long term conditions.

The Chair asked how many patients would be targeted and what outcome measures would be put in place. Morag Barrow advised that it is hoped to target 400 patients a year. The measures are currently being defined and Morag Barrow will table these in due course.

Dr Graham Alexander noted that the referral pathway should be quite straightforward but advised that he felt it may be very difficult to demonstrate the effectiveness of the initiative.

If the project is successful any scaling up to accommodate more patients would be dependant on there being sufficient volunteers coming forward in the community.
Murray Leys noted that this work needs to be reflected in the Single Outcomes Agreement.

David Heaney noted that a similar exercise project which was piloted in a Sheltered Housing complex had been very successful.

Morag Barrow advised the meeting that the Telehealth Pulmonary Rehabilitation Team had won national e-health award.

Decisions

The report was noted.

52. Hosted Services

52.1. Lothian Unscheduled Care Service (LUCS) Annual Review

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

- progress in relation to the redesign of LUCS operational
- to update on the redesign of the associate clinical director role, including new medical management appointments
- to update on the implementation of ST1 medical training
- to update on progress in relation to LUCS management of overnight district nursing across NHS Lothian.

Dr Jane Hopton noted the excellent work of LUCS in what had been a challenging but very successful year and commented on the excellent support provided to LUCs by General Practitioners.

Underlying demand and activity continues on an upward trend despite a reduction from 2009-2010 when activity was exceptionally high as a consequence of the H1N1 pandemic. Analysis of activity shows that patients in the under 4s and over 75s age brackets account for a higher proportion of LUCS contacts than would be expected on a simple capitation basis.

Two NHS Lothian independent reviews have confirmed that LUCS costs compare favorably with other services across Scotland.

In this year, significant progress was made in relation to the development of nursing education and training. The re-design of LUCs operation and nurse management is continuing.

Management of the overnight nursing services for Edinburgh, East Lothian and Midlothian will transfer to LUCS from 1st November 2011. West Lothian will transfer from 1st March 2012.

Decisions

The report was noted.
52.2. **Health Promotion**

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

The purpose of this report is to update the Committee on the work of the NHS Lothian Health Promotion Service (HPS).

The report noted how the work of the Health Promotion Service is undertaken through four core functions in the strategy.

- Information and knowledge management
- Programme and project development
- Organisational and partnership development
- Capacity and capability building

Much of the work of the Health Promotion Service is progressed in partnership with other organisations.

The report noted initiatives in areas such as breastfeeding, reduction of exposure to second hand smoke for children, alcohol brief interventions, workplace health and older people.

The Chair noted that in comparison with other areas the numbers engaged at Workplaces for East Lothian appeared to be quite low. Ginnie Moreton noted that East Lothian tends to have a lower number of large scale employers.

It was noted the Chamber of Commerce and the Federation of Small Businesses may be able to help in increasing the level of contacts that the service can have with employers in East Lothian.

**Decisions**

The report was noted.

53. **Carers Forum**

53.1. A verbal update was provided to the meeting.

Tony Segall noted a concern that an NHS Lothian leaving hospital pamphlet only appears to be referencing a contact point for Carers organisations in Edinburgh.

It is possible that there is a version of the document that is specific for each CHP area and David Small will clarify this with the Corporate Communications team.

**Decisions**

David Small to progress via Corporate Communications and provide **DS** feedback to Tony Segall.
54. **Public Partnership Forum (PPF)**

54.1 The Sub Committee considered minutes of the PPF Meeting of 4th October which were circulated to the meeting.

A small pilot study had taken place in 2 care homes in East Lothian reviewing the number of medicines which patients were being prescribed to identify any medicines which may be in conflict with each other or medicines that are no longer benefiting the patient.

The medicine reviews are conducted by GPs and Pharmacists and there is full consultation with the Care Home and the patient or their representative with patient safety and quality of prescribing being the key issues.

The pilot had identified a significant number of medicines that no longer needed to be prescribed and so the pilot is being extended to other Care Homes and patients not in Care Homes who have similar conditions.

**Decisions**

The minutes were noted.

55. **Community Health Partnership Committee Appointments**

55.1. There was no business raised under the item.

56. **A.O.C.B.**

56.1. **Agenda Structure for Sub Committee**

A draft agenda for future meetings of the CHP Sub Committee was circulated in advance of the meeting.

It was agreed that this format of agenda will be adopted from the meeting scheduled for December 2012.

56.2. **Private Fostering**

Ronnie Hill noted issues in relation to private fostering arrangements. There is a legal requirement to notify local authorities of such arrangements so that assessments can be conducted. The number of such arrangements in East Lothian is statistically well below the national average which suggests there may be a hidden problem.

There is evidence that children who are part of such arrangements have more health issues than the general population of children and there may also be links to child trafficking.

Ronnie Hill noted a programme of publicity about the need to raise awareness of private fostering arrangements so that any cases the Council is not currently aware of can be identified. Ronnie Hill asked that he be informed of any appropriate communication routes that is appropriate to be included as part of the initiative.
57. **Date of next meeting**

It was agreed that the next meeting would take place on Wednesday 14\textsuperscript{th} December 2011 at 1.00pm. The Quay Complex Musselburgh
<table>
<thead>
<tr>
<th>Topic</th>
<th>Decision</th>
<th>Action</th>
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<tbody>
<tr>
<td>36.2. Clinical Director’s Report</td>
<td>QOF Outcome Framework</td>
<td>IM</td>
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<td></td>
<td>The Clinical Director noted that this process had been effective in generating a good debate and follow up actions.</td>
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<td></td>
<td>The review meetings referred to will be written up and the output will be brought to a future meeting of the CHP Sub Committee.</td>
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<td></td>
<td>GP Lead for Palliative Care</td>
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<td></td>
<td>Dr Hazel McCutcheon has been appointed to this role and will be invited to a meeting of the CHP Sub Committee in the second half of 2012 to provide an update on the key issues.</td>
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<tr>
<td></td>
<td>Clinical Director’s Report</td>
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<td></td>
<td>The Clinical Director will ensure that the report is circulated for tabling at Neighbourhood Partnership meetings.</td>
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<tr>
<td>36.5. Neighbourhood Partnerships</td>
<td>In the absence of any Councillor representation at the meeting it was agreed that Peter Gabbitas and David White will meet with Cllr Paul Edie to brief him on the issues raised in the paper as he has expressed very considerable interest in this subject in the past.</td>
<td>PG/DW</td>
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<tr>
<td>36.6. Prescribing</td>
<td>The Acting General Manager noted that there is a workstream to look at prescribing waste and that he will update on this at the next meeting of the CHP Sub Committee on 1st February 2012.</td>
<td>RA</td>
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34. Welcome/Introduction/ Declarations of Interest/ Apologies

There were no declarations of interest.

Apologies were noted as above.

34.1 Minutes of Previous Meeting held on 5th October 2011

Ella Simpson had been at the meeting and Peter Gabbits had submitted apologies. The minutes will be updated accordingly.

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

34.2 Matters Arising Not Covered on the Agenda

All business was covered via the agenda.
35. **Presentation**

35.1. **Teach Back**

The sub committee received a presentation from Kate Burton.

The presentation highlighted how evidence showed that patients remember and understand correctly about 25% of the information they are given at healthcare consultations.

The Teach Back technique involves patients explaining in their own words at the end of a medical consultation what their understanding is, of the instructions they have been given.

The presentation noted the evidence received to date on how effective Teach-Back can be in increasing patient understanding.

Peter Gabbitas asked how the technique is being rolled out. Kate Burton advised that at the moment it is on a 'use it if you want to use it' basis but the Service Re-design Committee meeting on 19th December may seek to introduce it more systematically.

The importance of ensuring appropriate communication with carers after medical consultations was also noted.

36. **Items for Discussion / Information**

36.1. **Chairman's Report**

The Chair provided a verbal update on the activities he had undertaken that were relevant to the CHP since the last meeting of the CHP Sub Committee.

These included.
- Turf cutting for the new Wester Hailes Healthy Living Centre
- The Chair will be relinquishing his role on the NHS Lothian Staff Governance Committee and will be taking on a new role on the Healthcare and Governance Risk Management Operational Group.
- Attended the NHS Lothian Board meeting at the end of November.
- The Chair will attend the next meeting of the Edinburgh Partnership Board and asked that any members of the CHP Sub Committee advise him of any issues they would like him to raise at that meeting.

**Decisions**

The update was noted.

36.2. **Clinical Director’s Report**

The Sub-Committee considered a report which had been circulated in advance of the meeting. The key issues noted related to

**Keepwell Project**

The project is now funded through to 2015. Reviews of patients previously screened will now be arranged to determine what outcomes the patients have
experienced from the initial consultation. The project will also be rolled out to all GP Practices in Edinburgh.

QOF Outcome Framework

The Clinical Director noted that this process had been effective in generating a good debate and follow up actions.

The review meetings referred to will be written up and the output will be brought to a future meeting of the CHP Sub Committee.

Scottish Government Returns on Blue Badge Schemes

The Clinical Director noted the changes to the rules and operational management of this scheme which will in the future be supported from the Astley Ainslie site. Applications will be screened by Occupational Therapists with effect from January 2012.

GP Lead for Palliative Care

Dr Hazel McCutcheon has been appointed to this role and will be invited to a meeting of the CHP Sub Committee in the second half of 2012 to provide an update on the key issues.

Lanfine Redesign project

The plans to re-design the service involving a change of focus from in-patient to out-patients was highlighted. There has been a large scale consultation process which identified considerable areas of consensus over the need for re-design and how future service provision should be shaped.

The next steps in the process will involve a paper being taken to both the Service Re-design Committee and the CHP Sub Committee in February 2012 with very detailed proposals.

In response to a question from Jim Kendall it was noted that if the service model is changed to focus more out-patients then there will be resource savings.

Peter Gabbitas noted that there may be a need for some capital investment in infrastructure but there will be revenue benefits. It was emphasised that the work was being driven by clinical requirements.

The Chair noted that he felt the physical infrastructure of the Lanfine Unit was not fit for purpose but the quality of treatment delivered by staff was of a very high standard.

Infection Control Audit.

The results of the recent Infection Control audits were noted.

Decisions

The report was noted.

The Clinical Director will ensure that the report is circulated for tabling at Neighbourhood Partnership meetings.
36.3. **Finance**

36.3.1. **Finance Report to 31st October 2011**

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

The CHP is reporting an overspend of £2.874m for the seven months to 31st October 2011. Prescribing accounts for £1.877m of the overspend and Hosted / Core Services £953k.

There is unmet LRP in the year to date of £498k.

**Decisions**

The report was noted.

36.3.2. **Mid Year Review**

A report was circulated to the meeting.

The key issues relating to the overspend position were noted. The main factor is in relation to Prescribing where there are pricing and volume issues as well as unmet LRP. The overspend element relating to prices will be supported centrally but the CHP will be required to identify solutions for the volume issue and the unmet LRP.

There is a potential year end pressure in Core services of £420k A detailed financial review has taken place to identify savings to achieve a break even position by the end of the financial year.

A detailed recovery plan has been developed and some elements of non recurrent support have been secured to help underpin the position.

The Chair asked how the CHP would be able to address the unmet LRP as there are just over 3 months of the financial year remaining. The Acting General Manager advised that the LRP component should be achievable but the drug volume related issues would be much more challenging.

Peter Gabbitas noted that the position is very challenging but he has committed to achieving the unmet LRP but he feels that the volume issues may need to be supported by non recurring monies as the underlying reasons are not yet evidenced and there is nothing to suggest that these are controllable by the CHP.

Peter Gabbitas noted that the month 7 position had been a surprise and that he initiated a process of meetings with Managers to identify how the projected budget overspend could be addressed.

Seb Fischer commented that the voluntary sector was very concerned that overspends on budgets would consequently mean there would be reductions in funding to the 3rd Sector. Seb noted this perception has been exacerbated by the fact the Voluntary Sector does not feel that the financial allocation processes are as transparent as they used to be.
Peter Gabbitas responded that there is no direct relationship between overspends on CHP or NHS Lothian Budgets and any funding decisions for the 3rd Sector.

The Chair noted that he felt within the CHP there was a good degree of transparency on budget management issued.

Decisions

The report was noted as was the objective of achieving a break even financial position with the exception of the overspend that was attributable to drug volume increases.

36.4. Health Inequalities

The Sub Committee received a verbal report from Margaret Douglas, highlighting the following points.

- The Health Inequalities Standing Group recommendations on funding applications for Health Inequalities. Margaret Douglas thanked all who had contributed to the process and advised that the final recommendations will be communicated in February 2012.

- Health Impact Assessment work in Edinburgh City centre.

- Work being done in relation to the Asset based approach to health.

- Paul Hambleton is now c-chairing the Health Inequalities Standing Group in succession to David Jack.

Decisions

The update was noted.

36.5. Neighbourhood Partnerships

The Sub-Committee considered a report which had been circulated in advance of the meeting and in addition a short presentation was made by David White.

The paper noted the variance in involvement for the CHP with Neighbourhood Partnership activity in relation to the level of deprivation / inequality experienced in certain areas of the city. The commitment by the CHP to support Neighbourhood Partnerships was noted.

The capacity developed by the CHP to support Neighbourhood Partnerships was noted.

The mainstreaming of funding for Neighbourhood Partnerships was noted.

The report emphasised the core function of the Edinburgh Partnership as tackling inequalities.

The ‘Total Place’ approach within Edinburgh was highlighted. Ella Simpson noted that this is about working with the strengths of the local community to
drive through solutions to the recognised problems.

The resource consequences for the CHP of their involvement with Neighbourhood Partnerships was noted.

Ella Simpson commented on the need to retain focus on what outcomes are required. Ella Simpson stressed that inequality created by poverty is now at a level that is defined and understood as ‘wicked’ – i.e. very strong and embedded.

The draft SLA for the Partnership Board has set out the vision of tackling health inequalities and Ella Simpson noted that the delivery of this vision will require strong leadership at all levels.

The presentation made by David White noted the following key points.

- ‘life wrecking’ problems such as unemployment, alcohol etc were highlighted and it was emphasised that a considerable number of people experience multiples of these ‘wreckers’, often simultaneously.
- The proportion of people who need different levels of support to deal with these ‘wreckers’ was noted.

The issues on which neighbourhood partnerships could provide support to address these issues was noted.

Jim Kendall asked what level of confidence could be taken from the numbers used in the report. David White noted that the level of unemployment was a key statistic and there is strong evidence that this drives some of the other numbers used in the framework. There is also some testing of the numbers to be carried out in Craigmillar.

Peter Gabbitas noted that some organisational changes within Edinburgh Council should help to focus resource on addressing the issues as part of the ‘whole system’ approach.

The Chair asked if there was likely to be any change to the structure of Neighbourhood Partnerships after the council elections. Peter Gabbitas noted that it was too early to form a view on this.

In the absence of any Councillor representation at the meeting it was agreed that Peter Gabbitas and David White will meet with Cllr Paul Edie to brief him on the issues raised in the paper as he has expressed very considerable interest in this subject in the past.

Decisions

The report was noted.

The very strong progress made by the CHP in supporting Neighbourhood Partnerships was noted.
Prescribing

The Sub Committee received a presentation from the Acting General Manager and the Clinical Director.

A potential overspend of £6 million across NHS Lothian for the year to 31st March 2012 was highlighted.

Edinburgh CHP expenditure growth for the year is 2.4% - the growth for Lothian is 3.45 and the national growth figure for Scotland is 1.5%.

Volume growth for Edinburgh is 4.2% - the volume growth for Lothian is 4.7% with the national figure for Scotland being 2.9%.

The cost per patient in Scotland for 2011 – 2012 is £187 but for Lothian it is £158.

In relation to the projected £6 million overspend, £3.7 million is related to pricing assumptions that have proven to be incorrect. £1.3 million is down to increased volumes and £1m is unmet Local Reinvestment Programme targets. CHPs are required to manage the latter 2 issues with the pricing being addressed centrally.

Details of the initiatives being taken forward to identify potential savings were highlighted.

The Clinical Director noted that given the relative efficiency of Lothian as a prescriber, all of the straightforward issues had been tackled to achieve savings and it is becoming more challenging to identify areas where savings can be made.

The increases in volumes are hard to explain – the introduction of a new IT system may have been a factor. It is felt from evidence in Wales that the introduction of free prescriptions may result in some increased volumes for a couple of years but the overall impact is not thought to be significant.

Issues of patient behaviour in dealing with repeat prescriptions may need to be addressed. This relates to patients asking for repeat prescriptions for items that they are no longer using. This led to a discussion on the need for medication reviews and how opportunities that can be taken at any consultation to review the medication being taken by patients. The work being done on Polypharmacy for patients aged over 75 was noted.

Seb Fischer noted that most of these issues are not localised but are national and therefore there is a need for escalation to the Scottish Government for ‘bigger picture’ initiatives to come up with solutions. The Acting General Manager noted that there is a workstream to look at prescribing waste and that he will update on this at the next meeting of the CHP Sub Committee on 1st February 2012.

The Clinical Director noted the need for caution in the overall approach as there is a danger that the desire to generate savings could result in negative impacts for some of the most vulnerable patient groups. Prescribing is demand led with both the UK and Scottish Governments being keen to open up more services and encourage contact – this in return leads to increased prescribing.
The issue of engagement with GPs on the subject was considered to be very important as GPs account for the vast majority of prescribing decisions. Seb Fischer asked if GPs and Pharmacists are incentivised to prescribe more drugs. The Clinical Director and Fiona McCready noted that there is no financial incentive for GPs or Pharmacists to increase levels of prescribing but neither is there any incentive to reduce it.

As GPs are not budget holders for prescribing it is acknowledged that it is difficult to engage them in any discussion which appears to have a reduction in expenditure as the only objective. An option may be to look at how GPs can be given responsibility for a part of the prescribing budget and then the accountability factor may become helpful in reducing costs.

Jim Kendall noted that the culture always seems to drive discussions that are focused on giving financial incentives to GPs to take action and he feels that is neither appropriate nor what the public would expect to hear.

The disconnects between the responsibility for budget overspends and future allocation of budget was noted as being another big picture issue that needs to be addressed.

Decisions

The paper was noted and the challenges facing the CHP were recognised.

36.7 Achieving Sustainable Quality in Scotland’s Healthcare

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

The actions required on the part of the CHPs were noted by the Acting General Manager.

Decisions

The report was noted.

36.8 Rehab Bed Efficiencies

The Sub-Committee considered a report which had been circulated in advance of the meeting which noted proposals and potential options for bed efficiencies in the Rehabilitation Centre.

The paper detailed the drivers for the bed efficiencies including as examples the need to shift the balance of care, premises issues and cost efficiency savings requirements.

The paper noted the options for bed reductions noting dependencies on capital investment in facilities at the Astley Ainslie and future plans for the use of various sites including the Astley Ainslie, Liberton Hospital and the Royal Victoria Hospital.

The paper provided outline estimates of the potential costs savings for the options under consideration.
The consultation process including discussions at PPF meetings were highlighted.

Within the paper it was noted that Option 1 was the preferred option.

Jim Brown asked if the reduced number of beds would be sufficient support future demand. The Acting General Manager advised that there was good data on bed occupancy and a lot of work had been done on how treatments could be delivered in community settings. Work has also been done to consider the resource capacity requirements in the community. It was also noted that perhaps there has historically been a culture that was too risk averse in relation to the discharge of patients from hospital to the community.

Jim Kendall asked if there had been any consultation with existing users of the service and it was confirmed that a lot of very good work had been with existing patients. This had been used to inform the process.

Jim Kendall asked if the money was going to be spent in the right way and whether further investment in the existing service might be a more appropriate approach. The Acting General Manager noted that the next version of the paper will highlight why that option had been considered, but discounted.

It was noted that this approach also fits with the strategy in relation to capital investment for the Royal Edinburgh Hospital.

Decisions

The paper was noted and agreed subject to the capital funding issues which the Acting General Manager will progress.

The potential savings from this work were noted.

37. Items for Decision Making
38. Items for Review
38.1. 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.

38.2 Minutes from other Groups
38.2.1. Edinburgh CHP Performance Management Sub-Group – 21st September and 19th October 2011 - Copies of the minutes were circulated to members and noted.
38.2.2. Primary and Community Services – Healthcare and Governance Risk Management Operational Group. 13th September 2011
38.2.3. Edinburgh Alcohol and Drugs Partnership 17th August 2011 A copy of the minutes was circulated to members and noted.
38.2.4. Primary Care Joint Management Group 8th September and 13th October 2011 - A copy of the minutes was circulated to members and noted.

38.2.5. Primary Care Forward Group – 26th July and 4th October 2011. A copy of the minutes was circulated to members and noted.

It was noted that a possible grievance issue from GPs is being raised in relation to the application of LRP on the GMS budget. It is not clear what the formal route for this issue will be.

38.2.6. Edinburgh CHP Partnership Forum of 27th September 2011. A copy of the minutes was circulated to members and noted.

38.2.7. North Edinburgh PPF – 28th September 2011 - A copy of the minutes was circulated to members and noted.

38.2.8. South Edinburgh PPF – 29th September 2011. -A copy of the minutes was circulated to members and noted.

38.3. **LHP Reports**

There was no business raised under this item

39. **Questions from Members of the Public in Attendance**

39.1. There were no questions raised.

40. **Any Other Competent Business**

40.1. There was no other business.

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

41.21 The next meeting of the Edinburgh CHP Sub-Committee is scheduled for Wednesday 1st February 2012 at NHS Lothian, Waverley Gate, Edinburgh.
Note of the meeting of the Midlothian Community Health Partnership Sub-Committee (Public Session) held on Thursday, 24\textsuperscript{th} November 2011 at 2pm in The Midlothian Council Offices, Dalkeith.

Present: Eddie Egan, Chairman  
David Small, General Manager, Midlothian CHP  
Dr Jane Hopton, Asst General Manager, Midlothian CHP  
Councillor Jackie Aitchison, Midlothian Council Representative  
Liz Cregan, Chief Nurse, Midlothian CHP  
Tom Welsh, Midlothian Council  
George Wilson, Voluntary Sector Representative  
Andrew Duffy, Pharmacy Representative  
Julie Gardner, Carers Representative  
Mhairi Simpson, Health Promotions (for Mandy MacKinnon)  
Lynne Hollis Associate Director of Finance  
Morag Barrow AHP Manager  
Vivienne Baird, PPF Representative  
Sue Edmond, PPF Representative  
Dr Hamish Reid, Acting Clinical Director Midlothian CHP

Apologies: Thomas Miller, Unison Representative  
Michael Pearson, Director of Operations, UHD

In Attendance: John Skouse, Midlothian Council, Minute Item 40.1  
Eibhlin McHugh, Midlothian Council, Minute Item 40.1  
Clare Glen, Health Promotions, Minute Item 47.2  
Drew McErlean – Minutes

40. Apologies and Welcome

Apologies were noted as above.

40.1. Midlothian Older Peoples Strategy

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

John Skouse and Eibhlin McHugh of Midlothian Council attended the meeting to note the key issues from the report.

The Midlothian Joint Older People’s strategy 2011 – 2015 is being launched on 25\textsuperscript{th} November 2011.

The paper outlined the key demographic issues underpinning the strategy. The risk of failing to ensure the financial sustainability of the strategy was noted.

John Skouse commented on the positive feedback that had been received during the consultation process.

The growing importance of co-production in delivering services was noted.
David Small noted how this strategy compliments other strategies and commented that joint commissioning is key to help ensure cost efficiencies.

The Chair noted that he felt joint commissioning is the correct direction of travel but noted there are different governance requirements for Health and Local Authorities. David Small advised that there will be on-going discussions to ensure a practical solution that meets all governance requirements can be established.

Eibhlin McHugh noted that future provision needs to be focused within ‘care at home’ as much as possible using new telecare / telhealth opportunities.

In response to a question from the Chair, it was confirmed by John Skouse that the strategy is a good fit with what is planned in East Lothian as both councils are progressing in line with national government policy.

John Skouse noted that the strategy will specifically address the issues of respite care as this is a very significant issue. Eibhlin McHugh noted that more respite beds will be available and bottlenecks have been addressed.

Decisions

The report was approved.

David Small will provide updates to future meetings of the CHP Sub Committee in 2012.

41. Minutes of the Previous Meeting held 29th September 2011

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

42. Matters Arising / Action Plan

All matters were covered via the agenda. The Action Plan will be updated to note the progress / actions completed.

42.1. Healthcare Environment Inspections Report

A paper was circulated to the meeting.

Liz Cregan noted the background to the inspections carried out by the Healthcare Environment Inspectorate and noted that a series of mock audits have been carried out.

The Midlothian Community Hospital meets the requirements of the HEI standards.

Significant issues had been identified during the mock inspections at Community Hospital sites in East Lothian.

The Chair noted that he felt decisions on investment in existing buildings should be considered carefully against plans for a new East Lothian Community Hospital.
Decisions

The report was noted and the cost and risk of non compliance issues were recognised.

42.2 Telecare and Falls

A report was circulated to the meeting.

Tom Welsh noted the work which had been done between the NHS and Midlothian Council to establish the Rapid Response service as the single point of contact for all falls in Midlothian by June 2012.

Morag Barrow noted this is a very good example of joint working and is a major step in the right direction.

Morag Barrow referenced the project in Care Homes to address falls which had to date seen a drop of approximately 37% of falls. A formal report will be tabled at a future meeting of the CHP Sub Committee when the data has been verified.

Decisions

The Chair thanked those involved for the work completed in such a short space of time.

The report was noted. An update will be provided on progress towards the June 2012 target at a future meeting of the CHP Sub Committee. MB/TW

42.3. Dementia Demonstrator

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

The report set out the background of the Midlothian Dementia Demonstrator Site project work that began in April 2011 noting the service mapping that had taken place and what had been done to raise awareness of dementia issues across Midlothian. The project will run for the next 12 – 15 months.

The key aspects of the service re-design were noted and the work to be done by Queen Margaret University to add qualitative feedback to the quantitative analysis was noted.

Hamish Reid noted the need for further GP involvement in the project and will attempt to identify a suitable candidate who can take the work forward.

The Chair noted the importance of addressing dementia in people who have Down's Syndrome as they are likely to show signs at an earlier age.

David Small noted that there are links in place with Acute Division on work they are doing on the issue of Dementia.

Decisions

The recommendations in the paper were noted.
42.4 Implications for CHP OF Caring Together Carers Strategy for Scotland

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

The report set out the implications of the National Strategy for Carers for the delivery of local health services and recommended that the Midlothian Caring Together Action Plan be tabled at a future meeting of the Sub Committee.

Julie Gardener noted that 'Carers as equal partners' is a critical message.

The creation of the post of Carer Support Worker was noted and the role of a Young Carers worker is being taken forward.

A possible Carers Representative for the CHP Sub Committee has been identified and will attend the next meeting in January.

David Small asked how the audit referred to in section 2.3 of the report would be conducted. Julie Gardiner noted that questionnaires will be used and that the support of the CHPs to get this done will be very important.

The Chair noted the need for training opportunities for Carers at times that are suitable for them.

Decisions

The paper was noted and the recommendations were supported.

42.5 Achieving Sustainable Quality in Scotland’s Healthcare

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

David Small noted the key issues that are relevant to the CHPs with critical aspects being the development of a shared understanding of the challenges for patients and staff and closer integration of services.

David Small noted that the recent issues arising from the proposed re-provision of the Loanhead Podiatry clinic are an example of the sort of challenges that require close consultation and communication where quality and safety had to be balanced against geographic location of services. Sue Edmond noted that a lot of lessons can be learned from that case and noted that some views expressed publicly were not those formally adopted by the Midlothian PPF.

The Chair noted that the NHS Lothian Communications Department must consider how key issues and decisions are communicated.

Tom Welsh and Morag Barrow noted that the felt the paper reflected very much how things are currently done in practice.

The Chair noted that he felt the paper needed to make more reference to Social Care issues.
The Chair also noted that he felt there was a need to begin Health Promotion education in Schools so that young people develop an understanding of the key health issues at an early stage.

Dr Hamish Reid noted the need to manage expectations with the general public about what level of service could be provided in the future.

David Small suggested that the document be tabled at PPF meetings to get feedback and that it also needs to be aired within Council Planning structures. Sue Edmond commented that the issues in this paper could help to facilitate a discussion on budget and finance issues.

Tom Welsh felt that the paper provided an opportunity for wider engagement with the public.

Decisions

The paper was noted.

42.6. Payment Verification Paper

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

The paper outlined the process in place for ensuring that appropriate controls measures are in place for payments made to family health service practitioners (GPs, Dentists, Pharmacists and Optometrists).

It was noted that a similar report is being taken to the Operational Audit Sub Committee.

David Small noted that there were no major issues for Midlothian CHP.

The Chair noted the work being done across Lothian to recover what were in some instances, some quite significant sums of money.

Lynne Hollis noted that CHPs will become more engaged in overseeing the activities of independent contractors and a paper will be tabled at a future meeting of the CHP explaining how this will happen.

Andrew Duffy noted that the automation of the claim and payment process for Community Pharmacists should significantly reduce the opportunities for fraud.

Decisions

The report was noted.

42.7 PMS Expenditure by Community Health Partnership

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

Lynne Hollis noted that the Lothian budget was overspent by approximately £70k as at 30th September 2011. The main factor in this was the payment of ‘golden hello’s to GP Practices.
It was noted that premises costs per head in Midlothian are significantly higher than the Lothian average.

David Small noted that he would like to see movements in population changes reflected in future reports so that any changes to funding can be mapped.

The Chair asked if funding was moved to pay for complex care packages that are now supported and paid for in the community rather than a residential stay setting. Lynne Hollis noted that work was underway to ensure that this process operated effectively and efficiently.

David Small noted that there are a number of Services currently provided in hospitals which could be done in a Primary Care setting and some strategic work needs to be done to ensure that funding is moved from Secondary Care to Primary Care to follow the delivery of the work.

Decisions

The report was noted.

42.8 **Payment Matrix in Primary Care**

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

The paper detailed the background to the process of making payments to independent practitioners though Practitioner Services Division, a part of NHS Scotland.

A more detailed technical paper with specific details for Midlothian will be tabled at a future meeting of the CHP Sub Committee.

Decisions

The report was noted.

42.9. **Quality and Outcomes Framework**

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

Dr Hamish Reid noted the key issues emphasising that the overall scores were very high and that the paper demonstrates a very strong performance by GPs in helping to control chronic diseases.

Decisions

The report was noted and the very strong results for Midlothian GPs were recognised.
43. **General Manager’s Report**

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

**Delayed Discharges**

The validated October census showed 5 Midlothian patients with none in short stay beds and no patients over 6 weeks in post acute beds.

Cllr Jackie Aitchison noted the work being done to address the 3 of long delays in Learning Disability Services.

**Capital Projects**

Dalkeith Health Centre opened on 26th September 2011.

**Investors in People**

Reassessment is scheduled to take place on 5th, 6th and 7th December 2011.

**Older Peoples Mental Health Strategy**

The changes implemented as a consequence of the agreement of the strategy were noted.

**General**

It was noted that on 30th November in response to the National strikes a Sunday service will be operational – e.g. at Midlothian Community Hospital and in the District Nursing service.

It was noted that all General Practices will offer at least an emergency service but many will be providing more than this. It was noted that public awareness of what services are available needs to be promoted.

**Winter Planning**

Cllr Jackie Aitchison noted that work was being done to address any snow clearing requirements over the winter period. This will be focused on key priority areas and the details will be included in local publications.

**Homeopathy**

David Small referenced previous discussions on this issue and noted that the review will be recommenced and will cover all Homeopathy Services in Lothian. It will be chaired by a Consultant in Public Medicine. David Small will identify appropriate members of the review group and the reports from that group will be tabled at future meetings of the CHP Sub Committee.

**Decisions**

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

The sickness absence rate for October 2011 was 3.86%.

**Decisions**

The report was noted.

43.3. **Finance Report to 31st October 2011**

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

Midlothian CHP is reporting a net overspend of £664k of which £416k relates to Prescribing. The non prescribing element relates mainly to unmet LRP. £241k is an overspend in HCH services.

Management actions have been identified to address the shortfall in LRP on a non recurring basis and to ensure that the CHP achieves a break even position at the end of the financial year.

Lynne Hollis noted the actions being taken to address the overspend on Prescribing which across Lothian is still projected to be £6.1 million for the full year. The volume growth issues are being closely analysed. The work being done locally and nationally to look at prescribing issues and set the budget for 2012 – 2013 was noted.

The interface between Primary and Secondary Care on Prescribing issues is an area of focus for potential efficiencies.

Dr Hamish Reid noted that NHS Lothian is still a very low cost prescriber in national terms. Lynne Hollis noted that the budget setting process and the details of the allocated budget had been agreed by the CHPs.

The Chair noted concerns at legal and governance issues that prevent opportunities to re-cycle un-used medicines and he plans to continue to challenge this.

**Decisions**

The report was noted.

44. **Clinical Director Report**

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

The paper provided updates in relation to Care of the Elderly Mental Health Services, Child Adult Mental Health Services, the re-design of the ADHD service and winter planning with specific reference to the importance of maintaining the lab van service which had been adversely impacted during the previous winter.
It was agreed there needs to be appropriate communication between the Community Health Partnership and Midlothian Council in periods of bad weather to ensure coordinated action is implemented as quickly and cost effectively as possible.

Decisions

The report was noted.

44.2. 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 August 2011.

Decisions

The report was noted.

45. Chief Nurse Report

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

Child Protection

There were 63 children recorded on the Child Protection Register as of 30th September 2011.

The draft Edinburgh and Lothian Interagency Child Protection Procedures 2011 are now out for consultation. The end date for the consultation is 29th November 2011.

Adult Protection

The report noted a steady increase in Adult Protection activity in line with growing awareness of Adult Protection legislation.

The Public Protection Office is now operating from Croft Street in Dalkeith.

Community Nursing

The report referenced School Nursing Service Redesign, Modernisation of Community Nursing and the rollout of the Community TRAK nursing system.

Healthcare Associated Infections

There had been no instances of CDiff or SAB in Hospital Services and two instances of Clostridium Difficile in the period from 1st June – 31st August 2011 within Mid Lothian Community services.

The improved performance in relation to hand hygiene audits was noted.
Decisions

The report was noted.

46. **AHP Manager Report**

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

The report provided updates in relation to the Midlothian Active Choices programme which has now secured funding for the next 2 years.

The report provide details of the ‘Just being there’ – Red Cross Buddy Service which is being funded via the Transformation fund for the next 12 months and will be formally launched on 25th November 2012. It was noted that vetting / disclosure checks on volunteers is covered via the Red Cross governance processes.

It was noted that the AHP Team had recently been nominated for 4 national awards.

Decisions

The report was noted.

47. **Hosted Services**

47.1. **Learning Disability Services**

The Sub-Committee considered a report which had been circulated in advance of the meeting which was the Performance, Clinical Governance and Risk Management Report.

The paper noted there are 3 patients who are recorded as having delayed discharges and the work being done to place Midlothian residents in a new service.

The Learning Disability Service continues to comply with the 18 week referral to treatment target.

The Learning Disability service reported a breakeven financial position at the end of October 2011.

Approval has been given in principle to the redevelopment of one wing of the Greenbank Centre into an Intensive Care Unit.

It was noted that an interim investment has been made in the Learning Disability Service until such time as the level of funding from the Learning Disability Strategy is confirmed.

The Chair noted that following agreement at the last Sub Committee an interim investment plan for nursing has been agreed.

Decisions

The report was noted.
47.2. Health Promotion Service

The Sub-Committee considered a report which had been circulated in advance of the meeting on the subject of the Midlothian Sexual Health and HIV Workplan for 2012 – 2013. Clare Glen attended the meeting to note the key issues.

The four high level impacts for the next five years are –

1. There is reduced harm from sexual ill health and HIV
2. People with HIV live long and healthy lives
3. There are fewer unintended pregnancies
4. People make confident and competent decisions about sex

The report noted the work of the Midlothian Sexual Health and HIV Group in driving forward local actions.

Dr Hamish Reid noted the very good work that had been done to reduce the level of teenage pregnancies but work still needs to be done to educate young people to develop the confidence to discuss sexual health issues with their GPs.

It was noted that there are seven ‘C-card’ points in Midlothian but the Health Promotions Service would like to gain support for the introduction of more points. The requirements for hosting of such a service point were noted.

The Chair commented on the important role played by outreach services and noted that opportunities to provide more of these services need to be identified in the areas of Midlothian not currently supported with such a service.

Liz Cregan detailed the ‘Healthy Respect Clinics’ used within schools in East Lothian and suggested this approach could also be beneficial in Midlothian. Liz Cregan and Claire Glen will liaise on this.

Clare Glen noted that Community Pharmacies could play an important role in providing contraception advice.

George Wilson noted that if the MYPAS service was extended to East Lothian this may provide an opportunity to obtain an increased level of funding. David Small advised that he has had some initial discussions about this.

Decisions

The update was noted.

48. Carers Forum

The minutes of a meeting held on 25th October 2011 had been circulated in advance of the meeting and were considered by the Sub Committee.

The presentation made by Andrew Jackson on How we treat people’ had been very positively received.
Potential interest in the opportunity to represent Carers on the CHP Sub Committee was noted. The Chair advised it would be acceptable to have a pool of named representatives from which the attendees at each meeting could be chosen.

Decisions
The update was noted.

49. **Public Partnership Forum**

The minutes of a meeting held on 22nd September 2011 had been circulated in advance of the meeting and were considered by the Sub Committee.

The following issues were raised verbally.

The PPF have asked that their issues on patient transport be considered at the January 2012 meeting of the CHP Sub Committee and also be considered by the NHS Lothian Transport and Access Committee.

The PPF plan to have a meeting in January on the subject of Our Health our Future.

The work being done in relation to Neighbourhood Planning was noted.

The PPF asked that in future they be provided with advance copies of papers 10 days in advance of the CHP Sub Committee meeting dates. David Small will consider this and report back.

Sue Edmond has been elected Chair of the CHP.

It was noted that the previous Chair, Billy Peacock was currently in Hospital and the Chair asked that the best wishes of the CHP Sub Committee be sent to Billy.

Decisions
The update was noted.

50. **A.O.C.B.**

50.1 **Agenda Structure for Sub Committee**

A proposed change of format to the agenda for future meetings had been circulated in advance of the meeting.

It was agreed that the following agenda items would be added.

- Issues from Midlothian Council
- Joint Health Improvements

The new format will be adopted with effect from the meeting scheduled for January 2012.
51. **Date and Time of Next Meeting**

Thursday 26\textsuperscript{th} January 2012 \textat\ 14.00 in the Council Chambers, Buccleuch Street, Dalkeith
DRAFT

Minutes of the West Lothian Sub Committee held on the 13th October 2011 at 2 – 4pm in Room 1 Fauldhouse Partnership Centre, Fauldhouse

Present
Ellen Glass (EG) Councillor West Lothian Council (from item 16)
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
Theresa Douglas (TD) Chair, West Lothian CHCP
Sandra Mair (SM) Director of Operations
Jim Forrest (JF) Director, West Lothian CHCP
Jim Gallagher (JG) Chief Executive VSGWL
Gill Cottrell (GC) Chief Nurse
Julie Cassidy (JC) Public Involvement Coordinator
George Mackie (GM) GP East Calder
Alan Bell (AB) Senior Manager, Communities & Information
Bill Muir (BM) Lothian and Border Police Representative – Deputy
Phyllis Wood (PW) Education Officer – Deputy
Ann Marie Carr (AMC) CSM Housing – Deputy

Apologies
Marion Christie (MC) Head of Health
Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
Jane Houston (JH) Partnership Rep, West Lothian CHCP
Lindsay Seywright (LS) Assistant Principal West Lothian College
Claire Kenwood (CK) Lead for Mental Health
Moira Niven (MN) Deputy Chief Executive WLC
Caroline Wells (CW) Community Pharmacist, SJH
John Richardson (JR) Public Involvement Representative
James McCallum (JMc) Clinical Director
Ann Gee (AG) Head of Housing and Building
Karen Cavte (KC) Community Planning Manager, WLC
Lorraine Gillies (LG) Life Stages Manager
Stewart Murdoch (SM) Scottish Ambulance Service

In Attendance
Marjory Simpson (MS) Administrative Manager
Paul Currie (PC) Strategic Programme Manager
Marsha Scott (MS) TADP West Lothian Council

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**
The chair met with James Glover from Equality and Diversity prior to the meeting to review the work being carried out on impact assessments detailed on the submitted papers. During the meeting the chair fed back comments on work required in this area and good practice regarding impact assessments on the individual reports.

4. **DECLARATION OF INTEREST**
There were no declarations of interest.

5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**
The minutes of the previous meeting held on the 01/09/11 were approved as an accurate record.

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**
There were no minutes from the WLPPFHC.

9. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**
The PCJMG minutes 12/05/11 and 09/06/11 were considered.
Work is currently being carried out regarding the use of premier rate telephone numbers by GP practices.

10. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP**
The CFMG minutes 11/08/11 were noted.
JS informed the committee that the multi-agency induction day for new staff will continue to be held as this was felt to be an informative day for all staff members.
JK commented on the HIF fund approval by the Oversight group.

11. **MINUTES OF CHCP COMMUNICATION GROUP**
The minutes of the communication group meeting 10/08/11 were noted.
The next edition of West Life is in progress. The communication group is considering a change to the current footnote on e-mails which currently relates to smoking cessation proposing to change the clinical or service area being referred to on a quarterly basis.

12. **THEMED AGENDA – EARLY YEARS AND SCHOOL AGES- MINUTES**
JK talked to the paper informing the Sub Committee of the progress of the Early Years sub-group of the Children and Families Management Group towards meeting the outcomes in relation to the life stages.

The Early Years sub group of the Children and Families Management Group (EY CFMG) has strategic oversight of the planning and development of services and interventions for children 0 – 5 (and in some cases up to the age of 8) across West Lothian.
Five different areas are detailed in the report, aligning policy and strategy, community engagement and engagement with stakeholders, outcome indicators, funding early intervention and service redesign.

The outcome indicators use the Getting It Right For Every Child (GIRFEC) outcome categories incorporating the acronym SHANARRI Safe, Health and Active, Nurtured, Respected and Responsible and Included. They contribute to the Single Outcome Agreement (SOA) outcomes and are generally influenced by more than one service or intervention.

All service areas are systematically reviewing contracts and measuring performance to ensure they are effective. A robust action plan is being followed with the next steps involving a small working group to evaluate the work being carried out.

TD asked what the timescales were for the measurements to be carried out. JK stated that HIF was actively developing measurements and timescales with further guidance possibly coming from the EY change fund.

An issue was also raised regarding the perceived lack of opportunities to influence within the NHS regarding maternity services. There is currently no opportunity for input from the EY.

Awareness of the Life Stages was discussed.

13. STRATHBROCK BUNGALOW
JS talked to the paper informing the Sub Committee of the award of the contract for the delivery of short Break Care and Management Services for Children and Young Adults at Strathbrock Bungalow and to make members aware of the limits and possibilities of this resource. The members were asked to comment and discuss the opportunities for future development.

This resource will avoid families using resources outwith West Lothian avoiding additional transport costs.

The future development of this resource envisages that the ability to provide families coping with the demands of a disabled child with regular short breaks within West Lothian would help maintain the child at the family home. This would result in a reduction in high cost residential packages later on in the child’s life.

The Care Inspectorate visited the premises on the 11th October with no issues being raised.

JS offered to circulate additional updated information if requested by members.

BUSINESS AGENDA - MINUTES

14. SUICIDE PREVENTION
JK talked to the paper to inform the members of the activities and progress of Choose Life West Lothian as outlined in its annual report for 2011.

There were 781 suicides in Scotland in 2010 with 19 in west Lothian. The numbers are small but fluctuate from year to year and are therefore reported on a 3 year rolling period.
The national HEAT H5 target is to reduce the suicide rate between 2002 and 2013 by 20%. To ensure this target is met 50% of frontline key staff in mental health and substance misuse services, primary care and accident and emergency units are trained in suicide assessment tool/suicide prevention training programmes by 2010. This training programme target has been achieved.

The training programme is also being rolled out to separate streams of staff in multi disciplinary areas, and in partnership with police and teachers.

ISD currently report suicide figures on an annual basis that is broken down in to different regions

MS asked if there was any data collected regarding attempted suicides. At present this data is difficult to collect.

The Sub Committee support the continuation of this work.

15. **HOMELESSNESS REPORT UPDATE**

AMC talked to this paper giving an update on Health and Homelessness through the progress of the Homeless Strategy and Health & Homeless Action Plan.

The main target as a partnership duty is to except everyone who prevents unintentionally homeless, with the key objective to prevent homelessness in the first place.

Areas of progress include the introduction of a hospital homelessness discharge protocol, complete range of interventions and a holistic approach to preventing homelessness from happening in the first place.

The Homelessness team are working in close partnership with The Moving into Health team (MIH) and ongoing work is being carried out with the Tobacco, Alcohol and Drugs team supporting clients.

A recent inspection has been conducted by the Care Inspectorate.

There is currently a partnership approach with Addiewell Prison and from the 1/11/11 health care services in prisons will be provided by NHS.

AHP Manager (SW) to send information on the Working Health Services to AMC

16. **DQPC ACTION PLAN UPDATE**

PC talked to this paper informing the Sub Committee of progress with completions of the NHS Lothian Delivering Quality in Primary Care (DQPC) reporting template.

The action plan sets out a 5 year strategic vision for primary care in Scotland. Care will be increasingly integrated, provided in a joined up way to meet the needs of the whole person,  empowering the people of Scotland in the management of their care, care will be clinically effective and safe, delivered in the most appropriate way, within clear agreed pathways and primary care will play a full part in helping the healthcare system as a whole make the best use of scarce public resources.
The progress so far reports 12% complete 56% on track, a number not started or no data available.

Comments were made regarding the lack of information and input from pharmacy, dental and ophthalmology and require to be more focussed on the wider primary care team. There is also lack of evidence from patient representation.

A discussion took place regarding the work being carried out around care homes, with a care home review contract in place. AB gave a brief update on the progress of the change fund.

The chair highlighted concerns regarding the lack of information around risks, governance issues the PCPC no longer exists and the identification on how this was going to be driven forward. There is a requirement for CHP/CH(C)P representation and involvement from the public through the PPF.

The Sub committee accept the recommendations and are happy to contribute in the future and look forward to receiving future updates.

17. WEST LOTHIAN PARTNERSHIP FORUM FOR HEALTH AND CARE -
JC talked to the paper giving an update on the progress of the PPF HC 2010-12 Action Plan stating that the current action plan was coming to an end.
The majority of actions have been achieved but a number are on going.

The development of the new action plan is required to be aligned with the CHCP workplan. GC to take this forward.

18. HEALTHY WEIGHT PROJECT UPDATE
This paper was not considered by the sub committee due to its late submission, resulting in members being unable to read and prepare questions prior to the meeting. The paper will now be carried forward to the meeting held on the 23rd November.

19. ANY OTHER COMPETENT BUSINESS
No other business was discussed.

20. DATES AND VENUES OF FUTURE MEETINGS 2011
Meeting dates for 2011

24th November 2011 Bathgate Partnership Centre 2 – 4pm

The meeting closed at 4pm
DRAFT

Minutes of the West Lothian Sub Committee held on the 24th November 2011 at 2 – 4pm in Bathgate Partnership Centre, Bathgate.

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&E/Health Improvement
Theresa Douglas(TD) Chair, West Lothian CHCP
Jim Forrest (JF) Director, West Lothian CHCP
Julie Cassidy (JC) Public Involvement Coordinator
George Mackie (GM) GP East Calder
Phyllis Wood (PW) Education Officer
Marion Christie (MC) Head of Health
Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
Lindsay Seywright (LS) Assistant Principal West Lothian College
Caroline Wells (CW) Community Pharmacist, SJH
John Richardson (JR) Public Involvement Representative
James McCallum(JMc) Clinical Director
Ann Gee (AG) Head of Housing and Building
Lorraine Gillies (LG) Life Stages Manager
Stewart Murdoch (SM) Scottish Ambulance Service
Jocelyn O’Conner (JO) Lothian and Border Police Representative
Elizabeth Preston (EP) Associate Director of Operations
Sarah Sinclair (SS) Head of PFPI
Raj Rashid (RR) Programme Lead T4H

Apologies

Jane Houston (JH) Partnership Rep, West Lothian CHCP
Claire Kenwood (CK) Lead for Mental Health
Moira Niven (MN) Education
Karen Cawte (KC) Community Planning Manager, WLC
Jim Gallagher (JG) Chief Executive VSGWL
Gill Cottrell (GC) Chief Nurse
Alan Bell (AB) Senior Manager, Communities & Information
Sandra Mair (SM) Director of Operation

In Attendance

Marjory Simpson (MS) Administrative Manager

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**

   JO would like to raise an item under AOCB

4. **DECLARATION OF INTEREST**

   There were no declarations of interest.

5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**

   The minutes of the previous meeting held on the 13/10/11 were approved as an accurate record

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 minutes of the WLPPFHC on the 25th August were noted

9. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**

   The PCJMG minutes 08/09/11 and 13/10/11 were considered.
   There was a concern raised regarding the opening of only 2 pharmacies on Christmas day. There is however no obligation for pharmacies to open and this was the cover which operated last year.

98.1 **Questionnaire around care homes,**

   This covers the whole of Lothian.

106.2 **40/63 PCJMG Remit**

   The remit of this group had been discussed and the chair indicated that she would like the chairs of the CHP’s/CHCP to have an input to that in light of the demise of PCPC and to ensure complete incorporation of that committees area. MC will take this to the group and report back.

114.4 **Industrial Action**

   A discussion took place regarding the services which will be operating on the 30th Nov. JMc confirmed GP surgeries will be open. Oncology services will be operating as normal. Other professional services will be operating a Sunday service. There will be no radiology or lab van services. West Lothian schools apart from private public partnership (PPP) schools will be closed.

10. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP**

    There were no minutes available for the meeting
11. MINUTES OF CHCP COMMUNICATION GROUP

There were no minutes available for the meeting

12. NHS LOTHIAN CLINICAL STRATEGY

AJ talked to the presentation recommending the Sub Committee note the content of the paper and the key drivers for change. The clinical strategy will look at all the aspects of the NHS Lothian business but will also look at the work that it does jointly with local authority partners in the delivery of care. Seven key themes have been identified as a starting point for developing new models of care based on partnership working.

JK highlighted the work undertaken by the Community Planning Partnership and the strong mechanisms already in place. She indicated that the NHS Lothian Strategy would benefit from establishing links with these.

It was also noted that involvement is required from West Lothian Carers, Council Officers and HCPPF. AJ will take this forward. AJ left the meeting.


SS talked to the paper to inform the Sub Committee of NHS Lothian’s performance in respect of the Participation Standard 2010 – 2011 and the continuing requirements. The purpose of the standard is to drive improvement in how the NHS involves people in influencing their own care and to further develop public involvement practice in service planning and improvement.

As a whole Lothian did well with good participation from West Lothian. The work of the West Lothian Public Partnership Forum for Health and Care Services (WLPPFHC) featured in a number of the self assessment submissions.

EG asked how this information is fed back to the public. The annual report is available in health centres, minutes are posted on the West Lothian CHCP website, events are held across West Lothian and articles are also printed in the Health Link newspaper.

The chair asked for suggestions on how West Lothian CHCP could assist with improving this standard. Formal training was suggested with JK highlighting that the Community Development and Health programme continues to be offered for staff across the CPP. JK to feedback numbers of participants on recent CDH courses to TD. AG stated that tenants are now being used to inspect premises for housing. SS left the meeting.

14. CIRCLES OF RESILIENCE – EVALUATION UPDATE

JS talked to the report to provide feedback on the evaluation of the Circles of Resilence initiative that was presented to the Committee in February 2011. The Committee is recommended to note the positive evaluation feedback provided in the summary report.
The measures took place between Dec 2010 and June 2011 with 71 completed action plans. Positive results were recorded primarily being used in schools with this being progressed to social care settings. Young carers can also access this web based facility.

LS asked about the possibility of using this in colleges. JS will discuss this with LS.

A report will be brought back to the Sub Committee in 1 year.

15. **KEEP WELL – PROJECT UPDATE**

Ciara Byrne was unable to attend the meeting and due to the requirement for dialogue around the report, it will be brought back to the next meeting.

16. **CHCP SUB COMMITTEE WORKPLAN 2011 - 12**

JF talked to the CHCP workplan. Work is being carried out to theme it around the four Single Outcomes Agreement (SOA) outcomes that the Sub Committee is charged with delivering and that this version would be updated on a 6 monthly basis.

It was agreed that the workplan would adopt a consistent approach both in what level of activity was measured and how it was reported and that the Council’s main performance application Covalent would be a useful tool to capture this information.

Further development is required to convert the workplan to the Covalent version.

The workplan will be brought back to the next Sub Committee meeting.

17. **CHANGES TO SUB COMMITTEE MEMBERSHIP**

The changes to the membership were noted and the chair welcomed the new members attending the meeting to the Sub Committee.

18. **HEALTHY WEIGHT PROJECT UPDATE – T4H**

RR joined the meeting.

RR talked to the paper giving an update on the project outlining progress to date, future developments and priorities. The Committee are being asked to continue to support and promote the development of the Healthy Weight Community with the aim of developing a sustainable model which can be replicated throughout West Lothian.

A discussion took place around the recent project events and the excellent partnership work with schools although there are time restraints within the school curriculum.

The chair raised a concern regarding the lack of strategic direction and requested an action plan against timelines and budgets over the next 3 years. The Healthy Weight Project is currently monitored by a project board. There are members of the Sub Committee recently appointed to the project board.
The Sub Committee supports the project and would like further clarification on what support the CHCP could provide for the project. The chair would like a report brought to the Sub Committee every 2nd meeting.

19. ANY OTHER COMPETENT BUSINESS

JO raised a concern regarding the police service being called out to assist lifting patients who had fallen in their home. As the police do not have the appropriate training to assist these patients they would like to identify where these calls should be diverted to.

SW stated there is a crisis care re-enablement team being established in the New Year. Kirsty Stenhouse is currently the falls co-ordinator and SW will ask her to contact the police to establish a process to deal with these calls.

20. DATES AND VENUES OF FUTURE MEETINGS 2011

Meeting dates for 2012

26th January 2012 Bathgate Partnership Centre
8th March 2012 Bathgate Partnership Centre
26th April 2012
21st June 2012
30th August 2012
18th October 2012
6th December 2012

The meeting closed at 4pm
OPENING REMARKS BY THE CHAIR

The Chair welcomed Shulah Allan to the meeting, as a substitute for Robin Burley, and advised the Board members that it was expected that Shulah would very shortly be appointed by NHS Scotland as a permanent member of the Board.

MINUTE OF MEETING OF THE BOARD – 16 AUGUST 2011

The Board approved the minute of its meeting held on 16 August 2011 as a correct record, subject to the page numbers being amended to run from 558 through to 565.

In relation to the issue of premium rate telephone contracts (Item 1 on page 558), it was noted that the required information had not yet been provided to Board members. The Associate Director of Finance (NHS Lothian) undertook to do that by way of an e-mail to Board members.

RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decisions

(1) To note that Items 1, 2, 3, 4, 5, 7, 8, 10 and 11 were still in progress.

(2) To agree that Items 6 and 9 were completed and could be deleted.

(3) To agree that the Running Action Note should be updated accordingly.

MINUTES OF THE MEETINGS OF THE PRIMARY CARE JOINT MANAGEMENT GROUP HELD ON 9 JUNE AND 11 AUGUST 2011

The Board noted the minutes of the meetings of the Primary Care Joint Management Group held on 9 June 2011 and 11 August 2011.
5. **BEST VALUE REVISED GUIDANCE – PRESENTATION**

The Board heard a presentation by the NHS Lothian Corporate Governance and Value for Money Manager in relation to the revised guidance on “Best Value” issued by the Scottish Government on 6 April 2011.

The Board was advised that the nine characteristics from the original Guidance remained relevant, but that they had been re-organised and re-structured into five generic and two cross-cutting themes. The difference between governance and management was explained, and that the guidance stressed that the concern for Health Boards and similar public bodies should be with outcomes rather than with processes.

The Board was also advised of the approach taken by NHS Lothian to measure, monitor and scrutinise the achievement of best value and summarised the six main questions which were addressed by NHS Lothian in its best value arrangements.

In response to questions from Board members, it was noted that the statutory regime and guidance which applied to the council was different to that which applied to NHS Lothian, and that although a joint or common approach to securing best value between the partner organisations would be worthwhile, there were statutory and organisational reasons which made that difficult.

**Decisions**

(1) To note the presentation and to thank the Corporate Governance and Value for Money Manager for attending and providing the presentation.

(2) To agree that a copy of the presentation slide should be circulated to Board members.

(3) To agree that the Chair and the CHCP Director should consider the possibility of bringing the two best value regimes of the partner organisations together into a combined CHCP approach.

6. **JOINT COMMISSIONING PLANS**

The Board considered a report (which had been circulated) following up the Board’s consideration at its last meeting of the proposed joint commissioning approach.

The report explained that, as requested at the last Board meeting, the report had been considered at the Council’s Health and Care Policy Development and Scrutiny Panel on 8 September 2011, where the terms of the report were noted.

The appropriate governance and reporting route for NHS Lothian was presently under consideration with a view to securing NHS authorisation of the proposed joint commissioning process.

**Decisions**

(1) To note the actions taken following the last Board meeting.

(2) To approve the over-arching strategy and the subsequent development of care group plans.

(3) To agree that the strategy would be taken by the CHCP Director to the
NHS Service Redesign Committee for consideration before being brought back to the Board to conclude the process of approval.

(4) To agree that the administrative and development work on the strategy should continue in the meantime, but without any engagement with partner bodies until final Board approval was given.

7. **CONSULTATION ON INVOLVEMENT OF GPS IN ADULT PROTECTION PARTNERSHIPS**

The Board considered a report (which had been circulated) by the Acting Head of Council Services informing the Board of the proposed response to the Scottish Government Consultation on “Guidance to Multi-Agency Adult Protection Partnerships on the Involvement of GPs”.

The report advised that the Scottish Government had commenced its consultation on the Draft Guidance in July 2011, which recommended that multi-agency adult protection partnerships should develop local policies on the involvement of GPs in their processes.

The proposed response to the consultation was attached to the report as an appendix.

The report explained the process followed in drafting the response, and advised that the overall approach was to agree that the guidance was progressive but that it left a number of issues still to be considered and dealt with.

Decision

To agree the proposed response to the Scottish Government consultation.

8. **CLINICAL GOVERNANCE – MENTAL HEALTH STRATEGY FOR SCOTLAND 2011 – 2015**

The Board considered a report (which had been circulated) by the Clinical Director informing the Board of the Scottish Government consultation on a national mental health strategy.

The report explained the focus on the document was on 14 high-level outcomes that an effective mental health system was expected to deliver and that it brought together work to improve mental health services and mental health improvement with a view to building on the current approach and agreeing on a direction of travel for the next four years.

Decisions

(1) To note the launch of the consultation exercise on a mental health strategy for Scotland for the next four years.

(2) To note that a proposed response would be brought to the Board for consideration at a future meeting, prior to submission.

9. **CARE GOVERNANCE – SOCIAL POLICY INSPECTION**

The Board considered a report (which had been circulated) by the Acting Head of Council Services informing the Board of the inspection framework undertaken by the Social Care and Social Work Improvement (SCSWIS) Agency in respect of the Council’s Social Policy Service.
The report explained the recent inspection which had been undertaken, with an initial scrutiny level assessment being carried out in November 2010, and with the proposed scrutiny sessions thereafter having been completed in June 2010.

The report concluded by advising that the report from SCSWIS was not yet available, but that the outcome would be reported to the Board in due course.

**Decision**

To note that the SCSWIS report of the Social Policy inspection was not yet complete, and that details would be reported to the Board when available.

### 10. 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.

The report provided information in relation to mandatory training for Information Security, Data Protection and Freedom of Information, on voluntary severance arrangements implemented after the conclusion of the Tough Choices process, and in relation to the Mental Health Service, Allied Health Professionals, and Community Nursing.

**Decisions**

1. To note the updates on the areas of staff activity.
2. To congratulate staff on their work in implementing and dealing with the measures taken following “Tough Choices”.
3. To agree that the Chair should consider how that could be communicated to staff and to the public.

### 11. RESOURCE TRANSFER MONITORING REPORT TO 31 JULY 2011

The Board considered a report (which had been circulated) providing details of phased expenditure incurred in the period to 31 July 2011. The report advised that the council had invested £2.2m of the total £6.3m resource transfer monies to the end of July 2011.

The report further advised that the target figure of zero delayed discharge had been maintained in all sectors.

The resource transfer monitoring report was attached as an appendix.

**Decision**

To note the details of the resource transfer monitoring report.

### 12. 2011/12 REVENUE BUDGET MONITORING REPORT AS AT 31 JULY 2011

The Board considered a report (which had been circulated) by the Acting Head of Council Services and the Head of Health Services containing a joint report on financial performance in respect of the CHCP based on figures for the period to 31 July 2011.
The report advised that the anticipated draft outturn for the CHCP was for an under spend by £1,247,000.

In relation to the overall Social Policy Budget, the forecast was for an under spend of £1,444,000. In relation to the share of the CHCP budget for NHS Lothian, it was forecast that there would be a break even position.

The report outlined the reasons for the forecast positions, and the pressure areas for the council and NHS Lothian elements of the CHCP budget.

The actions being taken by service managers were summarised.

Decisions

(1) To note the forecast position for the CHCP budget based on figures to 31 July 2011.

(2) To note that service managers are taking action to address areas of financial pressure in their service areas to ensure a balanced outturn is achieved.

13. DIRECTOR’S REPORT

The Board considered a report (which had been circulated) by the CHCP Director setting out key areas of work in which the partnership had been involved since the last meeting.

The Board was advised of work carried out in relation to Southern Cross, the opening of Forest Walk Care Home (a new residential, respite and a support facility for people with physical disabilities), and the results of the Better Together Adult In-Patient Survey.

Decisions

To note the areas of work outlined in the report.

14. PRIMARY CARE GOVERNANCE ARRANGEMENTS – FRAUD REFERRALS AND OPERATIONS

The Board considered a report (which had been circulated) providing statistics on fraud referrals and operations raised from NHS Lothian during the year to 31 March 2011.

Detailed statistics were provided in the appendix to the report.

Decision

To note the statistics on fraud referrals and operations for NHS Lothian raised during the year to 31 March 2011.

15. PRIMARY CARE GOVERNANCE ARRANGEMENTS – PAYMENT VERIFICATION IN PRIMARY CARE

The Board considered a report (which had been circulated) containing information on the appropriate control measures in place for payments made to family health practitioners for the year 2010/11.
The payment verification measures and processes were outlined in the appendix to the report.

**Decision**

To note that appropriate control measures were in place within NHS Lothian for payments to family health practitioners.
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH & CARE PARTNERSHIP BOARD held within STRATHBROCK PARTNERSHIP CENTRE, BROXBURN on TUESDAY 8 NOVEMBER 2011

Present - Theresa Douglas (Chair), Ellen Glass (Vice-Chair), Shulah Allan, John Cochrane, Janet Campbell, John McGinty and John Richardson

Apologies - Mike Boyle, Jane Houston

In Attendance - Jennifer Scott (Interim Head of Council Services), Marion Christie (Head of Health Services), Lynne Hollis (Associate Director of Finance, NHS Lothian), Dr James McCallum (Clinical Director), Alan Bell (Senior Manager - Communities and Information, West Lothian Council), Fiona Duffy (Communications Officer, West Lothian Council)

1. OPENING REMARKS BY THE CHAIR

The Chair welcomed Shulah Allan to her first meeting as a permanent member of the Board in place of Robin Burley.

It was agreed that the Chair should write to Robin Burley to mark his departure and to thank him for his service on the Board and to the CHCP.

2. MINUTE OF MEETING OF THE BOARD – 27 SEPTEMBER 2011

The Board approved the minute of its meeting held on 27 September 2011 as a correct record, subject to it being noted that on Page 556 Shulah Allan was expected to have been appointed to the Board by NHS Lothian and not NHS Scotland.

3. RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decisions

1. To note and agree that items 1, 7 and 11-15 were still in progress.

2. To note and agree that items 2-6 and 8-10 were complete and could be delete.

3. To note that the Chair and John Cochrane would discuss with Graham Mackenzie arrangements for the provision of information to West Lothian Licensing Board in relation to its draft policy on over-provision.

4. To agree that the Running Action Note should be updated accordingly.

4. MINUTES OF THE MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP HELD ON 8 SEPTEMBER 2011

The Board considered the minute of the meeting of the Primary Care Joint Management Group held on 8 September 2011.
1. To note the minute.

2. In relation to item 97.3 on page 4:-

(a) To note that work was underway on a suite of reports in relation to the re-design of the Mental Health Service.

(b) To agree that the aim should be for relevant reports to be brought to the Board at its meeting in January 2012.

5. **MINUTE OF THE MEETING OF THE CHCP COMMUNICATIONS GROUP HELD ON 10 AUGUST 2011**

The Board considered the minute of the meeting of the CHCP Communications Group held on 10 August 2011.

Decision

To note the minute.

6. **MINUTE OF THE MEETING OF THE CHCP SUB-COMMITTEE HELD ON 9 JUNE 2011**

The Board considered the minute of the meeting of the CHCP Sub-Committee held on 9 June 2011.

Decision

To note the minute.

7. **MINUTE OF THE MEETING OF THE CHCP SUB-COMMITTEE HELD ON 1 SEPTEMBER 2011**

The Board considered the minute of the meeting of the CHCP Sub-Committee held on 1 September 2011.

Decision

To note the minute.

8. **MINUTE OF THE MEETING OF THE PRIMARY CARE FORWARD GROUP HELD ON 4 OCTOBER 2011**

The Board considered the minute of the meeting of the Primary Care Forward Group held on 4 October 2011.

Decisions

1. To note the minute.

2. In relation to item 57.2 on page 1, to note in particular that the Interface group operating in West Lothian is an example of an appropriate and effective forum for consideration of such issues.
3. In relation to item 67.3 on page 5, to note in particular the adversarial position taken by GPs and that an update would be brought to the Board when appropriate.

9. **CHAIR’S REPORT**

The Board considered a report (which had been circulated) by the Chair advising the Board of the activities carried out by her since the last meeting. The report advised the Board of activity in relation to the Scottish Patient Safety Programme, meetings with the Head of Equality and Diversity at NHS Lothian, the St John’s Hospital Stakeholders Group and a visit to the Family Nurse Partnership team. The report concluded by advising that a new schedule for Board visits was being developed and that Board members could put forward suggestions for inclusion.

**Decision**

1. To note the contents of the report.

2. Noted the Chair’s comment that those writing reports for the Board required to include more information about Equality Impact Assessments which had already been carried out in relation to the project or subject matter of the report, even if no such assessment were required in relation to the report itself.

10. **MODERNISING COMMUNITY NURSING IN WEST LOTHIAN**

The Board considered a report (which had been circulated) by the Chief Nurse providing a progress report on the implementation of Modernising Community Nursing in West Lothian.

The report set out the background to the programme through the Strategic Board initiated by the Scottish Ministers, the cluster working that had been introduced in West Lothian and its method of working, and the initial successful feedback. It went on to explain the identification of three practices to pilot intensive case management and the way that would work. It summarised the move to corporate case loads and a corporate approach to workloads and the steps taken to redesign the service in West Lothian.

**Decisions**

1. To note the progress to date regarding the implementation of Modernising Community Nursing in West Lothian.

2. To agree that officers should provide further information to Board members in relation to arrangement for night and out-of-hours cover.

3. To agree that officers should send by email a copy of the supporting report containing more detailed information on the implementation of the programme.
11. RESHAPING ARE FOR OLDER PEOPLE - UPDATE

The Board considered a report (which had been circulated) by the Acting Head of Council Services informing the Board of the progress of West Lothian’s Change Fund Plan, Reshaping Care for Older People.

The report explained the origins of the Change Fund and its principal aims, recent changes to it and the detail of the funding, and the local partnerships and West Lothian Partnership Programme Board which had been formed to progress local projects and to access the Fund. It set out the priority elements which had been agreed, the projects being pursued and the progress made in each. The Local Transition Plan was contained in the appendix to the report.

The report concluded by advising that, due to the substantial challenges being faced and the design and implementation of the necessary administrative processes, there would probably be an underspend in the first year, but that any such underspend could be carried forward into the next year of the programme.

Decision

1. To note that projects are progressing in re-ablement, integrated patient pathways for long terms conditions, technology and community capacity building.

2. To note that reports in relation to progress on those projects would be brought to the board when appropriate.

3. To agree to support the West Lothian Partnership Programme Board in implementing the West Lothian Change Plan.

4. To agree that Board members should be provided with the revised base line indices referred to on page 2 of the report.

12. CARE AT HOME SERVICE - CURRENT ARRANGEMENTS AND PERFORMANCE

The Board considered a report (which had been circulated) by the Acting Head of Council Services advising the Board of the current arrangements for and performance of the Care at Home Service.

The report set out the background to the work undertaken on a revised strategic direction for in-house domiciliary services, and the aims of the service redesign, all as had been built in to the Reshaping Care for Older People Programme. It went on to provide performance data, which had been requested by the Board, in relation to service demand levels, time allocations for visits, times for morning and evening visits to service users, and trends on user satisfaction.

Decisions
1. To agree to support the direction of travel as outlined in the report.

2. To note the service delivery arrangements for Care at Home users.

3. To note that the percentage of customers who rated the service as very good or excellent continued to increase.

4. To agree that Board members should be provided with details of the percentage of visits lasting 15 minutes or less, and the percentage achieved of compliance with user preferences for morning and evening calls.

13. NHS LOTHIAN BREAST SCREENING OUTCOMES

The Board considered a report (which had been circulated) by the Consultant in Public Health for NHS Lothian informing the Board of the variance between uptake of breast-screening in West Lothian and elsewhere.

The report and its appendix detailed outcomes for 2007/08, 2008/09 and 2009/10, but advised that it had not been possible to produce data in relation to the male population due to the very low number of cases, which meant there were data protection issues.

Decision

1. To note the report and the appended briefing note on NHS Lothian Breast Screening.

2. To agree that the Board should be provided with more information in relation to the information contained in the appended briefing note under “Incident Uptake” to explain which practices were involved, why some practices were not involved, and in relation to where the responsibility lies for ensuring involvement and full participation.

14. HEALTH AND CARE GOVERNANCE – QUALITY OUTCOMES FRAMEWORK ACHIEVEMENT 2010/11

The Board considered a report (which had been circulated) by the Clinical Director summarising the West Lothian GP Practices Quality & Outcomes framework achievement for 2010/11 and indicating the progress on the quality and productivity changes affecting practices in 2011/12.

The report set out details of achievement, and difficulties encountered in relation to changes in software systems and resulting comparison and data recording problems, and concluded by acknowledging that although variation in performance amongst practices existed for a number of reasons, practices were committed to improving their performance and the quality of care provided through full participation in the Quality Outcomes framework.

Decisions
To note the contents of the report and progress in improving quality in general practice

15. **HEALTH AND CARE GOVERNANCE – ASSESSMENT OF CARE HOME CLIENTS**

The Board considered a report (which had been circulated) by the Acting Head of Council Services updating the Board on the review process that had been carried out on the three West Lothian care homes affected by the Southern Cross situation.

The report explained the steps taken to deal with the Southern Cross situation as it affected West Lothian and the re-assessments carried out of affected residents which had involved updating personalised care plans to ensure that the new providers have full and up-to-date information.

The report concluded by advising that few issues or concerns had been raised by residents or their families, and that they had reported being well-informed by Southern Cross throughout.

**Decision**

To note the progress being made by staff to ensure that satisfactory arrangements are in place to safeguard the interests and welfare of residents in Southern Cross care homes in West Lothian

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 in the CHCP.

The report provided information on the council side on flu vaccinations for staff, severe weather winter preparation, performance management, and, on the health side, on Celebrating Success Awards and the implementation of the new national HR system, called Electronic Employee Support System (eSSS).

**Decisions**

1. To note the updates on the areas of staff activity.

2. To agree that the format of the report should be changed to an integrated service basis to reflect the close partnership working.

17. **2011/2012 REVENUE BUDGET – MONITORING REPORT AS AT 30 SEPTEMBER 2011**

The Board considered a report (which had been circulated) by the Acting Head of Council Services and the Head of Health Services containing a joint report on financial performance in respect of CHCP figures for the period to 30 September 2011.
The report advised that the anticipated draft outturn for the CHCP as a whole was for an overspend of £0.004 million.

In relation to the overall Social Policy Budget, the forecast was for an under spend of £1,444,000 and for the CHCP elements, an underspend by £1,228,000. In relation to the share of the CHCP budget for NHS Lothian, it was forecast that there would be an overspend of £1,232,000.

The report outlined the reasons for the forecast positions, and the pressure areas for the council and NHS Lothian elements of the CHCP budget, especially in relation to the share of the NHS Lothian prescribing budget apportioned to the CHCP.

The actions being taken by service managers were summarised, in particular the development of a prescribing recovery plan across the CHPs.

Decisions

1. To note the financial position and projection reported.

2. To note that service managers were taking management action to address areas of financial pressure within their own service areas to ensure a balanced outturn was achieved.

3. To congratulate all CHCP staff on achieving such a satisfactory budget position.

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 meeting.

The Board was advised of work carried out in relation to the Early Years Change Fund, the Social Care Emergency team Annual Report for 2010/11, Mental Health Day 2011, the Young Persons’ Counselling Service, CHCP branding and West Life.

Decision

1. To agree to support senior managers to put together plans to maximise the opportunity that access to the Early Years Change Fund will provide in line with the Life Stages approach.

2. To note the work of the Social Care Emergency Team.

3. To note the success of the seventh annual Mental Health Day.

4. To note the work of the Young Persons’ Counselling Service.

5. To approve the revised branding for CHCP design work set out in the appendices to the report.
19. **NHS SCOTLAND EFFICIENCY AND PRODUCTIVITY: FRAMEWORK FOR SR10**

The Board considered a report (which had been circulated) by the Head of Health Services informing the Board of a recent Scottish Government publication entitled NHS Scotland Efficiency and Productivity: Framework for SR10 which prioritised support and activities to NHS Boards in the strategic context of the Healthcare Quality Strategy for NHS Scotland and the 2010 Spending Review. The full publication was attached as an appendix to the report.

**Decision**

1. To note that the contents of the report and that the revised framework prioritised support and activities to NHS Boards in the strategic context of the Healthcare Quality Strategy for NHS Scotland and the 2010 Spending Review.

2. To agree that where reports are brought to the Board for information only, and involve consideration of lengthy documents, that the covering report should include an executive summary of the document, and a link to the full document, rather than the full document being copied and circulated to Board members.

20. **EFFICIENCY AND PRODUCTIVITY WORKSTREAM ON PRESCRIBING**

The Board considered a report (which had been circulated) by the Head of Health Services informing the Board of the output of the Efficiency and Productivity Workstream on Prescribing and which summarised the defined areas of work to be pursued over the next three years. The full publication was attached as an appendix to the report.

**Decision**

1. To note the output of the workstream from the workshop held on 27 June 2011 and that the defined areas of work that would be pursued over the next three years would be:

   (a) Using the new Quality and Productivity QoF measures proactively to ensure high quality Primary Care Prescribing.

   (b) HB Primary Care Prescribing Action Plans, Formulary Compliance [use of the Advisor Network and SMC to implement] Secondary & primary care interface.

   (c) Repeats & Waste, Patient Involvement, Awareness and Education.

   (d) Performance Management & Incentives.

2. To agree that where reports are brought to the Board for information only, and involve consideration of lengthy documents, that the covering report should include an executive summary of the document, and a link to the full document, rather than the full document being copied and circulated to Board members.
1. Internal

1.1 Vocational Rehabilitation - On 1 December I hosted the launch the NHS Lothian DVD "I'm VR". Our Vocational Rehabilitation services at Astley Ainslie is contracted by the UK Department for Work and Pensions to support those of working age in the Lothians who have injuries that are delaying their return to work. The main speaker was Dame Carol Black, UK lead at the Department of Work & Pensions for vocational rehabilitation.

1.2 REAS Visit - On 7 December I visited REAS, and was joined by three fellow Non-Executive Board members.

1.3 Cabinet Secretary’s Visit to Scottish Transplant Unit at the Royal Infirmary of Edinburgh - On 7 January I hosted the Scottish Government’s media event at the Scottish Transplant Centre at the Royal Infirmary to celebrate the 1,000 Scottish kidney and liver transplants. The event was well attended by the media and there was extensive coverage of two recent kidney and liver transplant recipients.

1.4 Opening of Birth Centre - On 11 January I hosted the official opening of the new Birthing Centre at the Royal Infirmary by the Cabinet Secretary. The £2.8M facility supports the significant increased birth rate in the Lothians (up from 8,538 annual births in 2004 to 9,915 in 2010). The Centre provides women with more choice in how and where they give birth. Patient feedback has been that it is more like a visit to a spa or hotel than to a hospital!

1.5 Estates Response to Storms - I am advised that prompt action and long hours from our estates staff were significant factors in limiting the damage to NHS Lothian buildings in the storms at the turn of the year. I am sure that Board members will wish me to add their thanks to those already communicated by senior management.

1.6 Mid Year Reviews - In December I completed the outstanding 2011/12 Mid-Year Performance Reviews for Non-Executive Board members.

1.7 Consort – I chaired the regular Consort Partnership Board on 24 January when matters of mutual interest were discussed.
2. External

2.1 Sustainable Procurement - On 15 December at the invitation of the Duke of Rothesay I attended a meeting at Clarence House to discuss food procurement. The session reviewed the experiences of NHS organisations which have procured local food supplies and found resultant improvements in both quality and costs. The Chief Executive is arranging management contact with Trusts reporting positive experiences.

Charles Winstanley
Chairman
18 January 2012
CHIEF EXECUTIVE’S REPORT

1. Local Initiatives

1.1 Success of Staff – Yet again, I am delighted to be able to report successes by our staff. Nurses involved in the Keep Well Team at the Edinburgh Access Practice were awarded the accolade of Nursing Team of the Year on 16 November at the General Practice Awards held in London. The award recognised their contribution in delivering healthcare to gypsy and travelling communities.

1.2 A team from Lothian won the Midwifery Leadership event hosted by Scottish Government and supported by the Royal College of Midwives and NES in November 2011.

1.3 Finally, Diane McInally, Community Midwife Team Leader has won the Johnson’s Scotland Midwife of the Year award. Diane has also been nominated for the UK-wide awards.

1.4 Visit to Edinburgh CHP - On 9 December I visited services within Edinburgh CHP. The visit included an opportunity to meet with colleagues from the Edinburgh Weight Management Team based at Leith Community Treatment Centre. The team’s work features the innovative use of information management technology to support people in the programme. While at Leith Community Treatment Centre I also heard a presentation on the work of the Willow Project, which is a highly innovative and nationally recognised programme focussing on women who have been in prison. I met clients in the group and heard how much they valued the wide range of support they received in helping them improve their physical and mental health.

1.5 I also visited the Family Nurse Partnership and met with staff and mothers engaged in the Lothian-based programme, which was a first for Scotland. Delivered by a team of six the programme is already showing significant benefits in maternity and child health in areas such as smoking reduction and breast feeding. Longer term benefits are anticipated in areas such as readiness for school, reductions in welfare dependency, employment and paternal involvement.

1.6 On 16 December I visited women’s services and, in particular, the new Birthing Centre, located at the Royal Infirmary. The environment and facilities available for mothers in the new Centre are truly outstanding and all the midwives I met were delighted to be able to give care and support in such an excellent environment. I also heard of the very interesting work being undertaken in the analysis of
information contained in our TRAK maternity system and how this is being used to manage risk and fluctuations in activity.

2. Regional Initiatives

2.1 I chaired the SEAT planning group meeting on 25 November. Items discussed included the co-ordination of severe weather planning, receipt of the annual report of the Learning Disabilities Managed Clinical Network, which has made significant contributions to the co-ordination and delivery of learning disability services across the region and progress reports on a number of cross-SEAT workstreams including work on rebalancing care in orthopaedic services, which involves capacity sharing between ourselves and Borders Health Board.

3. National Initiatives

3.1 Family Nurse Partnership Conference – I was delighted to be invited to speak at the national conference promoting the work of the Family Nurse Partnership, not only in Lothian but increasingly in other Boards in Scotland. I emphasised how important the work of the Family Nurse Partnership is in the context of our commitment to tackling health inequalities, as well as in changing the lives of young people and their children. The conference was extremely well attended from across Scotland and keynote address was given by the Cabinet Secretary, Nicola Sturgeon.

3.2 NHS in England – Top Leaders Programmes – A number of colleagues from NHS Lothian were approached to host a visit by members of the NHS in England Top Leaders Programme. The participants are drawn from a wide range of disciplines including finance, operation, strategy and business development. We were able to showcase the work of NHS Lothian as an integrated care system and, from the questions and discussion, it was clear that the model in Scotland attracted favourable responses. The organisers advised us that the session was extremely beneficial and the participants will be promoting the work of NHS Lothian amongst the 45 top leaders engaged in the English development programme.

James Barbour  
Chief Executive  
18 January 2012
QUALITY REPORT

1 Purpose of the Report
1.1 This report presents the updated Quality Report for January 2012.

2 Recommendations
The Board is asked to:
2.1 Review the quality measures presented.

3 Discussion of Key Issues
3.1 This report sets out Lothian’s core quality measures (with supporting technical appendix) and effectiveness measures for cancer.

3.2 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 when available by a summary of other measures which will be considered at the Board’s Healthcare Governance and Risk Management (HCGRM) Committee.

3.3 The latest key quality results are as shown in Table 1 and the accompanying graphs show trends over time. The constraints in relation to each of these data items have been presented to the board in previous quality reports.
Table 1: Summary quality results, January 2012

<table>
<thead>
<tr>
<th>Measure</th>
<th>Aim/target</th>
<th>Summary Results at August 2011</th>
</tr>
</thead>
</table>
| HSMR    | HSMR less than one.  
          | **SPSP national target to reduce HSMR by 15% by December 2012.** | HSMR remains stable at less than one for all three acute sites.  
          | Small reductions (from baseline Oct-Dec 07) in HSMR at RIE (5.2%), WGH (6.9%) and St. Johns (3.1%).  
          | - Figures 1a - 1c |
| Adverse Events | SPSP target to reduce by 30% by December 2012. | Significant (42%) reduction in the adverse event rate from baseline period (2007). - Figure 2 |
| Hospital Associated Infection(HAI) | HEAT targets for SABs and CDI relate to episodes/acute occupied bed days.  
          | **HEAT target for hand hygiene is 90% compliance. Local stretch target of 95%.** | S. aureus Bacteraemia achieving HEAT target.  
          | C. difficile Infection – achieving HEAT target.  
          | Hand Hygiene – achieving HEAT target and local stretch target. |
| Incidents with associated harm | Reporting of incidents with harm should not increase. | The reporting of incidents with associated harm remains stable - Figure 4 |
| Complaints | National target to acknowledge 100% of complaints within 3 days and to respond to 85% of complaints within 20 days | Increase (5.7%) in formal complaints in the last quarter, from 243 to 257.  
          | - Figure 5a  
          | 3-day compliance – 97%.  
          | 20-day compliance – 80%.  
          | - Figure 5b |
Figure 1a - Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – June 2011

Figure 1b - Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – June 2011

Figure 1c - Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2011

Figure 2 - Rate of Adverse Events per 1000 patient days. November 2008 to November 2010

Figure 3a – Progress against HEAT Target for S.aureus Bacteraemia (SAB)

Figure 3b – Progress against HEAT Target for C.difficile Infection (CDI)

Figure 4: Number of incidents associated with moderate or major harm or death reported per month in NHS Lothian (Oct 2009-Sept 2011)

Figure 5b – 20-Day Response Target across NHS Lothian, Quarterly (Apr 2009-Sept 2011)
NHS Lothian Incidents Reported with Moderate or Major Harm or Death

NHS Lothian 20-Day Response Target - Quarterly

Figure 5a – Formal Complaints per quarter across NHS Lothian (Apr 2009-Sept 2011)
3.4 The measures selected to reflect the effectiveness of the cancer care NHS Lothian provides are as follows:

- Smoking cessation rates
- Screening uptake
- Mortality rates

These measures reflect the central role of cancer prevention and early detection. Mortality rates reflect the timeliness and effectiveness of the health care received, but are also influenced by other factors such as stage of the cancer at presentation.

Cancer incidence (the number of new cases of cancer in a given time period) and cancer survival have not been included in the current set of measures. Cancer incidence is influenced by multiple factors, such as demographic and socio-economic factors. Cancer survival data also reflect a complex mixture of changes in cancer diagnosis and treatment over time, alongside changes in the lifestyle and behaviours of the underlying population. These data are not routinely produced at NHS Board level in light of the complexity of the analyses and the small numbers for some tumour groups.

3.5 **Smoking Cessation**

There are Scottish Government targets both for the overall number of successful quit attempts and the successful quit attempts by those in the most deprived groups. These run from April 2011 to March 2014.

Table 2 shows that Lothian is, to date, reaching the milestones required to meet both of these targets. To continue on this trajectory, NHS Lothian will continue to provide brief intervention training to encourage referrals to the service and will also continue to explore other innovative approaches.

<table>
<thead>
<tr>
<th>Total Successful Outcomes</th>
<th>Successful Outcomes (%) in Inequalities Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian 2,158</td>
<td>1,327 (61%)</td>
</tr>
<tr>
<td>Milestone for period 1,870</td>
<td>1,122 (60%)</td>
</tr>
</tbody>
</table>

Data extracted from National database on 10/11/11

3.6 **Breast Screening**

Data shows that during the most recent three years 2007/8-2009/10, overall uptake in NHS Lothian has remained stable at 72% (Table 3).

<table>
<thead>
<tr>
<th>Percentage uptake of Breast Screening by NHS Board (three year rolling average), females aged 50-70 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
</tr>
<tr>
<td>Scotland</td>
</tr>
</tbody>
</table>

This figure is above the QIS standard of 70% and below the Scottish average of 75%. Figures are similar for NHS Lothian, NHS Lanarkshire and NHS Greater Glasgow & Clyde where the majority of appointments are offered at a static centre. Uptake tends to be higher in Boards where the majority of screening is undertaken by mobile units. The balance of mobile to fixed mammography is currently the subject of a national review.

The lowest uptake groups are:

- Women new to screening (first invitation) and;
- Women who are invited out with five years of last attendance – i.e. previous non-attendees

In order to address these target groups we have been working closely with colleagues in primary care, health promotion, community development and cancer charities to promote the benefits of screening and also to provide staff with training and information to ensure a higher, positive profile of the programme at primary care level.

In Lothian, uptake levels vary across deprivation categories from 79% (least deprived) to 58% (most deprived). This pattern is reflected across Scotland. An ‘Immediate Action’ pilot has been established with the agreement of some practices to evaluate whether additional targeted primary care efforts can improve uptake at practice level. Participating practices with uptake rates less than 50% receive daily updates on women ‘defaulting or not attending’ for screening on the day of appointment and there is agreement that either a GP or nurse will make personal contact to encourage the women to rebook their mammography appointment. Evaluation of this was undertaken during 2011.

3.7 Cervical Screening

Table 4 shows the cervical screening uptake rates by age group compared with the overall Scottish rates. Uptake rates in women over 35 years are consistently higher than Scottish rates.

Table 4: Percentage uptake of Cervical Screening by NHS Board females aged 20-60 who had a smear taken within previous 5.5 years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>51.7</td>
<td>(52.6)</td>
<td>56.6</td>
<td>(57.5)</td>
</tr>
<tr>
<td>25-29</td>
<td>68.1</td>
<td>(69.0)</td>
<td>74.3</td>
<td>(74.7)</td>
</tr>
<tr>
<td>30-34</td>
<td>77.5</td>
<td>(78.2)</td>
<td>80.2</td>
<td>(80.6)</td>
</tr>
<tr>
<td>35-39</td>
<td>84.2</td>
<td>(84.3)</td>
<td>83.9</td>
<td>(84.1)</td>
</tr>
<tr>
<td>40-44</td>
<td>87.2</td>
<td>(87.7)</td>
<td>85.6</td>
<td>(85.8)</td>
</tr>
<tr>
<td>45-49</td>
<td>88.2</td>
<td>(87.9)</td>
<td>85.9</td>
<td>(86.1)</td>
</tr>
<tr>
<td>50-54</td>
<td>87.1</td>
<td>(87.4)</td>
<td>84.4</td>
<td>(84.7)</td>
</tr>
<tr>
<td>55-59</td>
<td>85.6</td>
<td>(86.0)</td>
<td>82.1</td>
<td>(82.8)</td>
</tr>
<tr>
<td>Overall</td>
<td>77.7</td>
<td>(78.1)</td>
<td>79.1</td>
<td>(79.5)</td>
</tr>
</tbody>
</table>

Source SCCRS/ISD Data for 2010-11

Minimum standard of 80% is currently subject to national review
Women aged less than 35 years have lower uptake rates for a range of reasons including confusion about the overall health message in relation to cervical screening. The Scottish Cervical Call Recall System (SCCRS) mailers and supporting health promotion materials have been recently revised in part to address this. There is also a review of the national screening programme by the Scottish Government in light of the growing medical debate concerning the age range for screening and the frequency of screening in women over the age of 50.

Overall the cervical screening programme has been very successful in reducing the incidence of cervical cancer. Age standardised incidence rates for Lothian have declined from 13.8 per 100,000 persons at risk in 1997 to 10.6 per 100,000 persons at risk in 2009. These rates correspond to a decline in annual cervical cancer registrations of 23% (62 to 52). An anonymised local audit of all invasive cancers takes place to support this work.

3.8 **Colorectal cancer screening**

The data in Table 5 shows the uptake rates for colorectal cancer screening, with Lothian slightly lower than the overall uptake across Scotland. Figure 6 shows that the uptake pattern nationally is also reflected in NHS Lothian, with lower uptake in the most deprived groups.

**Table 5: Bowel screening uptake rates for NHS Lothian and Scotland 1 November 2008 – 31 October 2010**

<table>
<thead>
<tr>
<th></th>
<th>Number of eligible people invited for screening* Lothian</th>
<th>% uptake Lothian</th>
<th>% uptake Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>114,187</td>
<td>46.7</td>
<td>50.0</td>
</tr>
<tr>
<td>Female</td>
<td>119,128</td>
<td>54.7</td>
<td>57.2</td>
</tr>
<tr>
<td>All</td>
<td>233,315</td>
<td>50.8</td>
<td>53.7</td>
</tr>
</tbody>
</table>

Source: ISD, NHS National Services Scotland - Bowel Screening Programme: Key performance indicators May 2011 Data submission

*Ineligible people include those who have had previous surgery to remove their colon

Much of the work to increase uptake rates has been nationally-led. Examples of this include:

- A co-ordinated effort across Scotland to promote Bowel Screening with materials produced and distributed by NHS Health Scotland.
- Throughout May and June 2010, large scale posters were displayed in the windows of 1195 pharmacies across Scotland to help raise awareness and encourage people to find out more and 'take the test'. These are still on display in many Lothian pharmacies.
- There was a case study about bowel cancer Men’s Health Matters newsletter as part of National Men’s Health Week in June 2010.
- The Scottish Government shared the statistics on the Scottish Bowel Screening Programme (June 2007- May 2010) at the end of August 2010 via a national press release to raise awareness that bowel screening saves lives.
- A short film which explains more about the test and how to complete it was launched in October 2009. The film is available in different languages with subtitles and British sign Language.

3.9 Mortality rates

Table 6 shows the mortality in Lothian and in Scotland over the period 2006-2010 for all cancers (excluding non-melanoma skin cancer) and for the four most common cancers: lung, colorectal, breast and prostate cancer.

In each case the rate of deaths standardised to the European population (to take account of differences in the populations) are presented, as are the Standardised
Mortality Ratios (SMRs). The SMRs show the rate of deaths in relation to the Scottish mortality rate; if the SMR is less than 100, then the mortality rate is less than the Scottish rate; if it is more than 100 it is greater than the Scottish rate.

For all cancers, the mortality rate in Lothian is lower than in Scotland, although it should be recognised that Scottish cancer mortality does not compare favourably with overall UK cancer mortality. For breast cancer the mortality rate is lower than the Scottish rate; for lung, colorectal and prostate cancer, the mortality rates are not significantly different to the Scottish rates. Mortality rates are also presented by Scottish Index of Multiple Deprivation (SIMD) (Figure 7). This shows Lothian’s position to be similar to that in Scotland overall, with a higher mortality in the most deprived groups. This reinforces the importance of targeting preventive programmes at this part of the population.

Table 6: European Age Standardised Mortality Rates and Standardised Mortality Ratios from all cancers and four types of cancer for Lothian and for Scotland for 2006-2010

<table>
<thead>
<tr>
<th>All excluding non-melanoma skin cancer</th>
<th>Lung cancer (excluding mesothelioma)</th>
<th>Colorectal cancer</th>
<th>Breast cancer</th>
<th>Prostate cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
<td>Scotland</td>
<td>Lothian</td>
<td>Scotland</td>
<td>Lothian</td>
</tr>
<tr>
<td>EASR</td>
<td>198.7</td>
<td>206.6</td>
<td>56.2</td>
<td>56.5</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>194.7</td>
<td>205.1</td>
<td>54.1</td>
<td>55.7</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>202.7</td>
<td>208.2</td>
<td>58.3</td>
<td>57.3</td>
</tr>
<tr>
<td>SMR</td>
<td>96.5</td>
<td>100</td>
<td>99.3</td>
<td>100</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>94.6</td>
<td>95.7</td>
<td>89.5</td>
<td>81.4</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>98.3</td>
<td>103.0</td>
<td>101.0</td>
<td>94.6</td>
</tr>
</tbody>
</table>

Data source: http://www.isdscotland.org/Health-Topics/Cancer/Publications/data-tables.asp?id=596#596

EASR: age-standardised mortality rate per 100,000 person-years at risk (European standard population)
CI: Confidence Interval
SMR: Standardised Mortality Ratio

Figure 7: Age-standardised cancer mortality rate per 100,000 population for Lothian and for Scotland by deprivation quintile for 2006 - 2010

Source: General Register Office for Scotland (GROS) (mortality and populations)
Data extracted November 2011.

4 Key Risks

4.1 Maintaining HSMR reductions at RIE, WGH and St. John’s. However, HSMRs continue to be less than 1 on all three acute sites, indicating that the number of observed deaths is fewer than the expected number.

4.2 Achieving the national 3-day and 20-day response rate target for complaints.

5 Risk Register

5.1 Maintaining HSMR reductions is captured on the Risk Register under Standard of Clinical Care (1077) and is identified as a medium risk.

5.2 Maintaining the national complaints targets is captured on the Risk Register under Litigation Exposures (1082) and is identified as a high risk.

6 Impact on Health Inequalities

6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.
7 Impact on Inequalities

7.1 This paper is a report on progress against the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010), Scottish Patient Safety Programme (assessed in May 2009) and the Complaints Modernisation Strategy (May 2010). The Strategy will have a positive impact on equality in terms of both patients and staff.

8 Involving People

8.1 There is extensive patient and carer involvement through the Cancer Network at a local, regional and national level.

9 Resource Implications

9.1 There are no resource implications associated with this report.

Dr David Farquharson
Medical Director
18 December 2011
David.farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Technical Appendix
Technical Appendix

Hospital Standardised Mortality Ratio (HSMR)
HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level ‘warnings’ for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

Adverse Events
Adverse events are currently measured at the three main acute sites using retrospective case note reviews using the ‘Global Trigger Tool’. An external review by the Institute for Healthcare Improvement (IHI) in February 2010 confirmed that NHS Lothian’s case note review process was robust and set the baseline for adverse event rates at 52 adverse events per 1,000 patient days.

S.aureus Bacteraemia (SAB) rate
This represents a HEAT target. From April 2011, new targets were set based on Acute Occupied Bed Days (AOBD). For NHS Lothian the target is to achieve a rate of less than 0.26 episodes of SABs per 1,000 AOBD by year ending March 2013.

C.difficile Infection (CDI) rate
This represents a HEAT target. From April 2011, new targets were set based on Total Occupied Bed Days (OBCD). For NHS Lothian the target is to achieve a rate of less than 0.39 episodes of CDI per 1000 AOBD by March 2013.

Incidents associated with harm
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.
NHS LOTHIAN

Board Meeting
25 January 2012

Director of Finance (Executive Lead)

FINANCIAL POSITION TO 30 NOVEMBER 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 eight 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 Recommendation

2.1 The Board is invited to note the improvement in the financial position during month 8 projected breakeven financial position for 2011/12.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an over spend of £2.3m for the first eight months of financial year 2011/12, a favourable movement in the month of £0.576m This reflects under delivery of £1.084m against the Local Reinvestment Plan (LRP) target (also referred to as efficiency target) and £1.232m of overspends on other budgets, represented in the main by prescribing.

3.2 Following the Mid Year Review, additional non recurring support has been allocated to operational budgets, recognising costs associated with demographic related activity (£2.3m) and prescribing price increases (£3.7m). In addition, a further £1.88m is reflected as an offset to the overall position at the end of November; which will be funded through other non recurring flexibility identified.

3.3 The month 8 results are summarised in Table 1 overleaf:
Table 1 – Financial Position to 30 November 2011

<table>
<thead>
<tr>
<th>Total</th>
<th>Outstanding Efficiency Savings</th>
<th>Net of Efficiency Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>University Hospitals Division</td>
<td>(440)</td>
<td>490</td>
</tr>
<tr>
<td>CH(C)Ps</td>
<td>(2,553)</td>
<td>(1,212)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(1,192)</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>9</td>
<td>(362)</td>
</tr>
<tr>
<td>NRAC support</td>
<td>1,876</td>
<td>0</td>
</tr>
<tr>
<td>Under/(Over)spend</td>
<td>(2,300)</td>
<td>(1,084)</td>
</tr>
</tbody>
</table>

3.4 Divisional commentary is set out below and detailed figures are included in Appendix 1.

**University Hospitals Division**

3.5 The University Hospitals Division is reporting an over spend of £0.440m for the period to date: an under spend of £0.423m against baseline budgets; over achievement of £0.490m against the agreed Local Reinvestment Plan (LRP) target; and a shortfall of £1.353m against local Divisional savings. The improvement in the baseline position masks a notable overspend of £0.380m in relation to Waiting Times, and work is ongoing to estimate the likely fully year financial impact to secure delivery of all targets by 31 March 2012.

3.6 The Division has delivered £14.65m (57%) of its annual efficiency target after 8 months. However, significant additional work remains in progress to secure substantial recurrent delivery of these savings.

3.7 Subject to the LRP and Waiting Times target risks, the Division anticipates being able to deliver breakeven against the baseline budget by the year end.

**Primary and Community**

3.8 The CHPs / CHCP / Primary Care services are reporting a net overspend of £2.553m for the period. The improvement to the position reflects the benefit of non recurring budget support for the prescribing pricing pressures, agreed through the Mid Year Review process. In addition, there has been an improvement in the underlying position (£0.536m). The residual over spend comprises three broad issues: prescribing (£1.639m); slippage on non-prescribing LRP (£0.520m) and HCH/GMS services (£0.393m).

3.9 Of the prescribing budget overspend, £0.692m relates to slippage on the savings target. The position continues to be based on a projected £1m attributable to unmet prescribing LRP.

3.10 As previously reported, prescribing volumes and expenditure continue to run above expectations across most areas. Prescribing volumes are influenced by the impact of public health campaigns (for example smoking) and more targeting of Quality
and Outcomes Framework (QOF) indicators will tend to generate additional prescribing costs. Smoking cessation, dementia, diabetes, respiratory and infections are significant contributors to this growth. It is also 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.

3.11 The prescribing recovery plan in place across the CHPs concentrates on tackling the issues of unmet LRP and volumes. The pricing position has been supported by additional non recurring flexibility agreed as part of the Mid Year Review process.

3.12 The improved overall Hospital and Community Healthcare (HCH) position reflects a combination of budgetary relief and the impact of management recovery plans which has continued into November from the previous month.

3.13 Slippage on the LRP target is largely attributable to the Edinburgh CHP, General Medical Services and Prescribing. Within all CHP/CHCPs there is still £3.9m of the annual LRP target for which schemes have not yet been fully developed which accounts for most of the slippage and work is continuing to address this shortfall. Prescribing accounts for 57% of the current plan slippage.

**Corporate Budgets**

3.14 Corporate Budgets are broadly delivering a balanced position for the period; with a net under spend of £0.009m, including slippage of £0.36m on LRP schemes.

3.15 As highlighted in previous months, the main issues with baseline budget performance are continuing overspends within Estates (particularly Facilities Management). In addition, there are one off set up costs within eHealth, for speech recognition initiatives. In relation to delivery of savings targets, the Mid Year Review forecast indicates full achievement in all areas, with the exception of Facilities and HR (combined £1m anticipated slippage). Work is continuing to identify additional schemes to meet the in year shortfall on a non recurring basis and to address the potential impact on recurrent delivery.

**Strategic Budgets**

3.16 Strategic Budgets are reporting a £1.192m overspend for the 8 months, which is largely related to Unplanned Activity (UNPAC) costs of the high cost psychiatric/learning disability cases (£1.452m), offset by extra recoveries on clinical claim legal costs £0.328m.

**Efficiency & Productivity**

3.17 As highlighted below, £25.4m of savings have been achieved during the first eight months of the year. It is important to note that the full year effect of the schemes generating these savings is in the region of £42.8m, and this is underpinned by 409 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 - Nov Target £000</th>
<th>April – Nov Actual £000</th>
<th>Slippage £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHD</td>
<td>26,840</td>
<td>25,840</td>
<td>14,160</td>
<td>14,650</td>
<td>490</td>
</tr>
<tr>
<td>CH(C)Ps/PCCO</td>
<td>14,514</td>
<td>14,507</td>
<td>6,921</td>
<td>5,709</td>
<td>(1,212)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>7,005</td>
<td>7,005</td>
<td>4,205</td>
<td>3,843</td>
<td>(362)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>1,771</td>
<td>1,771</td>
<td>1,181</td>
<td>1,181</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50,130</strong></td>
<td><strong>49,122</strong></td>
<td><strong>26,467</strong></td>
<td><strong>25,383</strong></td>
<td><strong>(1,084)</strong></td>
</tr>
</tbody>
</table>

3.18 With 53% of the year’s target delivered after eight months (£7m behind a straight calendar phasing), continued management focus on delivery of the efficiency target, and minimising recurrent carry forward, remains a priority for all budget holders. This is critical to the achievement of financial balance and a secure baseline position ahead of the financial planning cycle for 2012/13 and beyond. Ongoing discussion, detailed reporting and agreement of further management actions are being led by the monthly Efficiency & Productivity Group.

**Capital**

3.19 Expenditure of £47.2m has been incurred to the end of November against the programme for the year, reflecting progress with the re-provision programme. Major areas of core spending include: the Royal Victoria Building (£17.4m); Musselburgh Primary Care Centre (£9.1m); Chalmers Sexual Health Centre (£1m); Dalkeith Medical Centre (£2.2m); the birthing suite at the Royal Infirmary of Edinburgh (£2.2m), and development expenditure of £5m on the new Royal Hospital for Sick Children at Little France. Appendix 2 provides further detail.

**Activity**

3.20 High level activity figures are presented for the eight months April to November 2011, with the same months’ activity in the two previous years shown for comparative purposes. As well as the average activity in the twelve month period December 2010 to November 2011. The detail is attached as Appendix 3.

3.21 In recognition of the change in the balance between inpatient/day case work as efforts are made to meet/ exceed the BADS target of 80% day cases, elective inpatient activity and day cases have been added together to produce a total figure for elective workload.

3.22 In summary, the activity position for the eight months April to November 2011, compared to the same period in 2010, is as follows:

- Decrease in elective workload of 1,332 admissions (equating to 2%)
- Increase in emergency admissions of 2,841 admissions (an increase of 5.7%)
- Decrease in new outpatients of 1,193 (just over 0.7%)
- Decrease in births of 51 over all sites, 0.7% (increase of 51 births on RIE site)
• A very large increase in intensity of workload in the Neonatal Unit with intensive care occupied bed days up over 40% in the eight months, and a 2.5% increase in total occupied bed days in the Neonatal Unit
• Increase in diagnostic procedures of over 17%, an additional 2,831 procedures, (as efforts were made to achieve the 6 week maximum wait by the end of May, and to sustain the position thereafter)

3.23 The Health Intelligence Unit (HIU) has now undertaken a comparison of activity in the years 2009-10 and 2010-11 for the three main acute sites in Lothian based on an analysis of casemix using HRGs (Healthcare Resource Groups, groupings of activity which consume similar levels of resource – which are based on a combination of procedure, age and co-morbidities). Vascular Surgery has been selected for further analysis this month. Analysis of Vascular activity at HRG level shows that there has been a major shift in complexity of elective activity, with a slight decrease in complexity of the emergency workload.

<table>
<thead>
<tr>
<th>Patient type</th>
<th>Indicator</th>
<th>2009-10</th>
<th>2010-11</th>
<th>%change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>Occupied bed days</td>
<td>10,877</td>
<td>11,339</td>
<td>4.2%</td>
</tr>
<tr>
<td>Elective Inpatients</td>
<td>Occupied bed days</td>
<td>3,095</td>
<td>3,337</td>
<td>7.8%</td>
</tr>
<tr>
<td>Non-elective Inpatients</td>
<td>Occupied bed days</td>
<td>7,782</td>
<td>8,002</td>
<td>2.8%</td>
</tr>
<tr>
<td>All patients</td>
<td>Complexity</td>
<td>1.077</td>
<td>1.119</td>
<td>3.9%</td>
</tr>
<tr>
<td>Elective Inpatients</td>
<td>Complexity</td>
<td>0.864</td>
<td>0.933</td>
<td>8%</td>
</tr>
<tr>
<td>Non-elective Inpatients</td>
<td>Complexity</td>
<td>1.574</td>
<td>1.557</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Day cases</td>
<td>Complexity</td>
<td>0.618</td>
<td>0.685</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

3.24 The main changes between the two years impacting on elective inpatient activity are:

• An increase in complexity of varicose vein procedures
• An increase in the number/complexity of lower limb arterial surgical cases with clinical complications
• An increase in the complexity of amputations
• Decreases in complexity for therapeutic endovascular procedures, and non surgical peripheral vascular disease
• A decrease in the number of some aortic or abdominal surgical procedures

3.25 The key changes relating to Vascular day cases are:

• An increase in complexity of non surgical peripheral vascular disease cases, and of vascular access for renal replacement therapy
• A decrease in complexity of both primary unilateral and bilateral varicose vein procedures.

3.26 The increase in occupied bed days for Vascular elective inpatients seems to be explained by the changes in complexity between the two years. However the increase in occupied bed days for the emergency activity, although small, is
not understood as both overall emergency activity and the complexity of this workload have decreased.

3.27 Further detail on the conclusions of this exercise will be reported in subsequent months.

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 Executive Management Team 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
18 January 2012
carol.potter@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Financial Position by Service Area April – Nov 2011
Appendix 2: Analysis of Capital Expenditure by project
Appendix 3: Comparative activity analysis
# NHS Lothian Expenditure Summary

## November 2011

### APPENDIX 1

<table>
<thead>
<tr>
<th>Annual Budget 2010-11</th>
<th>YTD Budget</th>
<th>YTD Actuals</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
</tr>
</tbody>
</table>

### UNIVERSITY HOSPITAL DIVISION

- **Medical**
  - 118,422
  - 78,675
  - 79,723
  - (1,048)
- **REAS & MOE**
  - 65,799
  - 43,241
  - 43,679
  - (438)
- **Surgical**
  - 75,815
  - 50,047
  - 50,124
  - (78)
- **Labs, A&T, Critical Care, HDSU**
  - 116,782
  - 77,665
  - 76,907
  - 757
- **Women & Children & Neuroscience**
  - 88,835
  - 57,925
  - 57,647
  - 278
- **Radiology, Cancer & Head & Neck**
  - 97,066
  - 64,228
  - 63,898
  - 331
- **Corporate**
  - 15,336
  - 7,482
  - 7,725
  - (243)

### CHCP/CHPs/PCCO

- **East Lothian CHP**
  - 61,818
  - 42,608
  - 43,089
  - (481)
- **Edinburgh CHP**
  - 240,961
  - 162,889
  - 164,623
  - (1,734)
- **Midlothian CHP**
  - 68,802
  - 46,284
  - 46,602
  - (318)
- **West Lothian CHP**
  - 95,127
  - 61,360
  - 61,382
  - (22)
- **PCCO**
  - 13,493
  - (4,369)
  - (4,372)
  - 3

### STRATEGIC BUDGETS

- **SLAs/UNPACs/Non Contract Activity**
  - 10,024
  - 6,799
  - 8,251
  - (1,452)
- **Capital charges and Asset Impairments**
  - 52,660
  - 25,244
  - 25,375
  - (131)
- **Provisions for Pension Costs and Claims**
  - 11,367
  - 1,676
  - 1,351
  - 325
- **Commissioning from 3rd Sector**
  - 12,975
  - 9,172
  - 9,202
  - (30)
- **Reserves and Uncommitted Allocations**
  - 20,775
  - 1,051
  - 955
  - 97

### CORPORATE BUDGETS

- **Chief Executive’s Department**
  - 525
  - 350
  - 340
  - 10
- **Medical Director**
  - 990
  - 381
  - 317
  - 65
- **Consort**
  - 43,535
  - 29,198
  - 29,262
  - (64)
- **Communications**
  - 600
  - 399
  - 406
  - (8)
- **Ehealth**
  - 25,549
  - 15,053
  - 15,360
  - (307)
- **Facilities Management**
  - 77,248
  - 49,863
  - 50,506
  - (643)
- **Finance and capital planning**
  - 10,911
  - 7,238
  - 7,162
  - 76
- **Human Resources & OH&S**
  - 10,399
  - 6,103
  - 6,172
  - (68)
- **Nursing**
  - 4,138
  - 1,889
  - 1,796
  - 93
- **Pharmacy**
  - 12,216
  - 7,971
  - 7,464
  - 508
- **Planning**
  - 3,297
  - 2,068
  - 1,831
  - 238
- **Public Health**
  - 3,864
  - 2,430
  - 2,327
  - 104
- **Other**
  - (190)
  - (429)
  - (437)
  - 7

### MYR Flexibility

- **3,228**
- **1,876**
- **0**
- **1,876**

### Allocations to support Prescribing

- **0**
- **0**
- **0**
- **0**

### TOTAL

- **1,362,365**
- **856,365**
- **858,665**
- **(2,300)**
## APPENDIX 2

**Capital Expenditure**

<table>
<thead>
<tr>
<th>Schemes with Specific Funding</th>
<th>Agreed Programme £m</th>
<th>11/12 Expenditure year to date £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital</td>
<td>23.623</td>
<td>17.365</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>11.574</td>
<td>9.082</td>
</tr>
<tr>
<td>Dalkeith Medical Centre</td>
<td>2.186</td>
<td>2.177</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>1.000</td>
<td>0.290</td>
</tr>
<tr>
<td>Pharmacy Modernisation</td>
<td>0.013</td>
<td>0.013</td>
</tr>
<tr>
<td>Radiotherapy - Phase 6</td>
<td>0.052</td>
<td>0.047</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>1.649</td>
<td>1.600</td>
</tr>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>0.290</td>
<td>0.001</td>
</tr>
<tr>
<td>Radiotherapy-Other</td>
<td>0.032</td>
<td>0.000</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>0.349</td>
<td>(0.091)</td>
</tr>
<tr>
<td>Gullane Medical Centre</td>
<td>0.830</td>
<td>0.000</td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>0.060</td>
<td>0.038</td>
</tr>
<tr>
<td>Specialist Services and Genetics</td>
<td>0.252</td>
<td>0.000</td>
</tr>
<tr>
<td>Purchase of Items for Cancer Treatments</td>
<td>0.265</td>
<td>0.000</td>
</tr>
<tr>
<td>Prison Transfer of Assets</td>
<td>0.019</td>
<td>0.000</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>4.467</td>
<td>2.978</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>46.660</td>
<td>33.499</td>
</tr>
</tbody>
</table>

**NHS Lothian Formula Programme**

<p>| Statutory Compliance                          | 2.086               | 0.990                            |
| Medical Equipment                             | 5.300               | 1.253                            |
| E-Health Strategic Priorities                 | 2.071               | 0.536                            |
| National PACS Refresh 2007-17                 | 0.129               | 0.070                            |
| Traffic management                            | 0.555               | 0.177                            |
| Expansion of renal capacity RIE               | 1.050               | 1.434                            |
| Chemotherapy e-Prescribing &amp; Administration System (CePAS) | 0.133 | 0.049 |
| Laboratory Equipment                          | 0.302               | 0.207                            |
| Observation Ward A&amp;E Rie                      | 0.213               | 0.410                            |
| Management of Finance Leases                  | 0.432               | 0.378                            |
| Royal Hospital for Sick Children              | 6.799               | 5.049                            |
| Birthing suite (RIE)                          | 2.052               | 2.164                            |
| MCH Equipment                                 | 0.019               | 0.015                            |
| MCH Capital Grants                            | 0.132               | 0.041                            |
| Maternity Unit (SJH)                          | 0.123               | 0.007                            |
| Tranent                                       | 0.100               | 0.000                            |
| Speech Recognition                            | 0.205               | 0.205                            |
| HEI                                           | 0.500               | 0.000                            |
| E-Health scanners                             | 0.232               | 0.000                            |
| Completed Schemes under Review                | (0.576)             | (0.577)                          |
| <strong>Total</strong>                                     | 21.856              | 12.409                           |</p>
<table>
<thead>
<tr>
<th>Other sources of funding</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Breast Cancer Theatre WGH</td>
<td>0.377</td>
<td>0.294</td>
</tr>
<tr>
<td>Specific Allocations</td>
<td>0.417</td>
<td>0.000</td>
</tr>
<tr>
<td>Chalmers Hospital Redevelopment</td>
<td>1.147</td>
<td>1.006</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1.940</strong></td>
<td><strong>1.300</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>70.456</strong></td>
<td><strong>47.209</strong></td>
</tr>
</tbody>
</table>
## Elective Inpatient and Daycase Admissions by CMT

<table>
<thead>
<tr>
<th>Service</th>
<th>Apr - Nov 2009</th>
<th>Apr - Nov 2010</th>
<th>Apr - Nov 2011</th>
<th>Mthly Ave Dec 10 to Nov 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>1089</td>
<td>1008</td>
<td>882</td>
<td>118</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>6397</td>
<td>5690</td>
<td>5463</td>
<td>665</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>269</td>
<td>308</td>
<td>201</td>
<td>25</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>10358</td>
<td>10352</td>
<td>10085</td>
<td>1253</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>4687</td>
<td>4507</td>
<td>4367</td>
<td>539</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>9738</td>
<td>9707</td>
<td>9192</td>
<td>1174</td>
</tr>
<tr>
<td>Oncology</td>
<td>15849</td>
<td>15851</td>
<td>16506</td>
<td>2004</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Critical care</td>
<td>32</td>
<td>31</td>
<td>31</td>
<td>4</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>14549</td>
<td>13682</td>
<td>13127</td>
<td>1614</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>478</td>
<td>434</td>
<td>363</td>
<td>46</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>73</td>
<td>120</td>
<td>144</td>
<td>17</td>
</tr>
<tr>
<td><strong>All elective inpatient admissions</strong></td>
<td><strong>63523</strong></td>
<td><strong>61696</strong></td>
<td><strong>60364</strong></td>
<td><strong>7459</strong></td>
</tr>
</tbody>
</table>

## Emergency Inpatient Admissions by CMT

<table>
<thead>
<tr>
<th>Service</th>
<th>Apr - Nov 2009</th>
<th>Apr - Nov 2010</th>
<th>Apr - Nov 2011</th>
<th>Mthly Ave Dec 10 to Nov 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>23807</td>
<td>24725</td>
<td>26352</td>
<td>3299</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>2054</td>
<td>1994</td>
<td>2184</td>
<td>278</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>611</td>
<td>508</td>
<td>796</td>
<td>101</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>8365</td>
<td>8310</td>
<td>8768</td>
<td>1077</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>2338</td>
<td>2166</td>
<td>2092</td>
<td>266</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>2091</td>
<td>2101</td>
<td>2307</td>
<td>286</td>
</tr>
<tr>
<td>Oncology</td>
<td>1432</td>
<td>1521</td>
<td>1548</td>
<td>195</td>
</tr>
<tr>
<td>Critical Care</td>
<td>657</td>
<td>727</td>
<td>827</td>
<td>106</td>
</tr>
<tr>
<td>Women &amp; Children (excl Maternity)</td>
<td>7287</td>
<td>6954</td>
<td>7047</td>
<td>896</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>296</td>
<td>318</td>
<td>264</td>
<td>33</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>294</td>
<td>227</td>
<td>207</td>
<td>26</td>
</tr>
<tr>
<td><strong>All emergency inpatient admissions</strong></td>
<td><strong>49232</strong></td>
<td><strong>49551</strong></td>
<td><strong>52392</strong></td>
<td><strong>6563</strong></td>
</tr>
</tbody>
</table>
## NHS Lothian

### Activity Summary November 2011 (continued)

<table>
<thead>
<tr>
<th>Births</th>
<th>Apr - Nov 2009</th>
<th>Apr - Nov 2010</th>
<th>Apr - Nov 2011</th>
<th>Mthly Ave Dec 10 to Nov 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births - RIE</td>
<td>4335</td>
<td>4580</td>
<td>4631</td>
<td>574</td>
</tr>
<tr>
<td>Births - St John's</td>
<td>2040</td>
<td>1960</td>
<td>1874</td>
<td>236</td>
</tr>
<tr>
<td>Home Births</td>
<td>120</td>
<td>109</td>
<td>93</td>
<td>11</td>
</tr>
<tr>
<td>Births - Total</td>
<td>6495</td>
<td>6649</td>
<td>6598</td>
<td>821</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neonatal Unit Occupied Bed Days</th>
<th>Apr - Nov 2009</th>
<th>Apr - Nov 2010</th>
<th>Apr - Nov 2011</th>
<th>Mthly Ave Dec 10 to Nov 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care</td>
<td>1349</td>
<td>1368</td>
<td>1922</td>
<td>221</td>
</tr>
<tr>
<td>High dependency</td>
<td>1231</td>
<td>1608</td>
<td>1564</td>
<td>213</td>
</tr>
<tr>
<td>Special Care</td>
<td>4522</td>
<td>5016</td>
<td>4709</td>
<td>584</td>
</tr>
<tr>
<td>All NNU Bed Days</td>
<td>7102</td>
<td>7992</td>
<td>8195</td>
<td>1018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic procedures (scopes)</th>
<th>Apr - Nov 2009</th>
<th>Apr - Nov 2010</th>
<th>Apr - Nov 2011</th>
<th>Mthly Ave Dec 10 to Nov 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>12234</td>
<td>12910</td>
<td>15557</td>
<td>1842</td>
</tr>
<tr>
<td>Urology</td>
<td>2988</td>
<td>3323</td>
<td>3507</td>
<td>435</td>
</tr>
<tr>
<td>All scopes</td>
<td>15222</td>
<td>16233</td>
<td>19064</td>
<td>2277</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New outpatients by CMT</th>
<th>Apr - Nov 2009</th>
<th>Apr - Nov 2010</th>
<th>Apr - Nov 2011</th>
<th>Mthly Ave Dec 10 to Nov 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>19694</td>
<td>19965</td>
<td>20059</td>
<td>2484</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory,</td>
<td>9702</td>
<td>9129</td>
<td>9169</td>
<td>1264</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>1748</td>
<td>1824</td>
<td>2729</td>
<td>376</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>20701</td>
<td>20816</td>
<td>20530</td>
<td>2667</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>20418</td>
<td>20175</td>
<td>19737</td>
<td>2466</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>36326</td>
<td>36488</td>
<td>36138</td>
<td>4411</td>
</tr>
<tr>
<td>Oncology</td>
<td>8645</td>
<td>9341</td>
<td>10291</td>
<td>1248</td>
</tr>
<tr>
<td>Anaesthetics &amp; Theatres</td>
<td>662</td>
<td>836</td>
<td>902</td>
<td>104</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>35928</td>
<td>35541</td>
<td>34155</td>
<td>4181</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>3239</td>
<td>2207</td>
<td>1463</td>
<td>175</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>1643</td>
<td>1747</td>
<td>1703</td>
<td>207</td>
</tr>
<tr>
<td>All new outpatients</td>
<td>158706</td>
<td>117956</td>
<td>156876</td>
<td>19583</td>
</tr>
</tbody>
</table>
1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board members on the most recently available NHS Lothian performance data on Waiting Times as reported through local and national systems.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 receive this update report covering recent waiting times performance;

2.2 note the actions being taken to ensure Access Targets are brought back on trajectory; and

2.3 note that discussions are taking place with the Health Intelligence Unit to develop Dashboards containing this performance information for Board members on an ongoing basis. Progress on this work will be reported at the March Board meeting.

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 Period</th>
<th>Current Target / Milestone</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suspicion of Cancer referrals (62 days)</strong></td>
<td>Qt 3, 2011</td>
<td>Breast 100%</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cervical 77.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colorectal 97.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head &amp; Neck 94.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung 96.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lymphoma 83.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melanoma 94.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ovarian 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper GI 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urological 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>95%</td>
<td>97.8%</td>
<td>√</td>
</tr>
<tr>
<td><strong>31 day DTTTT - all cancers</strong></td>
<td>Qt 3, 2011</td>
<td>95%</td>
<td>98.9%</td>
<td>√</td>
</tr>
<tr>
<td><strong>18 weeks RTT: Composite Performance</strong></td>
<td>Nov 2011</td>
<td>87.5%</td>
<td>87.6%</td>
<td>√</td>
</tr>
<tr>
<td><strong>New outpatients - max 12 weeks from referral</strong></td>
<td>Nov 2011</td>
<td>0</td>
<td>1398</td>
<td>X</td>
</tr>
<tr>
<td><strong>Inpatient Case - max 9 weeks from referral</strong></td>
<td>Nov 2011</td>
<td>0</td>
<td>1547</td>
<td>X</td>
</tr>
<tr>
<td><strong>Drug and Alcohol Treatment - max 5 weeks from referral</strong></td>
<td>Oct &amp; Nov 2011</td>
<td>57.2%</td>
<td>59.1%</td>
<td>√</td>
</tr>
<tr>
<td>Wait for key diagnostic tests &gt; 4 weeks</td>
<td>Nov 2011</td>
<td>MRI</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CT</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barium</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ultrasound</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper endoscopy</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower endoscopy</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colonoscopy</td>
<td>149</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cystoscopy</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>329</td>
<td>X</td>
</tr>
<tr>
<td><strong>A&amp;E Waits - % of patients waiting 4 hours or less</strong></td>
<td>Nov 2011</td>
<td>98%</td>
<td>RIE – 92%</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>WGH – 97%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SJH – 97.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RHSC – 98.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95.10%</td>
<td></td>
</tr>
<tr>
<td><strong>Cataract Waiting Times - max wait 18 wks outpatient and inpatient combined</strong></td>
<td>Nov 2011</td>
<td>0</td>
<td>279</td>
<td>X</td>
</tr>
<tr>
<td><strong>Hip Surgery Waiting Times - % of Hip Fracture operations within 24 safe operating hours</strong></td>
<td>Nov 2011</td>
<td>98%</td>
<td>97.3%</td>
<td>X</td>
</tr>
<tr>
<td><strong>Wait for cardiac intervention to be &lt; 15wks (angiography, angioplasty and CABG)</strong></td>
<td>Nov 2011</td>
<td>0</td>
<td>0</td>
<td>√</td>
</tr>
<tr>
<td><strong>Audiology – Compliance with 12 week stage of treatment milestone from March 2011. (Progress towards an 18 week pathway due December 2011).</strong></td>
<td>Nov 2011</td>
<td>0</td>
<td>5</td>
<td>X</td>
</tr>
</tbody>
</table>

3.2 In the latest period, the following five 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
- Cardiac interventions – less than 15 weeks waiting times standard

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, Cataract and Hip Surgery Standards

During October and November, changes to waiting list management practice to ensure strict compliance with the Scottish Government New Ways Guidance and ending the practice of offering treatment in England for adult specialties (not including children) have led to a high number of breaches of the outpatient and inpatient/day case stage of treatment targets. These issues continue to impact on performance during December as the number of patients recorded as “unavailable” on waiting lists has decreased very significantly.

The position reported at the end of November is as follows:

<table>
<thead>
<tr>
<th>Disease Area</th>
<th>Outpatients</th>
<th>Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>27</td>
<td>358 (369)</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td></td>
<td>114 (16)</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>84 (4)</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>50 (1)</td>
<td>522 (215)</td>
</tr>
<tr>
<td>General Surgery</td>
<td>75</td>
<td>282 (66)</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>33</td>
<td>96 (10)</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>663 (49)</td>
<td>52</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>139 (9)</td>
<td></td>
</tr>
<tr>
<td>Pain control</td>
<td>8 (4)</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>269</td>
<td></td>
</tr>
<tr>
<td>Maxillofacial/Oral</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>Neurology/Neurosurgery</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Gynaecology</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>30 (27)</td>
<td>74 (74)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1398 (94)</strong></td>
<td><strong>1547 (750)</strong></td>
</tr>
</tbody>
</table>

N.B. Numbers in brackets () are Oct figures

Capacity elsewhere in Scotland has been sourced in an effort to address these issues, and to date capacity for a number of procedures has been offered by NHS Borders from the end of last year (December 11); other adjoining health boards were unable to offer capacity. In addition, all available capacity at Golden Jubilee National Hospital is being utilised and, as there remains a significant imbalance between current available capacity and demand, cases have been sent to Spire Murrayfield as has been discussed and agreed with the Scottish Government Health Directorates.
Clinical Management Teams have produced recovery plans for those specialties with significant numbers of breaches, and a risk assessment of the actions proposed has been undertaken. This shows the highest risk specialties to be Orthopaedic Surgery and Urology for both outpatients and inpatients/day cases. However, there remain risks in other areas, notably potential difficulty in delivering the volume of additional activity required over winter months when traditionally bed pressures are experienced.

In addition to the stage of treatment targets reported, there were 279 breaches of the national cataract standard, 221 relating to 1st eye cataracts and 58 for the 2nd eye pathway. Additional activity is being undertaken and this has been effective in reducing the number of cataract breaches (provisional information for the end of December shows an improving position with breaches reduced to circa 160).

4.2 Wait for Diagnostic Tests

In line with the agreement with the Scottish Government Health Directorates waits for these tests (upper and lower endoscopy and colonoscopy) will fluctuate between four and six weeks. The six week standard was met at the end of November. At the end of November there were 329 patients waiting between 4 and 6 weeks for these tests, including 47 flexible cystoscopies (previously these were meeting the 4 week target). Waits for the 4 key Radiology tests remain at less than 4 weeks.

Work is continuing to ensure that surveillance patients are brought in for their investigations within the appropriate timescale.

4.3 A&E Waits

Performance for the month of November across all sites was 95.1%; this was impacted adversely by high activity in A&E and lack of available acute beds due to high numbers of patients whose discharge was delayed, leading to lengthy waits for admission.

This continues to be an area of focus to improve performance through:
- ensuring 100% performance for Flow 1 (minors)
- ensuring reliable and responsive "pull" from downstream sites and maintaining a focus on delayed discharge numbers remains important
- 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

4.4 Audiology

At the end of November there were a total of 5 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 2012, waits are to be reduced to a total pathway time of 18 weeks (nine weeks for each stage), and plans are in place to achieve this.

5 Risk Register

5.1 A number of service areas highlighted in this report are working on capacity plans which will bring a number of people waiting back into line by the end of March 2012. These are being reviewed by the UHD SMT on an ongoing basis. In addition the review of Standing Operating Procedures in relation to complying with Waiting Times will also be concluded by the end of January 2012 and will also feature as part of capacity plans moving forward.

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 Through the work being done in developing capacity plans and the review of operating procedure as highlighted above, colleagues from across the system will be engaged in the process.

9 Resource Implications

9.1 Through the recovery plans that are being developed there may be the need for additional resources. These will be identified on a service by service basis.

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Acting Director of Strategic Planning  
18 January 2012  
alex.mcmahon@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
25 January 2012

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 November and December 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>November</td>
<td>136</td>
<td>95</td>
<td>41</td>
<td>15</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td>December</td>
<td>120</td>
<td>80</td>
<td>40</td>
<td>27</td>
<td>2</td>
<td>37</td>
</tr>
</tbody>
</table>

3.3 At census point in November, NHS Lothian continued to report high numbers of patients delayed along similar numbers over the previous months. The most recent census in December has seen an improvement, with a lower overall number delayed, though there has been a significant increase in the number delayed over 6 weeks and an increase in the average length of stay. Whilst there has been an improvement on previous month’s performance, the number of patients delayed continues to be a cause for concern for the Lothian partnership.
3.4 The table below sets out the performance across the Partnership areas for November and December. 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>Nov</td>
<td>Dec</td>
<td>Nov</td>
<td>Dec</td>
</tr>
<tr>
<td>Overall</td>
<td>72</td>
<td>61</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Over 6 weeks</td>
<td>13</td>
<td>26</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 72 and 61 delays in November and December, with 13 and 26 delayed over six weeks in the same time frame. As with previous months, the main reason for delay as identified by the Director of Health and Social Care remains care home choice, though there are also issues in providing care at home within the city.

3.6 East Lothian, despite a rise to 15 delays December, there have been no patients delayed over 6 weeks this financial year.

3.7 Midlothian continues to ensure patients are discharged timely and with no delays over 6 weeks, have managed to meet the national standard continuously for the previous 12 months.

3.8 West Lothian has no patients delayed in both November and December.

3.9 The overall number of patients delayed puts significant pressures on the whole hospital system, from A&E through to continuing care. As a result of this, and following intervention by the NHS Lothian Chief Executive and his opposite number at the City of Edinburgh Council, a range of actions are underway in partnership with Edinburgh Council to ensure patients are discharged to a more appropriate setting and to achieve the local target of 48 by the January census.

3.10 This has included focusing on increasing the number of packages of care, particularly for those who need support at home for 14 hours or less per week, increasing reablement, expanding capacity within the Intermediate Care Service and additional beds being made available within NHS Lothian as well as through care home placements with external providers. In detail, this includes:

- 20 additional social care workers providing reablement
- an additional overnight social care team
- an additional 1,500 hours of home care /care at home
- pharmacists undertaking medication reviews
- 1,050 social care staff trained on how to assist people with their medications
- equipment & adaptations, including additional drivers and professional advisers
- innovations through the third sector mainly to build capacity

Extensive planning has occurred, with and recruitment underway which will see enhancements as Edinburgh moves forward with further improvements, including:

- community therapy services
• telehealth equipment and staff
• a further overnight social care team
• a further 150 staff trained in medication procedures, to complete the in-house staff cohort
• additional carer support on discharge from hospital

This work, along with a number of new initiatives featured within the Change Fund, will support further reductions in the numbers of patients experiencing a delay.

3.11 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 November and December.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Codes</td>
<td>Nov Dec</td>
<td>Nov Dec</td>
<td>Nov Dec</td>
<td>Nov Dec</td>
</tr>
<tr>
<td></td>
<td>25 21</td>
<td>&lt;5 &lt;5</td>
<td>&lt;5 5</td>
<td>7 8</td>
</tr>
</tbody>
</table>

3.12 Overall, the number of patients coded as complex remains higher than previous months and work continues to find discharge solutions for these patients. We continue to have a high number for whom interim care home placements has been deemed inappropriate, with 13 being reported in December, reflecting increasing numbers of frail patients and those with dementia.

3.13 As a result of the above, there has been a corresponding increase in the average length of stay to 135 days, though this still remains relatively low compared to previous performance, which was 187 days in December 2010. It is also worth noting that 3 Learning Disability patients, who have been experiencing significant delays, are now going to a bespoke commissioned supported accommodation in Midlothian in late February, which is a very positive outcome.

4 Key Risks

4.1 The key risks are the increasing number of delays and the resulting pressure this creates on patient flow across health and social care.

5 Risk Register

5.1 The risks associated with delayed discharge continue to be managed in partnership with local authorities.

6 Impact on Health Inequalities

6.1 This section is not relevant to this performance report.
7 Impact on Inequalities

7.1 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.

8 Involving People

8.1 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.

9 Resource Implications

9.1 There are no direct resource implications associated with this report.

Alex McMahon
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18 January 2012
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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* and Meticillin Sensitive *Staphylococcus aureus* Bacteraemia to target resources for a sustained reduction and continue the roll-out of the of the Meticillin Resistant *Staphylococcus aureus* screening programme.
- Support the development of an escalation process for failure to comply with hand hygiene policy.
- Increased compliance with best practice, as recommended by the Antimicrobial Management Team.
- Recognise the need for ongoing work to maintain standards in anticipation of announced and unannounced Healthcare Environment Inspectorate visits.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 21 episodes of *Staphylococcus aureus* Bacteraemia recorded in December 2011 (3 Meticillin Resistant *Staphylococcus aureus*, 18 Meticillin Sensitive *Staphylococcus aureus*), compared to 25 in November 2011 (0 Meticillin Resistant *Staphylococcus aureus*, 25 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.

3.2 *Clostridium difficile* Infection: there were 15 episodes of *Clostridium difficile* Infection in patients aged 65 or over in December 2011, compared to 23 in November 2011. Currently, NHS Lothian is on trajectory to achieve the Health Efficiency Access Treatment Target of 0.39 cases or fewer by 1000 acute bed days by March 2013, with a current rate of 0.35.
3.3 The sixteenth bi-monthly national hand hygiene audit report was published on 30/11/11. This indicated that NHS Lothian is achieving a hand hygiene compliance of 95%, matching the overall national average compliance. Hand hygiene education and training continues to be delivered to non-compliant staff groups as dictated by audit results. A standard operational procedure for escalation of non-compliance with hand hygiene has been developed and is currently in consultation phase with staff partnership and other key stakeholders. Discussions regarding revision of existing training for nurses in training and their supervisors are underway with education providers.

3.4 Meticillin Resistant *Staphylococcus aureus* National Screening Programme: to date, the Screening Programme has screened more than 5,000 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, this entire group has been appropriately screened using the alternative nose and throat swabs. Roll-out has been completed; focus is now on robustness and capability.

3.4.1 Process development: a Key Performance Indicator reporting pilot is underway as part of a three board pilot for all boards in Scotland. Transition plans are in place for handover to the sustaining nursing team and this activity will be completed in February 2012.

3.4.2 Communications: ward level feedback continues and formal monthly reports are being developed. Hospital information road shows are continuing, as are workshops with Public Patient Fora.

3.5 Healthcare Environment Inspectorate: NHS Lothian were advised that during the announced Healthcare Environment Inspectorate Inspection at Liberton in December 2011 the Inspectors would be focusing on older people in acute care and as this was a test inspection for the Healthcare Environment Inspectorate a report was not expected. However, it is now understood that NHS Lothian will be provided with a private report which may be subject to Freedom of Information enquiries. The sixteen week Action Plan update for the Unannounced Inspection to the Royal Infirmary Edinburgh was returned to the Healthcare Environment Inspectorate prior to the deadline on 22/12/11.

3.6 Antimicrobial Management Team: in clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is at target level (95% compliance with Guidelines) for the Royal Infirmary Edinburgh but below the target level for the Western General Hospital. Documentation of indication for antibiotic treatment remains at the target level of 95% documentation of indication for both the Western General Hospital and the Royal Infirmary Edinburgh. For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy is currently below target level but administration of single dose antibiotic prophylaxis is at the target level (95% compliance with Guidelines and administration of a single dose).

3.6.1 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.
3.7 Domestic Services: work is ongoing around the movement from Patient Environment Audit Team Audits to Patient Experience Quality Indicators Audits, with a pilot audit scheduled for 31/1/12.

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of 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 increases 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 and loss of public/patient confidence.

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, which falls disproportionately on groups protected by equalities legislation.
8 Involving People


9 Resource Implications

9.1 The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection is variable but estimated to be between £4,000 and £15,000. This is contributed to by increased length of stay and additional treatment required.

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Director of Public Health & Health Policy  
19 January 2012  
alison.mccallum@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
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 November 2011

- During December 2011 there were 21 episodes of SAB recorded in NHS Lothian (3 MRSA, 18 MSSA)
- There were 15 episodes of CDI in patients aged 65 or over in December 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](http://www.nhsinform.co.uk/Health-Library/Articles/S/staphylococcal-infections/introduction)

MRSA: [http://www.nhsinform.co.uk/Health-Library/Articles/M/mrsa/introduction](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:


There were 21 episodes of Staphylococcus aureus Bacteraemia recorded in December 2011 (3 Meticillin Resistant Staphylococcus aureus, 18 Meticillin Sensitive Staphylococcus aureus), compared to 25 in November 2011 (0 Meticillin Resistant Staphylococcus aureus, 25 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)

There were 15 episodes of *Clostridium difficile* Infection in patients aged 65 or over in December 2011, compared to 23 in November 2011. Currently, NHS Lothian is on trajectory to achieve the Health Efficiency Access Treatment Target of 0.39 cases or fewer by 1000 acute bed days by March 2013 with a current rate of 0.35.

**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.washyourhandsoftthem.com/](http://www.washyourhandsoftthem.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 16th bi-monthly national hand hygiene audit report was published on 30/11/11. This indicated that NHS Lothian is achieving a hand hygiene compliance of 95%, matching the overall national average compliance. Hand hygiene education and training continues to be delivered to non compliant staff groups as dictated by audit results.

A standard operational procedure for escalation of non compliance with hand hygiene has been developed and is currently in consultation phase with Staff partnership and other key stakeholders.

**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)

Work is ongoing around the movement from Patient Environment Audit Team (PEAT) Audits to Patient Experience Quality Indicators (PQI) Audits with a pilot audit taking place on 31st January 2012.
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 24 incidents of gastro-enteritis investigated in NHS Lothian. Of these, norovirus has been confirmed in six (25%) of the incidents by the Virology laboratory. In the remaining 18 (75%) 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

NHS Lothian were advised that during the announced Healthcare Environment Inspectorate Inspection at Liberton in December 2011 the Inspectors would be focusing on Older People in Acute Care and as this was a test inspection for the Healthcare Environment Inspector a report is not expected. The Sixteen Week Action Plan Update for the Unannounced Inspection to the Royal Infirmary of Edinburgh was returned to the Healthcare Environment Inspectorate prior to deadline on 22nd December 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 is below the target level for the Western General Hospital. Documentation of indication for antibiotic treatment remains at 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 is currently below target level but administration of single dose antibiotic prophylaxis is 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 5000 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, this entire group has been appropriately screened using the alternative nose and throat swabs. Rollout has been completed; focus is now on robustness and capability.

Process development: KPI reporting pilot underway as part of a three board pilot for all boards in Scotland. Transition plans in place for handover to sustaining nursing team and this activity will be completed in February 2012.

Communications: Ward level feedback continues and formal monthly reports being developed. Hospital information road shows continuing as are workshops with PPFs.
SAB There were 21 SAB recorded during December 2011 (3 MRSA & 18 MSSA). The lowest number recorded in the last 12 month period is 14 (June 2011).

CDI There were 26 CDI recorded in December 2011, 15 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.

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Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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Quarterly Rolling Year *Clostridium difficile* Infection Cases per 1000 Total Occupied Bed Days for HEAT Target Measurement

Quarterly Rolling Year *Staphylococcus aureus* Bacteraemia Cases for HEAT Target Measurement
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: [http://www.washyourhandsofthem.com/](http://www.washyourhandsofthem.com/)

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: [http://www.hfs.scot.nhs.uk/online-services/publications/hai/](http://www.hfs.scot.nhs.uk/online-services/publications/hai/)

The first page of each hospital Report Card gives the hospitals cleaning compliance percentage in both graph and table form.

Understanding the Report Cards – ‘Out of Hospital Infections’

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 2 SAB during November 2011 and 5 SAB during December 2011.

**Clostridium difficile Infection (CDI)**
There were 11 CDI during November 2011 and 10 CDI during December 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**

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Western General Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There was 4 SAB recorded during November 2011 and 2 during December 2011.

**Clostridium difficile Infection (CDI)**
There were 12 CDI during November 2011 and 3 CDI during December 2011.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MSSA Bacteraemia Cases**
**St Johns Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during November and 1 during December 2011.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during November and 2 during December 2011.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Liberton Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There were NO SAB recorded during November and 2 during December 2011.

**Clostridium difficile Infection (CDI)**
There were NO CDI recorded during November and December 2011.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

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Royal Hospital for Sick Children

**Staphylococcus aureus Bacteraemia (SAB)**
There was NO SAB recorded in November and 2 in December 2011.

**Clostridium difficile Infection (CDI)**
There were NO CDI recorded in November and 1 in December 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**

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**Royal Victoria Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**  
There was 1 SAB recorded during November and none during December 2011.

**Clostridium difficile Infection (CDI)**  
There were NO CDI recorded during November and December 2011.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**Community Hospitals**

**Staphylococcus aureus Bacteraemia (SAB)**
There was only 1 SAB recorded in the last 12 month period.

**Clostridium difficile Infection (CDI)**
There were 3 CDI recorded during November and 2 during December 2011.

This is the new Report Card Format introduced by Scottish Government July 2011
Out of Hospital Infections

**Staphylococcus aureus Bacteraemia (SAB)**
There were 17 SAB recorded during November and 9 SAB during December 2011 that were identified as Out of Hospital Infections.

**Clostridium difficile Infection (CDI)**
There were 8 CDI recorded during November and 8 CDI during December 2011 that were identified as Out of Hospital Infections.

This is the new Report Card Format introduced by Scottish Government July 2011
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

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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.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
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.

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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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**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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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

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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.

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Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

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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.

**Total Staphylococcus aureus** Bacteraemia (SAB) Cases

- **MRSA Bacteraemia Cases**
  - January: 1
  - December: 0

- **MSSA Bacteraemia Cases**
  - December: 0

**Clostridium difficile** Infection (CDI) Cases in Patients ages 15 and over

- **MRSA Bacteraemia Cases**
  - January: 2
  - December: 2

- **MSSA Bacteraemia Cases**
  - December: 2
NHS LOTHIAN ANNUAL REVIEW: THURSDAY 27 OCTOBER 2011

1. This letter summarises the main points discussed and actions arising from the Annual Review at Waverley Gate in Edinburgh on 27 October.

2. As you know, I want to ensure the rigorous scrutiny of NHS Boards’ performance whilst encouraging as much direct dialogue and accountability between local communities and their Health Boards as possible. That is why, from this year, Ministerial attendance at Board Annual Reviews will be at least every two years, generally on an alternating basis. As one of the Boards that did not have a Review chaired by a Minister this year, you conducted the Review meeting in public on 27 October. You clearly outlined progress and challenges in key areas and gave local people the opportunity to question Board representatives. I asked Government officials to attend the Annual Review in an observing role and this letter summarises the main points and actions arising from the meeting.

APF/ACF Engagement

3. As in previous years, all Boards are expected to submit a written report to Ministers on their performance over the previous year and plans for the forthcoming year. This self-assessment paper gave a detailed account of the specific progress the Board has made in a number of areas and was made available to members of the public to inform the discussion at the Annual Review. You continued the practice of holding a meeting between the Board and representatives of the Area Partnership Forum (APF) and also received a report from the Area Clinical Forum (ACF). NHS Lothian has continued to closely involve the ACF and APF in the work of the Board over the past year. The ACF are actively engaged with the implementation of the Quality Strategy, and other workstreams including, the Scottish Patient Safety Programme, the 18 weeks referral to treatment waiting time target and the development of the Palliative Care Strategy. Work with the APF has been instrumental in achieving a significant reduction in staff sickness absence levels and you also discussed...
workforce planning, the staff survey, health and safety and the challenges associated with the e-KSF target (Electronic Knowledge Skills Framework).

**Introduction and opening comments**

4. After your introductory comments, and a summary of the feedback from the ACF provided by Professor Pat Murray and the APF from Vice-Chair Eddie Egan, the Chief Executive, James Barbour provided an overview of the progress that NHS Lothian has made in a number of areas over the last year. This included the Board’s clear focus on patient safety, effective governance and performance management; and on the delivery of significant improvements in local health outcomes, alongside the provision of high quality, safe and sustainable healthcare services.

**Improving the Quality of Care and Treatment for Patients**

5. This year’s Annual Reviews continue the clear focus on the Quality agenda, which is underpinned by the national **Quality Strategy**. The Quality Strategy sets out NHS Scotland’s vision to be a world leader in healthcare quality, described through three Quality Ambitions: effective, person centred and safe. The Strategy seeks to improve the quality of care patients receive from the NHS, recognising that the patient’s experience of the NHS is about more than speedy treatment - it is the quality of care they get that matters most. As such, I was pleased to hear how the Board of NHS Lothian is continuing to demonstrate leadership on the local implementation of the Quality Strategy, and the Board is taking this forward through a local Quality Improvement Strategy. NHS Lothian provided assurances that the Board and its committees are fully committed to robust clinical and financial governance, clinical effectiveness, risk management and patient safety, in line with the national Quality Ambitions and Outcomes.

6. NHS Lothian has undertaken considerable local work to strengthen the quality of care and **patient safety**, as confirmed in a recent report from Healthcare Improvement Scotland on the Board’s work with the Scottish Patient Safety Programme (SPSP). The aim of the SPSP was a 30% reduction in adverse events and a 15% reduction in Hospital Standardised Mortality Ratios (HSMR) in Scotland’s acute hospitals by the end of 2010. NHS Lothian’s HSMR has continued to decrease and remains consistently under 1%. The Board has also achieved an impressive 43% reduction in adverse events since November 2008, supported by a variety of improvement methods. The Board has reviewed incident management policies and procedures and revised incident investigation protocols, which has all helped contribute to this improved performance.

7. In the priority area of **infection control**, the Board is to be congratulated on achieving the Clostridium Difficile Infection (CDI) target for the period ending March 2011. Between April 2010 and March 2011 there were 355 cases of CDI recorded in patients aged 65 and over, a fall of 36% compared to the previous year. In the same period there were 135 cases for patients aged 15 to 64 (a reduction of 47% on the previous year). In 2010 there were 35 deaths associated with CDI (in which CDI was noted as a contributory cause). This is a fall of 34% on the previous years and part of a general downward trend in NHS Lothian. However, the Board failed to meet its target for Staphylococcus Aureus Bacteraemia (SAB) for the period ending March 2011. Between April 2010 and March 2011 there were 315 cases of SAB recorded in NHS Lothian. This is a decrease of 13% compared to the previous year when there were 361 cases. I am naturally disappointed that NHS Lothian has not met its overall SAB target. However, I note that the number of cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) has reduced by 16% and this is a significant achievement. This is a challenge for a number of Boards in Scotland; as such, it would be
useful to understand if any particular intervention has made a significant contribution to this reduction and would encourage the learning to be shared with other Boards. NHS Lothian has also taken steps to improve local Healthcare Associated Infection (HAI) processes, for example through involvement in the 90 day rapid improvement programme, with the Infection Control team and SPSP working closely to build on SAB improvement work and ensure the necessary reduction in SABs to meet the new HEAT target.

8. The Healthcare Environment Inspectorate (HEI) made announced and unannounced visits to the Western General Hospital and an announced inspection to St John’s Hospital during the period covered by the Annual Review. Overall, the inspection teams found evidence that NHS Lothian is complying with the majority of HAI standards to protect patients, staff and visitors from the risk of acquiring an infection. However, the inspections have identified a number of areas for improvement and I expect to see continued improvement in this area over the coming year. It remains vitally important to continue to ensure that all infection prevention and control policies and procedures are in place and all protocols and procedures are followed. You have provided assurance that effective infection control remains a top priority for NHS Lothian and that considerable efforts continue to be made to deliver significant improvements.

9. NHS Lothian met the majority of the main key waiting time and other access targets in 2010/11. The Board did not meet the 9-week inpatient and day case target between December 2010 and January 2011, with adverse weather having an impact on services and increased waiting times. NHS Lothian successfully managed to reduce the number of patients waiting over the target as at 31 March 2011 to 71 patients. NHS Lothian did achieve the 12-week new outpatients target as at 31 March 2010 and has sustained this standard over the last year. The Board also performed very well against both the 31-day and 62-day cancer targets and has been above target in each quarter so far. I am grateful to all local staff for their efforts in securing this strong performance against the cancer targets. Looking to the future, it is important that the Board continues to make every effort to improve performance on the remaining waiting time targets as it moves towards the 18-week referral to treatment target, and I congratulate the Board on being ahead of trajectory on the delivery of this target.

**Improving Health and Reducing Inequalities**

10. Congratulations on significantly exceeding the required number of Inequality Targeted Health Checks for 2010/11, delivering 5,876 checks against a target of 2,902. NHS Lothian continues to deliver Keep Well; an anticipatory care approach which aims to identify people who are not currently in touch with health services, and to provide them with a health check in order to identify any health problems or poor health behaviour at the earliest stage. Keep Well is primarily led in Lothian by staff from the Board’s Community Health Partnerships who work closely with GP practices to successfully deliver the programme.

11. NHS Lothian will finish the 3-year Smoking Cessation target period having exceeded the required number of quits for 2010/11, delivering 11,653 quits against a target of 11,218. I commend the consistent performance from the Board and look for sustained performance to ensure full delivery of the new HEAT target for 2011-14. NHS Lothian also exceeded the HEAT target for Alcohol Brief Interventions (ABIs) between April 2008 and March 2011, delivering 29,884 against a target of 23,594. I expect to see continued improvement in meeting the target for 2011/12 and I am pleased to hear that you are currently ahead of trajectory. I would also commend NHS Lothian for the good performance and progress around alcohol and drug waiting times with 90.5% of clients getting an assessment
appointment within four weeks of referral and 96.2% receiving treatment within four weeks. I look forward to seeing continued and sustained progress to achieving the 2013 target.

12. NHS Lothian significantly exceeded their Child Healthy Weight Interventions (CHW) target. The Board used a mixed method approach to deliver the target and ensure access to programmes across the Board area. These included; small group and community-based work, a family-centred intervention called ‘Get Going’; and a whole school approach which linked closely with the wider community. Progress against the exclusively breastfed target has been a challenge for most NHS Boards. To encourage progress locally NHS Lothian has this year updated its local Breastfeeding and Infant Feeding Strategy, with a focus on improved staff training, provision of peer support and awareness raising; including thought the ‘Best buddies’ programme. I look forward to seeing the fruits of these initiatives in the shape of further improvements in breast feeding rates in the coming year.

Shifting the Balance of Care

13. The Scottish Government has been working in partnership with COSLA, NHS Scotland, and the Third and Independent sectors for the last 18 months on our Reshaping Care for Older People programme. Our policy goal is to help older people to stay safe and well and as independent as possible, in their own homes or another homely setting. The Change Fund of £70m for 2011-12 has been introduced to enable health and social care partners to implement local plans for making better use of their combined resources for older people’s services. The Fund will provide bridging finance to facilitate shifts in the balance of care from institutional to primary and community settings, and should also influence decisions taken with respect to the totality of partnership spend on older people’s care. The Joint Improvement Team (JIT) is working with all 32 Partnerships on the practical application of the Change Plans they submitted in order to access funds. JIT is advising Partnerships on the planning and systems they will need to have in place to create the right care services in the right settings, and is helping Partnerships to implement a series of Core Measures to ensure Change Plans are aligned with, and will support the delivery of, the Quality Strategy Ambitions. NHS Lothian, in conjunction with its local Partnerships has set out plans on how it intends to use its allocation of the Change Fund.

14. NHS Lothian met the zero standard for Delayed Discharges in April 2011 and performance has improved steadily since 2008. However, there has been a slight increase in recent months in the number of patients delayed over six weeks and I expect the Board to continue to work in partnership with the relevant local authorities to improve performance. As you know, this is a priority area for the Government and I look forward to seeing sustainable progress made in this critical area in the months and years ahead.

15. NHS Lothian is performing well against the mental health HEAT targets. The Board has now exceeded the Dementia Diagnosis Registration target and also met the target for reductions in Psychiatric Readmissions. I launched The Standards of Care for Dementia in June 2011. These standards relate to everyone with a diagnosis of Dementia in Scotland and apply to people living in their own homes, care homes and hospitals. I am pleased at the progress that has been made in developing the community-based intensive outreach service for young people with severe mental health problems, and the impact that this has had, both on decreasing admissions to adult wards and on shortening lengths of admissions to the specialist unit in Edinburgh. This is a model which we are encouraging other Boards to adopt. The Board is confident that performance will continue to be strong in this area and you have provided assurance that you will meet the 26 week Child and Adolescent Mental Health Services target by March 2013.
Finance and Efficiency

16. Clearly it is vital that NHS Boards achieve both financial stability and best value for the considerable taxpayer investment made in the NHS. I am therefore pleased to note that the Board met all three financial targets for 2010-11 alongside the 2% Efficient Government target for the year. I note you provided an update on the Board’s progress on the financial plan for the current financial year, including the achievement of the 3% 2011/12 efficiency savings target. You confirmed that you are actively monitoring the achievement of all local efficiency programmes and, whilst the position is challenging, the Board is currently on course to achieve the planned end-year financial position. It was also reassuring to hear that the Board’s efficiency and productivity programme is fully informed by the Quality Strategy, and that NHS Lothian is ensuring that, together with other NHS Boards, you are sharing and learning from examples of best practice in this area.

17. In terms of workforce, the Board did not achieve the HEAT target on Knowledge and Skills Framework (KSF) implementation by the end of March 2011, however further work has been carried out and the Board has now delivered the target of 80%. The 2010 Staff Survey results showed an encouraging improvement against the Board’s performance in 2008. This is clearly testament to the Board’s successful endeavours to improve against the Staff Governance Standard. Significant improvements have been made in the last twelve months, in partnership with the APF, in reducing staff sickness absences and I congratulate the Board for this achievement.

Capital Finance

18. NHS Lothian has successfully delivered a number of capital projects over the last year, such as the Midlothian Community Hospital and the Chalmers Sexual Health Centre, where the improved facilities are now benefitting patients. Construction is also well underway at the Royal Victoria Hospital and Musselburgh Primary Care Centre both of which are scheduled for completion in 2012. The Board are working closely with the Scottish Government and the Scottish Futures Trust in the development of combined proposals for the Royal Hospital for Sick Children and Department of Clinical Neurosciences, and I welcome the Board’s commitment to delivering the new facilities in Autumn 2016.

Clinical Strategy

19. Following the Annual Review the Board held workshops with the public and some of these discussions will, as part of NHS Lothian’s wider stakeholder engagement process, feed into the development of the Board’s new Clinical Strategy. I am keen to be kept updated as this work progresses and my officials will stay in touch as you continue with the development of the strategy.

Public Question and Answer Session

20. I understand that you took questions from members of the public in attendance at the end of each agenda item during the Review – as well as offering a further opportunity for questions at the end of the Review – and this worked well. My officials informed me that this was an engaging and informative session with a wide range of topics being covered. A number of questions related to patient waiting times and the stroke and cancer patient pathway. Other questions covered: amenable mortality rates, the importance of strong communication between primary and secondary care and a request for a Myalgic Encephalomyelitis Managed Clinical Network. You and your team were able to answer the majority of questions on the day and undertook to provide written responses to questions.
where this was more appropriate. I am grateful to you and your team for your efforts in this respect, and to the audience members for their attendance, enthusiasm and considered questions.

Conclusion

21. I would like to thank you and your team for conducting a constructive and informative Annual Review. It is clear that the Board is making significant progress in taking forward a challenging agenda on a number of fronts; including improving access, maintaining tight financial control and driving forward the Quality agenda. However, I am assured that you are not complacent and you recognise that there remains much to do. The Board must maintain a clear focus on its financial position and ensure that progress on your health improvement and healthcare provision commitments is maintained. I have included a list of the main action points from the Review in the attached annex.

Best wishes

NICOLA STURGEON
ANNEX

NHS LOTHIAN ANNUAL REVIEW: MONDAY 27 OCTOBER 2011

ACTION POINTS

The Board must:

- Keep the Health Directorates informed of progress with the local implementation of the Quality Strategy and Change Fund.

- Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection.

- Ensure there is sustainable progress made in relation to identified requirements and recommendations in Health Environment Inspection reports.

- Keep the Health Directorates up to date with progress on the local efforts to meet the breast feeding HEAT target.

- Work in partnership with local authorities to improve performance on delayed discharges, reducing the overall length of delays and bed days lost.

- Continue to achieve in-year and recurring financial balance; and keep the Health Directorates informed of progress in implementing the local efficiency savings programme.
NHS LOTHIAN

Board Meeting
25 January 2012

Director of Human Resources & Organisational Development (Executive Lead)

NHS LOTHIAN HEALTH AND SAFETY POLICY

1 Purpose of the Report

1.1 The purpose of this report is to seek the approval of the Board to the revised NHS Lothian Health and Safety Policy.

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 attached Health and Safety Policy.

3 Discussion of Key Issues

3.1 There is a statutory requirement for NHS Lothian to have an approved Health and Safety Policy and ensure that it is reviewed and updated on an annual basis. Following the annual review of the existing policy by the Health and Safety Committee, amendments were deemed appropriate, specifically in relation to the inclusion of schematic organisational diagrams. The revised policy has been approved by the Health and Safety Committee and is now being submitted for formal approval.

3.2 The key changes to the existing Health and Safety Policy are in relation to the introduction of a system of audit based on the Royal Society for the Prevention of Accidents (RoSPA) systems. This includes audit of the high level health and safety management of an organisation. The initial use of the system to evaluate Estates and Logistics identified the need to expand significantly sections of the current NHS Lothian Health and Safety Policy, with the addition of clear organisational charts. On this basis the policy was updated and amended, and subject to consultation prior to consideration by the NHS Lothian Health and Safety Committee.

4 Key Risks

4.1 The health and safety of staff, patients and visitors represent key risks to NHS Lothian in terms of staff confidence in the employer, regulatory action including
prosecution, civil liability, and organisational reputation. Key action in relation to mitigation of these risks is an effective health and safety management system which requires an appropriate and fit for purpose health and safety policy at its cornerstone.

5 Risk Register

5.1 Based on the revision of the policy, actions are now in hand for the inclusion of generic staff health and safety risks within the existing NHS Lothian risk register. These generic risks support and put into context specific item health and safety risks which have been, and continue to be, included within the register as they are identified.

6 Impact on Health Inequalities

6.1 A Rapid Impact Assessment of the revised Health and Safety Policy was undertaken on 8 April 2011. A copy of the Rapid Impact Assessment is attached as Appendix 2.

7 Impact on Inequalities

7.1 A key element of the policy must be to deliver a management system for all staff, and an equitable access to services required by the policy.

8 Involving People

8.1 The proposed policy has been subject to formal consultation. Comments received from the consultation were considered in detail by a drafting group, including partnership representation, and the policy amended accordingly.

8.2 The initial policy, and this revision, have been developed in partnership, and endorsed by the NHS Lothian Health and Safety Committee which is a partnership body.

9 Resource Implications

9.1 There are no resource implications associated with the revision of the Health and Safety Policy.

Alan M Boyter
Director of Human Resources and Organisational Development
18 January 2012
alan.boyter@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Health and Safety Policy
Appendix 2: Rapid Impact Assessment
NHS LOTHIAN

HEALTH AND SAFETY POLICY

NOVEMBER 2011

Unique ID: NHSLHSP07/11
Category/Level/Type: Level 1
Status: Final
Date of Authorisation: November 2011
Date added to Intranet:
Key Words: Health and Safety

Author (s): Chris Kalman, Alan Boyter
Version: 9
Authorised by: NHS Lothian Health and Safety Committee
Review Date: November 2012
NHS Lothian attaches the greatest importance to health and safety. We believe a strong commitment to health and safety is an integral feature of an efficient and effective organisation and an essential element of our commitment to the quality of the services we provide. We will ensure our commitment to improving health and safety performance is reflected throughout the organisation. We will provide the financial and physical resources necessary to support implementation of the Health and Safety Policy. We will strive to create an environment where work related injury and illness do not occur in our employees or contractors, and that our activity does not cause injury or illness to patients or members of the public. It is our policy to implement standards of health and safety at least as rigorous as required by legislation. We will undertake regular reviews of our health and safety performance correcting any areas where non compliance is demonstrated, and produce formal annual plans for ensuring continued improvement. Our employees will be trained in workplace health and safety and encouraged to adopt a healthy lifestyle. We will also monitor the health and safety performance of our contractors.

We will establish organisational arrangements to ensure the aims of the Policy are effectively implemented throughout the organisation and progress is monitored. This will include a signed Local Framework Document stating the commitment and organisation for health and safety at a local level and to establish that arrangements are, as a minimum acceptable level of performance, to be beyond legally compliant. We will appoint competent advisers in health and safety, occupational health and other relevant disciplines and ensure their effective integration into the system for health and safety management. We will seek to maintain and develop the active co-operation of all staff in improving standards of health and safety. In particular we attach great importance to our partnership arrangements and the role of the NHS Lothian Health and Safety Committee and encourage the appointment of safety representatives by all recognised trade unions, professional organisations and staff associations. NHS Lothian will regularly brief its employees on their obligation in law to act in accordance with the health and safety instructions and training given to them, to report to their supervisor any serious deficiency in health and safety arrangements they discover, and to have due regard for the health and safety of themselves and others.

This Statement of Intent forms part of the Health and Safety Policy, which also gives details of organisational arrangements. It is further supplemented by procedures developed to fit the needs of its operational and corporate directorates. A copy of the full policy document is kept on the health and safety section of the intranet, in every department, in the health and safety manual and it is available to all staff.

Professor James J Barbour OBE
Chief Executive

Signature:                                                                    Date:
1. Aims

- To ensure the safety and wellbeing of the full diversity of employees, patients, and that of others affected by the work of NHS Lothian. (see section 12)
- To establish and maintain health and safety as a key objective of the organisation.
- To comply with all relevant statutory provisions.
- To treat health and safety as a core management function.
- To plan to identify risks and implement adequate controls.
- To seek to progressively improve standards of health and safety performance.
- To ensure effective means of communication and co-operation.
- To establish competency in health and safety.
- To ensure control of the health and safety management system.
- To establish a clear organisational framework and management systems with channels of communication to ensure the aims are pursued vigorously and effectively.

2. Organisation

2.1 General

The NHS Lothian Health and Safety Committee, chaired by the Director of Human Resources/Organisational Development (Human Resources/Organisational Development) will take the lead in developing the general strategy for health and safety management, assisted by the specialist advisers reporting to the Director of Occupational Health and Safety (OHSS), and other specialists coordinated by the OHSS Director for this purpose. Others participating in the NHS Lothian Health and Safety Committee will include the nominated senior managers from all of the major operational and corporate units and staff representatives nominated through the NHS local partnership arrangements.

The NHS Lothian Health and Safety Committee reports to the Staff Governance committee and may refer certain strategic issues involving both clinical and non-clinical risks to the Healthcare Governance and Risk Management Committee.

In implementing this strategy, operational and corporate divisions will each nominate a senior manager to coordinate effective health and safety management. This will entail the formation of appropriate consultative committees or subgroups, the implementation of procedures for local and central risk assessment, the implementation of NHS Lothian policies, the active monitoring of performance, the effectiveness of risk control measures, and procedures for review and audit. (see Appendix 1 Health and Safety Governance Chart).

The nominated chairpersons of the local H&S committees, will report on behalf of their directorate, to the NHS Lothian Health and Safety Committee. (see Appendix
2) for an example of this accountability, using Facilities’ Health and Safety Governance Chart. They will enlist the help of the relevant specialist advisers and will consult directly with the OHSS Director to determine the most effective deployment of advisory staff.

Risks to the well being of staff, patients and others, arise from all aspects of NHS Lothian’s undertakings. There is no clear separation of clinical and non-clinical risk, and NHS Lothian will continue to develop an integral approach to managing risk. This requires the continued collaboration of Occupational Health and Safety Service staff with colleagues with specialist responsibility in the role.

The provision of an improved and safe working environment is a key element of the Staff Governance Standard. The system of consultative committees and the NHS Lothian Health & Safety committee itself, are endorsed by the NHS Lothian Partnership Forum as the appropriate NHS Lothian-wide approach to health and safety.

The NHS Lothian Partnership Forum is supported by occupational health and safety expertise and advice to allow it to fulfil its role. Issues relevant to occupational health and safety are referred between the partnership forum and the health and safety committee as they arise. Policies related to health and safety require endorsement from the Lothian Partnership Forum.

Where deemed appropriate by the NHS Lothian Health and Safety Committee, NHS Lothian wide groups dealing with specific specialist risks will be established (e.g. the NHS Lothian Radiation Protection Committee). These groups will report directly to the NHS Lothian Health and Safety Committee. Chair persons are nominated by the Health and Safety Committee and membership consists of senior management nominees from operational and corporate units and relevant practitioners. The committees will also include the relevant specialist advisers.

2.2 Accountabilities

2.2.1 NHS Lothian has a statutory duty as an employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all its employees and the others, principally patients and visitors, affected by its work. All other responsibilities described here are part of the internal arrangements made by the organisation to fulfil its legal duties.

2.2.2 NHS Lothian Board
The Chief Executive has ultimate responsibility for health and safety in NHS Lothian and for the effectiveness of this policy. He will receive and, as appropriate, delegate for action, official communications on health and safety matters from the Scottish Executive and outside agencies such as the Health and Safety Executive.
2.2.3 **Director of Human Resources & Organisational Development in conjunction with the OHSS Director will:**

- chair the NHS Lothian Health and Safety Committee
- report to the NHS Lothian Board through Staff Governance Committee on the implementation of the Policy, the strategy set by the Chief Executive and on the health and safety performance of the organisation.
- ensure the continuing development of the health and safety strategy and the management system to ensure the strategy is pursued.
- ensure that policies are in place to give a consistent approach to serious risks
- ensure that the process exists to monitor the effectiveness of these policies as part of the appraisal of health and safety performance.
- ensure that the training provided by the organisation is commensurate with the needs of staff to mitigate against risks to health and safety.
- ensure that consistent and appropriate systems are established for the management of health and safety risks throughout the organisation.
- chair an annual health and safety review meeting provided with a report by the NHS Lothian Health and Safety Committee and will approve the objectives for health and safety in the coming financial year and seek confirmation of their fulfilment.

2.2.4 **Medical Director, Executive Nursing Director, and Director of Human Resources and Organisational Development**

will ensure that the clinical governance and health and safety strategies develop in tandem and in a manner consistent with the demands on the organisation as a whole. In practice this will entail ensuring that risk registers and priorities for action are consistent with the needs of patient care and with health and safety law.

2.2.5 **Chief Operating Officer and General Managers** of operational and corporate units have responsibility for the health and safety of their staff, the implementation of the Policy, the objectives set by the Chief Executive, and for monitoring the performance of their parts of the organisation. This role includes the establishment and maintenance of appropriate local consultative committees with Partnership involvement.

2.2.6 **Directorate and department managers** have an important role in applying the general policy into the effective assessment and control of risk. In addition to the general responsibility for the safety of their staff, their main responsibilities are:

- to make effective arrangements for health and safety in the directorate or department, including a signed Local Framework Document stating the commitment and organisation for health and safety, following the approach described in the “Health and Safety Manual” (guidance prepared and maintained by the Health and Safety Department)

- this will include arrangements for risk assessment, for the identification and implementation of the precautions and procedures necessary to ensure safety, and details of individual responsibilities and channels of communication for the effective implementation of the policy;
• to oversee the implementation of the directorate/departmental arrangements and to make adequate resources available for their implementation. In most hospital directorates this is likely to involve the delegation of responsibilities for practical risk assessment and control to charge nurses and equivalent line managers, while maintaining effective oversight and direct management of key risks.

• to make arrangements for consultation with staff members on health and safety matters within the directorate/department in order to promote the development of a universal and collaborative health and safety culture;

• to ensure the implementation in their areas of authority of relevant NHS Lothian policies and procedures;

• to familiarise themselves with the legal obligations relevant to the work of the directorate/department;

• to ensure that health and safety training needs including induction courses are assessed and an appropriate training plan devised and implemented with records of attendance;

• to ensure the competence of those undertaking the key tasks in health and safety management in the directorate/department;

• to establish appropriate arrangements for monitoring the implementation of the policy and the precautions established;

• to undertake a quarterly update of health and safety management in the directorate/department especially risk assessments and action plans;

• to incorporate into strategic plans those major elements of the action plan which require resource allocation thereby seeking the best possible standards of service provision, health and safety management, risk management and, where relevant, clinical governance.

• To ensure that all staff within their areas of responsibility understand all communications on health and safety matters and that equality and diversity has been considered as to the means of this communication

2.2.7 Health and Safety within NHS Lothian is a Partnership activity. Staff are involved in relation to all Health and Safety policy development, monitoring and review of Health and Safety performance and development of local procedures for risk control.

2.2.8 All line managers are responsible for ensuring that work is undertaken safely in their areas of authority. The safety of staff in day to day work is therefore one of their primary concerns. This requires an active approach to the identification of hazards, the assessment of the severity of the risks they pose, and the implementation of the necessary steps to avoid or control them. Subject to the arrangements established by the directorate or department manager, line managers may be called upon to maintain the ‘Template’ for
health and safety management in their area and to document local arrangements for safe working. Where managers find themselves unable for technical reasons to meet these obligations, they should seek advice from the Health and Safety Department. If the difficulties are of a managerial nature, the matter should be referred through normal management channels. To ensure that all staff within their areas of responsibility understand all communications on health and safety matters and that equality and diversity has been considered as to the means of this communication

2.2.9 All employees will
- be made aware of the local arrangements for health and safety by their managers;
- avoid any act or omission which might endanger themselves or others;
- report promptly to management, any hazard or incident which might have gone unnoticed or been inadequately dealt with;
- follow the safety precautions they are told about, and co-operate actively with their managers in using safety measures and improving standards of health and safety in their department.
- confirm to their manager that they have understood communications on health and safety matters and make known any difficulties with such

3 Technical Support

3.1 The Health and Safety Department is part of the Occupational Health and Safety Service. It is the primary source of support to those with line management responsibilities in health and safety. The department will support the management of health and safety by:
- giving advice on the assessment and control of workplace risks;
- giving advice on statutory requirements and the legal implications of health and safety problems;
- involving other specialist advisers when appropriate, if the first enquiry was with the Health and Safety Department.
- maintaining the “Health and Safety Manual” and “Health and Safety Homepage” as a health and safety management tool for directorate and department managers;
- identifying risk areas requiring direct intervention;
- auditing the performance of the health and safety management system;
- devising compliance strategies to meet statutory obligations.

3.2 The Health and Safety Department is headed by the Head of Health and Safety and is one function within the Occupational Health and Safety Service, headed by the Director of Occupational Health and Safety. Professional Health and Safety Advisers are based at a number of locations, with operational and commercial units each having an identified focal point adviser for unit specific advice.
3.3 NHS Lothian will appoint specialist advisers for other key risks: infection control, radiation protection, violence and aggression, manual handling, fire safety. The Director of Occupational Health and Safety, assisted by the Head of Health and Safety will provide coordination of these services to ensure they operate in a consistent and efficient manner.

4 Consultation and Cooperation

4.1 Committee Structure
The Director of Human Resources and Organisational Development will chair Health and Safety Committee on behalf of the Chief Executive. The Committee will be the means by which changes in health and safety arrangements covering the organisation as a whole are discussed with staff health and safety representatives prior to implementation. (see Appendices 1, 2 and 3 for diagrams of this structure). Its constitution and membership are given in separate documentation which is held by every member of the Committee and by the Health and Safety Department.
Operational and corporate units will also establish health and safety committees and/or subgroups under joint chairmanship with partnership (see appendix 3). The function of these committees will be to set local arrangements for the monitoring of compliance with implementation of the NHS Lothian policy and the objectives set by the Chief Executive, and to permit consultation with staff representatives of health and safety matters. The remit of these committees will be set locally and approved by the NHS Lothian Health and Safety Committee. (see Appendix 2 for an example of this using Facilities’ Health and Safety Governance Chart).

There will also be permanent committees or short-life working groups to develop and monitor the effectiveness of strategies for specific risks. The NHS Lothian Health and Safety Committee will maintain oversight of these risks and receive reports from the relevant groups.

4.2 Consultation and Cooperation - General
It is the responsibility of every manager to ensure good local communications and consultation on health and safety matters and to maximise the contributions of staff members.
NHS Lothian welcomes the nomination of health and safety representatives by trade unions, staff associations and professional bodies. They will be provided with the facilities required to permit them to undertake inspections and other functions described in the Safety Representatives and Safety Committees Regulations 1977 and Health and Safety (Consultation with Employees) Regulations 1996. NHS Lothian encourages the commitment and cooperation of the trade unions and staff associations in pursuing high standards of health and safety and expects a team approach to continuous health and safety improvement.
5  Training
It is the responsibility of directorate/department managers to identify the health and safety training needs of their staff and to ensure that these are met. The arrangements for this will be set out in the directorate/department health and safety documentation.

Mandatory Health and Safety training includes a range of courses, including those provided directly from Occupational Health and Safety Services staff.

6  Joint Working with other Employers
Many of the premises occupied by NHS Lothian also house employees of other organisations. The senior managers with responsibility for the site will ensure that arrangements are established for effective consultation on the health and safety implications of joint working and shared facilities. Where employees of NHS Lothian work in the premises of another employer (e.g. the universities, local authorities, external contractors) the relevant directorate/department manager will establish arrangements for cooperation and coordination to ensure the health and safety of staff.

7  The Manual, Policies and Procedures
It is the general responsibility of directorate and department managers to assess the risks arising from the work they have responsibility for and to implement suitable control measures. The principle “generic” systems for health and safety management are laid down in the manual, but in addition there may also be specialised policies and procedures. There are, however, some matters for which a Lothian-wide approach has been established. Policies and procedures for these matters will be prepared by the Health and Safety Department or other specialists and approved by the NHS Lothian Health and Safety Committee or other NHS Lothian executive committee. The ratification process for H&S related policies can be found within the “Development of NHS Lothian Policies and Procedures” document. (Appendix 5).
A list of some health and safety related policies and procedures is appended (see Appendix 4); the list will be updated on the intranet/electronic version of this Health and Safety policy without complete revision of the policy.

8  Occupational Health
In recognition of the potential of work to cause adverse effects on the health of individual members of staff, NHS Lothian will provide occupational health services including a consultant occupational physician and qualified occupational health nurses. The service will include pre-employment screening of all new staff members; the referral by management of members of staff whose health may be adversely affected by their work; and routine health surveillance where work practices create a significant risk of adverse health effects and where an
appropriate health surveillance technique might contribute to the system of protection.

9  Review of Performance
A quarterly cycle of review of risks, risk assessment, and action plans will take place throughout the organisation to facilitate a continuing improvement in health and safety standards and the appraisal of problems by the appropriate levels of management. At each level, the review report will highlight issues requiring attention and will indicate where satisfactory resolution lies at a higher level. The review reports will be one of the inputs to the NHS Lothian Health and Safety Committee in proposing new priorities for action annually.

10  Audit of Performance
The Health and Safety Department will undertake regular audits of the health and safety management system. The audit will provide an objective appraisal to permit comparisons with successive years and to highlight priorities for action.

11  Review of Policy
The Health and Safety Department will review this policy every 3 years or following any significant change and recommend changes as required to the NHS Lothian Health and Safety Committee.

12.  Equality and Diversity
Health and Safety issues are a concern for all staff and groups of users of NHS Lothian's services and premises. The equality & diversity page on the intranet includes a wide range of information about the issues and how these might be addressed:


Consideration must be given to particular groups who may be affected by more local policies and procedures as listed in the following link:
http://www.nhslothian.scot.nhs.uk/your_rights/equalityanddiversity/Rapid%20Impact%20Assessment%20guidance.doc
Appendix 1
HEALTH AND SAFETY GOVERNANCE CHART

NHS LOTHIAN HEALTH AND SAFETY COMMITTEE
Joint Chairs: Dir. HR/OD/Senior Staff Side Rep.

Edinburgh CHP
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit eg. SMART, Risk Mgt.

REAS
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit eg. Incident Mgt.

EAST/MID CHP
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit eg. Nursing, LDS, SMS.

WEST CHCP
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit eg. Dental.

CORPORATE
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit eg. ? site based or dept based.

FACILITIES
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit ie.. SE and NW.

UHD
H&S Group
Joint Chairs: Senior operational manager/Staff Side Rep.

Local sub group with H&S in remit eg. QIT, Risk Mgt. CMT

Local sub group with H&S in remit eg. Dental.
Appendix 2

FACILITIES HEALTH and SAFETY GOVERNANCE CHART

NHS LOTHIAN HEALTH and SAFETY COMMITTEE

- Edinburgh CHP
- REAS HS Committee
- East & Mid HS Committee
- West Lothian CHCP
- Facilities (Dir. of Operations)
- LUHD HS Committee

Heads of Service could rotate as Chair of Facilities Safety Group

- S/E Facilities Safety Group
- N/W Facilities Safety Group

Health and Safety Action Plans/Issues from Estates, Domestic Services, Laundry and Logistics/Catering

Health and Safety Action Plans/Issues from Estates, Domestic Services, Laundry and Logistics/Catering

KEY

- Accountability and Monitoring/Reviewing route
- Information and Support route only
NHS Lothian Health and Safety Committee
Remit and Membership

The NHS Lothian Health and Safety Committee is established in compliance with the Health and Safety at Work etc Act 1974, Safety Representatives and Safety Committees Regulations. It is an essential element in NHS Lothian’s implementation of the Staff Governance Standards, which stipulate that staff are entitled to be:

• Well informed
• Appropriately trained
• Involved in decisions which affect them
• Treated fairly and consistently
• Provided with an improved and safe working environment

The committee facilitates the responsibility of the Director of Human Resources and Organisational Development, who is the nominated director for health and safety, to ensure, on behalf of the Chief Executive, NHS Lothian’s compliance with health and safety law, the Staff Governance Standards, and a continuing improvement in health and safety performance.

The committee reports to the Staff Governance Committee and through it, to the Board; it may also refer matters to the Healthcare Governance and Risk Management Committee when appropriate.

The Health and Safety Committee meets at least four times a year, or more frequently if required by the Chair. It will have a quorum of eight. The minutes of meetings will be publicised on the intranet. The practical work of the Committee include the following.

1. Approves and develops health and safety policies.
2. Establishes strategic objectives for the development of health and safety performance in line with the health and safety policy and for a continuing improvement in health and safety culture at all levels in the organisation.
3. Ensures the organisation has the necessary infrastructure to meet its statutory obligations in health and safety and to implement its policy.
4. Sets priorities and action plans for improving health and safety performance, and establishes any necessary sub-groups to achieve the objectives.
5. Receives such reports and audits as it requires to demonstrate progress in health and safety management throughout the organisation.
6. Develops other procedures as it may deem necessary for the improvement of health and safety performance.
7. Ensures an adequate response to events such as those arising from: HSE inspections, reports from other agencies, and serious incidents requiring Board-level intervention.
8. Submits an annual health and safety report to the Board.
9. Specialist groups reporting to the Health and Safety Committee include:
   • Radiation Protection Committee
   • Healthy Working Lives Group
The membership of the committee includes:

- Director of Human Resources and Organisational Development – Chair
- Employee Director
- Partnership representatives to be appointed by the Partnership Forum
- Chief officers (or their representatives) of UHD, the CH(C)Ps, REAS.
- Director of Facilities
- Medical Director representative
- Nurse Director representative
- Finance Director representative
- AHP Associate Director representative
- Director of Occupational Health and Safety
- Head of Health and Safety
- Head of Manual Handling
- Risk Manager
- Head of Centre for Management of Aggression
- Infection Control Manager
- Other specialist advisers nominated by the Chair

The Director of Human Resources and Organisational Development will nominate a member of the committee to chair a meeting in the event of his absence.
Appendix 4
HEALTH AND SAFETY RELATED POLICIES

The following are matters for which there are Lothian wide policies or procedures. The list will be updated on the health and safety homepage of the intranet, without complete revision of the Health and Safety Policy:

http://intranet.lothian.scot.nhs.uk/NHSLothian/Corporate/A-Z/OccupationalHealthAndSafety/HealthAndSafety/Policies/Pages/default.aspx

- Manual Handling
- Contractors
- Radiation (ionising and non-ionising)
- Fire
- Incident Reporting
- Waste
- Infection Risks
- Asbestos
- Violence and Aggression
- Incident reporting and investigation
- Stress and mental health
- Latex
- Gloves
Appendix 5.
Development of NHS Lothian Policies and Procedures:
3. Rapid Impact Assessment summary report

Each of the numbered sections below must be completed

1. **Title of plan, policy or strategy being assessed.**

   NHS Lothian Health and Safety Policy

2. **What will change as a result of this proposal?**

   To ensure continual improvement in the safety and wellbeing of all employees, visitors and others who access NHS Lothian services or premises and to ensure the improvement and continuity within NHS Lothian in the interpretation and conformity to legislation, Health and safety At Work Act (1974), and associated regulations therein.

3. **Briefly describe public involvement in this proposal**

   No direct involvement but RIA group as detailed below.

4. **Date of RIA**

   8th April 2011

5. **Who was present at the RIA? Identify facilitator and any partnership representative present**

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Date of RIA training</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Glover</td>
<td>Head of Equality and Diversity</td>
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</table>
### 6. Population groups considered

<table>
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<tr>
<th>Population Group</th>
<th>Potential differential impacts; further consideration to be given to these groups when assessing specific policies /procedures (i.e. H&amp;S related policies that are written under this overarching H&amp;S general policy whereby specific risk controls maybe stated.)</th>
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<td>minority ethnic people (incl. gypsy/travellers, refugees &amp; asylum seekers)</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language, or because they have limited literacy skills.</td>
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<td>women, men and transgender people</td>
<td>No specific impacts identified; further consideration to be given to these groups when assessing specific policies /procedures.</td>
</tr>
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<td>people in religious/faith groups</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
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<td>disabled people</td>
<td>Some potential for impacts in respect of particular policies, such as those dependent on communication, comprehension or mobility; further consideration to be given to these groups when assessing specific policies /procedures.</td>
</tr>
<tr>
<td>older people, children and young people</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
</tr>
<tr>
<td>lesbian, gay and bisexual people</td>
<td>No impacts identified; further consideration to be given to these groups when assessing specific policies /procedures.</td>
</tr>
<tr>
<td>people of low income</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
</tr>
<tr>
<td>people with mental health problems</td>
<td>See comments on disability above. Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have</td>
</tr>
</tbody>
</table>
limited use of English as a language as well as limited literacy skills.

<table>
<thead>
<tr>
<th>homeless people</th>
<th>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</th>
</tr>
</thead>
<tbody>
<tr>
<td>people involved in criminal justice system</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
</tr>
<tr>
<td>people with low literacy/numeracy levels</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
</tr>
<tr>
<td>staff</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
</tr>
<tr>
<td>carers</td>
<td>Impacts identified for all groups listed here include effective communication of this policy whereby groups may not understand wording of policy should they have limited use of English as a language as well as limited literacy skills.</td>
</tr>
<tr>
<td>Other groups (please specify)</td>
<td>In some cases the impacts of a particular policy within the Health &amp; Safety family might affect a group not listed above. This will vary from policy to policy and will be identified either in a specific RIA for that policy or will be mitigated by the general statements in the overarching H&amp;S policy.</td>
</tr>
</tbody>
</table>

7. What positive impacts were identified and which groups will they affect?

<table>
<thead>
<tr>
<th>Impacts</th>
<th>Affected populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITIVE IMPACT ON: equality, lifestyles, social environment, physical environment, access to and quality of services (for the overarching H&amp;S policy).</td>
<td>Positive impacts on all groups as listed in above table.</td>
</tr>
<tr>
<td>Consideration be given to communication: Further consideration to be given to the language used in some key parts/messages of the document that apply to those groups who may have difficulty in understanding English. The overarching policy will guide those developing policies and procedures that sit beneath it so that they include reference to equality &amp; diversity issues, and are subjected to RIA in their own right where appropriate.</td>
<td></td>
</tr>
<tr>
<td>Further actions required here i.e. change in words used in</td>
<td></td>
</tr>
</tbody>
</table>

3
key sections of the policy, use of “a choice of easier language” and also the use of local and effective departmental communication methods, that the local manager commits to e.g. “tool box talk/summary”, sign off sheets, possible use of a translator.

Also consideration given to how best to communicate this “high level” policy and key information within it, to all staff and others, at all levels within the organisation.

An NHSL higher level Policy Implementation Group are also looking into the issue of effective communication of policies to all relevant stakeholders.

8. What negative impacts were identified and which groups will they affect?

<table>
<thead>
<tr>
<th>Impacts</th>
<th>Affected populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No negative impacts, provided further consideration has been given to the language used in some key parts of the document.</td>
<td>No negative impacts, on any of the groups mentioned above.</td>
</tr>
</tbody>
</table>

9. Evidence available at the time of the RIA

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Available?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data on populations in need</td>
<td>Yes</td>
<td>Broad population data available.</td>
</tr>
<tr>
<td>Data on service uptake/access</td>
<td>Yes</td>
<td>Broad data on service users available.</td>
</tr>
<tr>
<td>Data on quality/outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research/literature evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation and involvement findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good practice guidelines</td>
<td>Yes</td>
<td>Established good practice in fire procedures</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Yes</td>
<td>Draft copy of H&amp;S Policy</td>
</tr>
</tbody>
</table>

10. Additional Information and Evidence Required
NONE

11. What communications needs were identified? How will they be addressed?
Consideration be given to communication:

- Further consideration to be given to the language used in some key parts/messages of the document that apply to those groups who may have difficulty in understanding English and also the use of local and effective
departmental communication methods, that the local manager commits to eg. “tool box talk/summary”, sign off sheets, possible use of a translator.

- Also consideration given to how best to communicate this “high level” policy and key information within it, to all staff and others, at all levels within the organisation.
- An NHSL higher level Policy Implementation Group are also looking into the issue of effective communication of policies to all relevant stakeholders.

12. **Recommendations**

See comments relating to communication and amendments to content of policy mentioned above.

13. **Specific to this RIA only, what actions have been, or will be, undertaken and by when? Please complete:**

<table>
<thead>
<tr>
<th>Specific actions (as a result of the RIA)</th>
<th>Who will take them forward (name and contact details)</th>
<th>Deadline for progressing</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review choice or wording in key parts of the policy.</td>
<td>Anne James</td>
<td>End of April 2011</td>
<td>End of May 2011</td>
</tr>
<tr>
<td>Add a statement to clarify that equality and diversity has been considered in the effective communication of this policy to all groups as listed in the above checklist and in any local procedures for risk control made therein.</td>
<td>Anne James</td>
<td>End of April 2011</td>
<td>End of May 2011</td>
</tr>
</tbody>
</table>

14. **How will you monitor how this policy, plan or strategy affects different groups?**

Work in conjunction with the Head of Equality and Diversity.

15. **Who will be consulted about the findings of this impact assessment?**

Head of Equality & Diversity. Head of Health & Safety. NHSL Health & Safety Committee. The report will be posted on the NHS Lothian internet for wider comment.

16. **Has a full EQIA process been recommended? If not, why not?**

No. RIA considered sufficient for this policy document which has been written to meet full safety requirements of all groups.
Manager's Name: Anne James

Date: 8th April 2011.

Please send a completed copy of the summary report to:

James Glover, Head of Equality and Diversity
James.Glover@nhslothian.scot.nhs.uk

Note that you will be contacted by a member of NHS Lothian’s impact assessment group for quality control and/or monitoring purposes.
NHS LOTHIAN

Board Meeting
25 January 2012

Acting Director of Strategic Planning (Executive Lead)

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 the last meeting of SEAT took place on 25 November 2011 and the next meeting is scheduled for 17 February 2012. This update is provided on the basis of the discussions that took place at this recent meeting.

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 As noted previously, 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. Updates provide on these are outlined below.
3.2 Rebalancing Orthopaedics

It is intended that from April 2012, NHS Borders will no longer refer non complex patients to NHS Lothian and provide a ‘See and Treat’ model for NHS Lothian patients requiring a range of agreed procedures. Initial discussions have taken place on the financial arrangements to support this model.

3.3 Performance Standards and Minimising Variation

Further work will be undertaken on determining thresholds for interventions, with the Medical Directors agreeing to take forward work on hip and knee procedures.

3.4 Technology

As previously highlighted to SEAT, there are potential efficiencies to be realised through increased radiographer reporting of plain films. Meetings with individual Boards are being arranged to progress further and identify savings.

3.5 Complex Care Packages

The Learning Disability Managed Care Network Manager will lead the development of a Commissioning Group and has asked that Boards nominate representatives for the Group. This work compliments the NHS Lothian Disability Strategy and the work that we are now looking at in relation to repatriation of out of area patients.

3.6 Corporate Services

SEAT noted that work on HR services would now be looked at by NHS Borders and NHS Lothian with NHS Fife intending to make savings through further local and national work. Public Health colleagues have identified the possibility of savings within Boards through further regional working.

Additional work streams to note:

3.7 The 12 bedded regional Eating Disorder Unit based at St John’s was officially opened by the Minister for Public Health on 24 January 2012.

3.8 SEAT Learning Disabilities Managed Care Network

SEAT noted the Learning Disabilities Managed Care Network Annual Report, commending the considerable work undertaken over the last year. SEAT also considered the Progress Report on the Models of Care Project which outlines a conceptual framework for Learning Disability Services to support effective and efficient planning. SEAT will consider the recommendations including financial considerations in the Final Report which will be presented in May.

3.9 SEAT Telestroke Pilot Project

SEAT received the six month evaluation of the South East Telestroke Project, highlighting that 55 patients had been thrombolysed out of hours using the hub and spoke model of service delivery. In addition to improving the quality of life for these
55 patients, an associated saving of around £300k has been made to health and social care. Commitment to sustaining this work was agree and is being progressed through the support of Professor Martin Dennis.

4 Key Risks

4.1 Partnership working is a key element of ensuring the successful delivery of the projects/works strands highlighted above. The work of the Interim Director with others is to ensure that we have an agreed work plan and that we minimise any risk to progress not being made and in turn maximise the opportunities offered through regional working.

5 Risk Register

5.1 Boards will be expected to record any issues as appropriate within their own risk register.

6 Impact on Health Inequalities

6.1 The thrust of all of the work streams identified above will be to either reduce inequalities or drive improvements in the delivery and access of care and treatment. No individual equality impact assessment has been undertaken in respect of writing this paper as this is simply highlighting and commenting on existing work streams.

7 Impact on Inequalities

7.1 As above.

8 Involving People

8.1 Within individual work streams people will be involved in the shaping of any proposals but also in any consultation that may be required in respect of any proposed changes to service delivery.

9 Resource Implications

9.1 The resource implications are none in respect of the writing of this paper which has simply acted to provide further information in respect of work already underway and fully supported.

Alex McMahon
Acting Director, Strategic Planning
18 January 2012
Alex.mcmahon@nhslothian.scot.nhs.uk
COMMUNICATIONS RECEIVED

1 Purpose of the Report

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Government:

<table>
<thead>
<tr>
<th>No.</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CEL(2011)026</td>
<td>NHSScotland information assurance strategy</td>
</tr>
<tr>
<td>2</td>
<td>BBRWG(2011)001</td>
<td>Blue Badge circular 01/11</td>
</tr>
<tr>
<td>3</td>
<td>CEL(2011)027</td>
<td>Up-dated adult exceptional aesthetic referral protocol (June 2011)</td>
</tr>
<tr>
<td>4</td>
<td>PCA(M)(2011)017</td>
<td>The Primary Medical Services, Directed enhanced services (Scotland)2011, Palliative Care (no2).</td>
</tr>
<tr>
<td>5</td>
<td>SGHD(CMO)(2011)014</td>
<td>Carbon monoxide (CO) poisoning: Needless deaths, unnecessary injury.</td>
</tr>
<tr>
<td>6</td>
<td>PCS(AFC)(2011)008</td>
<td>Pay deductions following strike action on 30 November 2011</td>
</tr>
<tr>
<td>7</td>
<td>PCA(M)(2011)019</td>
<td>General medical services statement of financial entitlements for 2011/12</td>
</tr>
<tr>
<td>8</td>
<td>PCA(P)(2011)014</td>
<td>2011-12 Electronic claim training payment amendment to claim deadline.</td>
</tr>
<tr>
<td>9</td>
<td>SGHD(CMO)(2011)015</td>
<td>Changes to the newborn blood spot screening programme</td>
</tr>
<tr>
<td>10</td>
<td>CEL(2011)028</td>
<td>Review of NHSScotland pin policies</td>
</tr>
</tbody>
</table>


Signatures: MD, DPH&HP, DPHHP, COO, DOF, DHR & OD, DSPM, MD, GMPCC, DSP, GMPCC, DHR & OD.
<table>
<thead>
<tr>
<th></th>
<th>PCA(P)(2011)016</th>
<th>Pharmaceutical services: Amendment to Annex A: Discount clawback scale for proprietary drugs.</th>
<th>22/12/11</th>
<th>DSP, GMPCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>PCA(M)(2011)020</td>
<td>The national health service (primary medical services performer lists) (Scotland) amendment regulations 2011</td>
<td>21/12/11</td>
<td>DSP, GMPCC</td>
</tr>
<tr>
<td>13</td>
<td>CEL(2011)031</td>
<td>Annual leave policy</td>
<td>19/12/11</td>
<td>DHR&amp;OD</td>
</tr>
<tr>
<td>14</td>
<td>CEL(2011)032</td>
<td>Revised workforce planning guidance 2011</td>
<td>19/12/11</td>
<td>DHR&amp;OD</td>
</tr>
<tr>
<td>15</td>
<td>PCA(O)(2012)001</td>
<td>General Ophthalmic services</td>
<td>10/01/12</td>
<td>DSP, GMPCC</td>
</tr>
<tr>
<td>16</td>
<td>PCA(P)(M)(2012)001</td>
<td>Seasonal influenza immunisation 2012-13: Vaccine supply arrangements.</td>
<td>12/1/12</td>
<td>DHR&amp;OD, DSP, DPHHP, DOC, GMPCC</td>
</tr>
</tbody>
</table>

James Barbour  
Chief Executive  
16 January 2012

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