NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 28 MARCH 2012
TIME: 9:30 A.M.
VENUE: BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

AGENDA

Welcome to Members of the Public and the Press

Apologies for Absence

1. Minutes of the Previous Meeting of Lothian NHS Board held on 25 January 2012
   CJW *

2. Matters Arising
   2.1. Royal Hospital for Sick Children/Department of Clinical Neurosciences Projects Outline Business Case
       SG v

3. Committee Minutes for Adoption (Indicative Timing 9:40 - 9:50 a.m.)
   3.1. Area Clinical Forum - Minutes of the Meeting held on 2 February 2012
       PM *
   3.2. Audit Committee - Minutes of the Meeting held on 28 February 2012
       SGR *
   3.3. Finance & Performance Review Committee - Minutes of the Meeting held on 8 February 2012
       GW *
   3.4. Healthcare Governance & Risk Management Committee - Minutes of the Meeting held on 7 February 2012
       PM *

* = paper attached  # = to be tabled
v = verbal report  p = presentation

For further information please contact Peter Reith, 35672, peter.reith@nhslothian.scot.nhs.uk
3.5. Mutuality and Equality Governance Committee - Minutes of the Meeting held on 21 February 2012  
3.6. Service Redesign Committee - Minutes of the Meeting held on 20 February 2012  
3.7. Staff Governance Committee - Minutes of the Meeting held on 29 February 2012  
3.8. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 14 December 2011  
3.9. Edinburgh Community Health Partnership Sub-Committee Minutes of the Meeting held on 1 February 2012  
3.10. Midlothian Community Health Partnership Sub-Committee Minutes of the Meeting held on 26 January 2012  
3.11. West Lothian Community Health & Care Partnership Sub-Committee Minutes of the Meeting held on 26 January 2012  
3.12. West Lothian Community Health & Care Partnership Board Minutes of the Meetings held on 10 January 2012  

4. Chairman's Report  

5. Chief Executive's Report  

6. Policy & Strategy (Indicative Timing 10:00 - 10:40 a.m.)  
6.1. Integration of Health & Social Care  
6.2. Developing the Clinical Strategy “Our Health, Our Future”  

7. Governance (Indicative Timing 10:40 - 11:00 a.m.)  
7.1. Quality Report  
7.2. Prison Healthcare Governance  

8. Performance Management (Indicative Timing 11:00 a.m. - 12:30 p.m.)  
8.1. Financial Position to 31 January 2012  
8.2. Delivering Waiting Times  
8.3. Tackling Delayed Discharge  
8.4. Paediatric and Neonatal Services at St John’s Hospital  
8.5. Local Delivery Plan 2012/2013  
8.6. Healthcare Associated Infection Update  
LUNCH 12:30 p.m.  

9. Other Items (Indicative Timing 1:00 - 2:30 p.m.)  
9.1. The Edinburgh Guarantee  
9.2. NHS Lothian Business Continuity Management Programme  
9.3. Backlog Maintenance Issues in Relation to the NHS Lothian Estate  
9.4. Pharmaceutical Care Services Plan 2012
9.5. Committees

9.5.1. Committee Chairs  CJW *
9.5.2. South East Scotland Research Ethics Committees  DF *

9.6. Update on SEAT Activities  DF *


11. Communications Received  JJB *

12. Date, Time and Venue of Next Meeting: Wednesday 23 May 2012 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

13. Resolution to take items in closed session

Dates of Meetings in 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 10.15am on Wednesday, 25 January 2012 in the Space 3, Howden Park Centre, Howden, Livingston, West Lothian.

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) and Mrs J K Sansbury (Chief Operating Officer).

Non-Executive Directors: Dr C J Winstanley (Chair); 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); Mr P Johnston; Mrs J McDowell; Professor P Murray; Mr B Peacock; Dr M Prowse; Mr S G Renwick; Mr G Walker (from 11.20am); Mr I Whyte and Dr R Williams.

In Attendance: Mr D Weir (Corporate Services Manager); Professor A McMahon (Acting Director of Strategic Planning and Primary Care) and Mr S R Wilson (Director of Communications).

Apologies for absence were received from Councillor J Aitchison, Professor J Iredale and Councillor P MacLennan.

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 as he was now an employee of the City of Edinburgh Council, which was referenced in some of the papers. The Chair advised that Mr Renwick should signal his intention to withdraw from debate if he felt there was any potential conflict.

105. Chair’s Opening Comments

105.1 The Chair thanks Mrs Douglas and Mr Forrest for hosting the West Lothian Community Health and Care Partnership presentation held immediately prior to the formal public Board meeting. He commented the visit to West Lothian concluded NHS Lothian’s programme of visits to each of the geographical areas.
105.2 The Chair welcomed back Mr Peacock following his recent illness.

105.3 The Board agreed the Chairman’s proposal to move to a paperless agenda and Board members would from early in the beginning of the financial year 2012/13 receive Board and Board Committee papers as downloads on iPads provided to them for the period of their tenure as Board Members. He commented this would lead to significant reductions in photocopying and agenda delivery costs. Mr Weir would progress.

105.4 The Chair reminded colleagues that the Board had previously agreed a revised Board paper template, subject to a 6-month pilot period. He commented the pilot period had now expired and he would welcome comments back to himself on the template.

106. Minutes of the Previous Meeting of Lothian NHS Board held on 23 November 2011

106.1 The Minutes were approved as a correct record.

107. Matters Arising

107.1 Older People’s Inspections – Mrs Hornett reminded the Board that at the previous meeting concerns had been raised about certain aspects of the older people’s inspection process. She advised since then NHS Lothian, NHS Tayside and NHS Greater and Clyde Health Boards had been inspected. The inspections had been carried out on a test basis to reflect concerns raised by the service and consequently healthcare records had not been inspected. Mrs Hornett advised Liberton Hospital had been inspected on 8 December 2011 with the focus being on observations of care on four wards.

107.1.1 Mrs Hornett advised the feedback given to staff from inspectors on the day of the inspection had been extremely positive and had confirmed there were no issues of concern identified with positive comments being made around dignity, respect and communication. At that point, she commented the experience for staff had been positive and patient care had not been disrupted and interaction with the inspectors had been positive. She commented there had been no intention, given the test status of the inspection, to issue a formal report. She commented, however, subsequently a report had issued and unfortunately this did not reflect the feedback on the day and raised issues not considered during the informal debrief and this had resulted in considerable dissatisfaction amongst staff, who felt demotivated. Mrs Hornett commented she would be responding vigorously on the accuracy of the report and on the disconnection between its formal contents and the positive feedback given on the day of the inspection.

107.1.2 Mrs Hornett advised the issue in respect of the inspection team’s access to healthcare records had apparently been resolved with records being accessible in future, although to date this determination had yet to be received in writing.
107.1.3 Mrs Hornett advised the Chief Executive of the NHS in Scotland had written to Boards advising the environment and older people inspection processes would be separated in order to allow a focus on the improvement methodology.

107.1.4 The Vice-Chair reported the inspection process had been discussed at the Partnership Forum where concerns still remained around access to patient records and clinical confidentiality. He commented it was unacceptable for inspectors to provide positive feedback to staff on the day of an inspection and to then issue a contradictory written report. He and partnership colleagues welcomed a transparent inspection process but could not countenance the current position as detailed by Mrs Hornett and commented moving forward this would be unsustainable.

107.1.5 Mr Anderson commented the inspection process had been discussed in detail at the Edinburgh CHP performance management group where it had been agreed it would be helpful to have full details of the methodology of inspections, certification arrangements for training of inspectors as well as evidence of competence of the inspectors. The Chair advised this had also been raised at the Chairmen’s Group at national level.

107.1.6 Mrs Hornett advised she was working with Dr McCallum, the Caldicott Guardian around the records issue.

107.1.7 The Board noted the update report from Mrs Hornett and expressed concern that process issues appeared still not to have been resolved despite previous concerns having been articulated.

108. Committee Minutes

108.1 Area Clinical Forum – Minutes of the Meeting held on 17 November 2011 – the Board adopted the Minutes. Professor Murray commented the Area Clinical Forum continued to have a focus on the transfer of prison healthcare to the NHS and also on the pharmaceutical services care plan.

108.1.1 Professor McMahon, at the request of several Board members, undertook to bring an update paper to a future Board meeting setting out the transitional and operational management arrangements around the prison transfer. The Vice-Chair advised the Staff Governance Committee had a focus on this area and meetings had been held on an individual basis with affected staff. Mr Whyte commented following discussion at East and Midlothian CHP, the transfer had been included on the local risk register and full reports would be made through the appropriate CHP governance arrangements.

108.2 Finance and Performance Review Committee – Minutes of the Meeting held on 14 December 2011 – the Board adopted the Minutes.

108.2.1 Mr Renwick commented although the Minutes suggested East and Midlothian Councils had withdrawn from shared services discussions he, as Chair of the
Transport and Access Committee, had held a positive meeting with Midlothian Council, who were keen to participate.

108.2.2 The Vice-Chair suggested if parties were withdrawing from shared services discussions, they should share the reasons for this with other colleagues.

108.3 Healthcare Governance and Risk Management Committee – Minutes of the Meeting held on 15 December 2011 – the Board adopted the Minutes. Professor Murray commented within the University Hospitals Division there had been a decrease in the adverse event rates and this should be celebrated.

108.4 Mutuality and Equality Governance Committee – Minutes of the Meetings held on 14 October and 13 December 2011 – the Board adopted the Minutes.

108.4.1 Mrs McDowell commented in both sets of Minutes there was reference to the Committee’s comments on the form of the Board template and she would ensure these were fed back to the Chair as previously agreed. She advised copies of the Equality and Human Rights annual report would be circulated to Board members.

108.5 Service Redesign Committee – Minutes of the Meeting held on 19 December 2011 – the Board adopted the Minutes.

108.6 Staff Governance Committee – Minutes of the Meeting held on 22 November 2011 – the Board adopted the Minutes.

108.6.1 The Vice-Chair provided a positive report on the outcomes of the day of industrial action commenting there had been clear partnership evident between Trades Union and management colleagues in the provision of what was essentially a Sunday service. Mr Boyter commented that the Board’s business continuity arrangements and planning had worked well.

108.7 East Lothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 28 October 2011 – the Board adopted the Minutes and noted Mr Whyte’s previous comments around the monitoring of the transfer of prison health services.

108.8 Edinburgh Community Health Partnership Sub-Committee – Minutes of Meeting held on 7 December 2011 – the Board adopted the Minutes. Mr Anderson provided feedback on discussions around “Teach Back” the North Edinburgh Public Partnership Forum and prescribing where he suggested that the lengthy debate demonstrated the CHP was taking this situation seriously.

108.9 Midlothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 24 November 2011 – the Board adopted the Minutes. The Vice-Chair drew the Board’s attention to work that was ongoing with care homes resulting in a significant reduction in the number of falls. He commented positive work was also underway to reduce referrals to dementia inpatient services thereby allowing people to stay in their own homes for longer.
108.10 West Lothian Community Health and Care Partnership Sub-Committee – Minutes of the Meetings held on 13 October and 24 November 2011 – the Board adopted the Minutes.

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

109. Chairman’s Report

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

109.2 The Chair commented he had chaired the joint meeting with Consort the previous day where issues of mutual concern had been discussed. He stressed it had been emphasised Disclosure checks were an inherent requirement of the contract that had to be fully discharged and NHS Lothian was, therefore, disappointed at the recent lack of compliance in this area. He advised assurances had been provided about future performance in this area. The Vice-Chair commented this was an alarming position and questioned whether any financial redress would be provided to NHS Lothian for this fundamental breach of contract. Mrs Sansbury commented if financial penalties could be applied they would be, although she stressed the staff affected had been support and management staff and not clinicians.

110. Chief Executive’s Report

110.1 The Chief Executive provided the Board with a report on his local, regional and national activities since the previous Board meeting covering the success of staff at national award ceremonies, a visit to the Edinburgh CHP, chairing the SEAT Planning Group on 25 November 2011, speaking at the Family Nurse Partnership conference and hosting a visit by members of the NHS in England top leaders programme. He further advised he had been particularly impressed with the work of the Willow Project, which he had visited with Mr Gabbitas, which related back to previous discussions around the prison health service.

110.2 Mr Anderson advised he had found the work of the Keep Well team inspiring and felt it would be beneficial for the Board to receive a presentation on this work at an appropriate point. Dr Farquharson and Dr McCallum would liaise around the timing of such a presentation.

110.3 Mr Johnston questioned whether the Chief Executive was aware of any particular link between the Family Nurse Partnership and the Early Years change fund. The Chief Executive and Mrs Hornett both reported they had not understood there was any such link. It was noted the pilot was to be extended to other Health Boards and NHS Lothian would be making a bid for additional funding. Dr Prowse commented this was an area where philanthropic funding should also be investigated, as well as Scottish Government Health Department funding.
111. Quality Report

111.1 Dr Farquharson advised the purpose of the quality report for this month was to set out the effectiveness measures for cancer care in Lothian. He provided the Board with details of the key quality results for Hospital Standardised Mortality Rates (HSMR), adverse events, hospital associated infection, incidents with associated harm and complaints. Dr Farquharson advised the constraints in relation to each of these data items had been presented to the Board in previous quality reports.

111.2 Dr Farquharson commented in respect of cancer performance that the report covered the three key themes of prevention, early detection and mortality. He reported breast screening was subject to a national review. He commented cervical screening rates in Lothian were above the national average for people over 35 years of age but slightly below the national average for those under 35 years of age. Dr McCallum provided details of the possible reasons for this advising the screening programme had been reviewed and a report was currently with the Cabinet Secretary.

111.3 Mr Whyte commented from the report he felt rates of screening in general could be better and also commented in respect of the mortality for prostate cancer that the report was unclear about actions being taken by NHS Lothian to encourage men to look after their health. He was aware of charitable work in this area. Dr Farquharson commented a national programme was in place with a view to increasing awareness of the disease. Dr McCallum commented the Keep Well programme engaged with men in the more deprived populations to increase awareness. She advised prostate cancer was increasing across the globe with many of the causes being environmental. She commented there was no screening programme for prostate cancer because the disease was difficult to treat and required the right balance of care on a person-to-person basis.

111.4 Dr Farquharson in response to a question from Councillor Cochrane commented although national work was ongoing around prostate cancer, he was unaware of any specific local initiatives, with the exception of the introduction of new drugs, the benefits of which would become more apparent with their extended use. He commented there would be a need to avoid conflicting messages between local and national initiatives with there requiring to be absolute clarity about the benefits of any new approaches prior to these being rolled out for further use.

111.5 Dr Prowse commented she felt there was a need to consider how best to make use of social networking to encourage people to attend earlier for screening and, in order for this to be successful, there would be a need to address any areas of deficit around IT literacy and fluency. Mrs Hornett advised she was looking at work to scope developments in this area, which would require to address issues around confidentiality. She commented a successful “app” had been produced in respect of organ donation and she would keep the Board updated on progress in this developing area. Dr McCallum undertook to speak
to Mr Anderson outwith the meeting in respect of arrangements in place to follow-up people who did not attend for screening appointments.

111.6 Mr Burley commented in respect of mobile telephony and new technology that a positive presentation had been received on this area at the Service Redesign Committee. He felt there was a need to look at health within the wider round of technology. He stressed the need to make the use of technology accessible with integrated interfaces such as mobile telephones and digital televisions. Mrs Hornett concurred advising aspects like this would be addressed through the Clinical Strategy.

111.7 Dr Farquharson and Mrs Hornett advised they would address issues around patient satisfaction scores at a future meeting when primary care data would be available. Mrs Hornett commented the fast frequent outputs from the 5x5x5 project would assist in this work. The Chairman and Dr Farquharson would discuss how to integrate the information contained in the Board report with the Quality Alliance Board.

111.8 The Board noted the quality report update for January 2012 with the focus on cancer.

112. Financial Position to 30 November 2011

112.1 Mrs Goldsmith advised the financial position to the end of November was showing an improvement with the October overspend of £2.8m having been reduced to £2.1m for November. She advised this had been the most up-to-date information available at the time the Board papers had issued and commented the December position was now available and a further reduction to £1m would be reported to the Executive Management Team in the first instance and thereafter through the Board governance structure, including the Finance and Performance Review Committee.

112.2 Mrs Goldsmith commented she had funded price changes on prescribing and stressed a lot of work continued with CHPs to bring operational budgets into balance and off-setting non-recurrent savings were being generated to cover the position. She advised that she had commissioned a piece of work with National Services Scotland (NSS) to review the trends on prescribing linking those to both demographics and the GMS contract. She advised the prescribing position remained a challenge, particularly in respect of increasing volume. She further reported that additional financial support to cover the waiting times position would be discussed at the Finance and Performance Review Committee in March 2012.

112.3 Mrs Goldsmith reported the key risks remained around the Local Reinvestment Plan (LRP) with there being a particular need to make delivery as recurrent as possible, although this would not all be achieved in the current financial year. She advised further work continued around the UNPACS budget with options being considered about how to deliver services locally in order to make the position more sustainable.
Mrs Goldsmith reported increasing levels of information was now available on activity and she felt there was now merit in producing a separate activity report, which she would prepare in the first instance for the Executive Management Team and the Finance and Performance Review Committee to provide full detail behind activity movements and case mix changes.

The Vice-Chair and CH(C)P Chairs confirmed the prescribing position remained a key focus with further engagement needed with GPs. The possible impacts of the provision of free prescriptions and the ageing population were discussed. Mr Whyte commented it was important to recognise national policy changes had been imposed with no budgetary provision.

Dr Williams commented he felt General Practitioners were fully engaged in this debate and reminded colleagues Lothian GPs were the most cost effective prescribers in Scotland. He did not feel work at the margins would produce significant savings because of the already positive Lothian performance. He felt, therefore, there would be a need to look at bigger issues through the Difficult Decisions Group chaired by Dr Farquharson to focus on areas where prescribing on the NHS might be withdrawn or reduced. Dr Prowse commented there was no single solution in addressing the prescribing position, although she supported the development of predictive modelling, which she felt would be of benefit in understanding the position moving forward.

Professor Murray advised the current areas of focus in respect of prescribing were around polypharmacy, repeat prescribing and waste. She assured the Board every possible effort was being made to manage the drugs position and gave a flavour of work currently in progress. She commented the forthcoming Board Development Day in February would consider the position in full detail.

Mrs Allan suggested it would be important to be able to evidence where the provision of medication allowed people to be treated outwith the hospital environment. The Chair concurred commenting in many instances the process of medication negated the need for more intrusive procedures such as surgery.

Mr Renwick advised he was opposed to Mrs Goldsmith’s intention to extract activity data as a separate report from the finance paper commenting he welcomed the present holistic position which, he commented, was soon to include income also. He felt there was a need to consider horizon scanning processes in the future, although he was encouraged by the improvement in the month 9 financial position. He advised there was also a need to identify new capital charges that would need to be accommodated within the financial plan. Mr Walker felt in terms of activity that data on occupied bed days and case complexities would be particularly beneficial, as well as consideration of how to cope with increases in activity whilst meeting LRP targets.

Mrs Goldsmith commented she appreciated the points made about activity and would give this appropriate focus. She advised the Finance and Performance Review Committee had agreed to receive reports on income and reporting on this would commence in March/April 2012. She advised horizon scanning of future financial issues would be addressed as part of the financial plan which would subject to scrutiny by the Finance and Performance Review Committee.
112.11 The Board noted the paper detailing the financial position of NHS Lothian to 30 November 2011, as well as the Director of Finance’s verbal update on the position to the end of December. The Board welcomed Mrs Goldsmith’s confirmation that financial break-even would be achieved for 2011/12.

113. Delivering Waiting Times

113.1 Professor McMahon advised the Board the report was prepared using the most up-to-date information available. He advised NHS Lothian was making generally positive performance in meeting waiting time targets.

113.2 The Board was advised by Professor McMahon that the 4-week access target remained a challenge and work continued to identify ways of meeting targets.

113.3 Mr Renwick asked whether Professor McMahon had a sense of the trajectory for November moving into December and also details of how patients became unavailable on the waiting list. Mrs Sansbury provided details around the delivery of the current guidance on refusal of two reasonable offers offering three options advising there was differing application across Scotland of how the guidance was applied. She advised in Lothian the practice hitherto followed in the operating division had been to suspend patients for a period, although this position had been cancelled by her in November. Mrs Sansbury commented there were continuing discussions across Scotland to reach a consensus then the guidance would be updated.

113.4 Mr Renwick questioned what the waiting times trip position would look like moving into December. Mrs Sansbury reported this would deteriorate because of the rigorous approach which she had now introduced in respect of suspension. She anticipated the inpatient position would be around 2,550 with the outpatient position yet to be validated. She advised the information would be reported into the Scottish Government Health Department. Mr Renwick acknowledged the clear explanation and update.

113.5 Mrs Sansbury commented in order to deal with the capacity risk in mitigating the backlog, additional staffing and theatre time had been made available locally, and efforts were underway to maximise efficiency in current lists as well as utilising opportunities in other Boards and the private sector. Mrs Sansbury advised the position was being monitored on a weekly basis. The Chair questioned whether all the necessary capacity would be secured by the end of March 2012. Mrs Sansbury advised she was working on plans and timings in discussion with the Scottish Government Health Department and there were some specialties that were challenging, including orthopaedics, and of which the Scottish Government Health Department were aware. She was also concerned to make sure that all additional capacity was secured and provided in a manner which met NHS Lothian’s standards, and ensured patient safety.

113.6 The Board noted the update report on NHS Lothian’s progress toward achieving the waiting list targets.
114. **Tackling Delayed Discharge**

114.1 Professor McMahon advised there had been an improvement in the December delayed discharge position, although there remained people delayed over 6-weeks and there had been an increase in the length of stay. He was working closely with local authority partners to address outstanding issues.

114.2 The Vice-Chair commented whilst he recognised the good work across partnerships, he was concerned as Employee Director that there had been 180 patients in the acute division in the previous week who should have been receiving treatment elsewhere. The Vice-Chair suggested other forms of provision such as properly supported hotel accommodation should be considered for people who did not need intensive packages of care. Professor McMahon undertook to consider this position, as well as comments made by Mr Anderson in the next Board paper taking account of experience south of the border.

114.3 Councillor Edie commented when he had spoke to his Director the previous day about the Edinburgh target, he had been advised the target for January 2012 was 48 and a positive performance level of 46 would be delivered. He reminded the Board of the particular challenges experienced with the unplanned closure of the Elsie Inglis Nursing Home. He commented the position was further exacerbated by the lack of available people wanting to work in the home care environment. He advised an innovative approach to creating more capacity was being investigated by the Council.

114.4 Councillor Edie sought confirmation on the number of beds removed from the acute sector. Professor McMahon undertook to provide details around the number of redesign beds to Councillor Edie outwith the meeting. Mrs Sansbury stressed, however, within the University Hospitals Division redesign requirements were put in place before any beds were removed from establishment.

114.5 The Chief Executive commented in respect of the waiting times position, he had discussed his concerns with Ms Bruce, Chief Executive, City of Edinburgh Council and Mr Gabbitas, Joint Director of Health and Social Care on 13 December 2011. He advised Ms Bruce had responded stating she was supportive in the short-term to using Edinburgh change fund resources to support the provision of extra beds in the NHS. The Chief Executive advised he had asked Professor McMahon to follow-up a risk assessment in respect of this potential way forward.

114.6 The Chief Executive stressed the delayed discharge position required regular dependable and daily flow through Lothian hospitals. Councillor Edie suggested this would need engagement from the private and voluntary sectors.

114.7 The Board noted the position in respect of achieving the delayed discharge target.
115. **Healthcare Associated Infection (HAI) Update**

115.1 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 (SAB) and clostridium difficile and the position was monitored on a weekly basis. She advised there had been 21 episodes of SAB recorded in December 2011 (3 meticillin resistant staphylococcus aureus, 18 meticillin staphylococcus aureus) compared to 25 in November 2011 (0 meticillin resistance staphylococcus aureus, 25 meticillin sensitive staphylococcus aureus). She commented currently NHS Lothian was on trajectory to achieve the health efficiency access treatment (HEAT) target of 0.26 cases or fewer per 1,000 acute occupied bed days by March 2013, with a current rate of 0.32.

115.2 Dr McCallum commented in respect of clostridium difficile infection, there had been 15 episodes of clostridium difficile infection in patients aged 65 or over in December 2012, compared to 23 in December 2011. Currently NHS Lothian was on trajectory to achieve the health, efficiency access treatment target of 0.39 cases or fewer by 1,000 acute bed days by March 2013, with a current rate of 0.35.

115.3 Dr McCallum commented preliminary reports in respect of hand hygiene compliance demonstrated the medical staff position was significantly improved with a level of 100% compliance being achieved, although this required validation. She commented the MRSA screening programme was progressing well, although clarity was needed on how this would continue in the longer term. She advised discussions were ongoing in respect of the existing model and how best to deliver it to older people.

115.4 Dr McCallum commented she had met the antimicrobiological team the previous day and good progress continued in this area. She reminded the Board winter was the season for norovirus and each morning she and Mrs Sansbury, along with other clinical colleagues, received reports of cases and actions being taken across NHS Lothian. Dr McCallum commented at this time of year clusters of clostridium difficile presented and if more than one case was evident within NHS Lothian this was fully investigated.

115.5 Dr McCallum commented in respect of the unannounced inspection at St John’s Hospital positive feedback on the quality of care and effectiveness had been received. She commented areas had been identified for improvement based on the informal feedback and plans were in place to ensure this occurred.

115.6 The Vice-Chair commented staff side colleagues recognised the importance of work in this area. He reported, however, in some instances under certain clinical emergency conditions, it was not always practical for clinical staff to wash their hands in the way prescribed by the audit process.
115.7 The Board noted the positive work being undertaken to address healthcare associated infection.


116.1 The Board noted the positive letter of 22 December 2011 to the Chair from the Cabinet Secretary providing feedback on the NHS Lothian annual review meeting held on 27 October 2011.

117. NHS Lothian Health and Safety Policy

117.1 Mr Boyter commented there was a statutory requirement for NHS Lothian to have an approved Health and Safety Policy and to ensure it was reviewed and updated on an annual basis. He advised the revised policy circulated to the Board had been approved by the Health and Safety Committee and was now being submitted for formal approval.

117.2 Mr Boyter commented the key changes to the existing Health and Safety Policy were in relation to the introduction of a system of audit based on the Royal Society for the Prevention of Accidents (ROSPA) system. He commented this included audit of the high-level Health and Safety management of an organisation. He advised the initial use of the system to evaluate Estates and Logistics identified the need to significantly expand sections of the current NHS Lothian Health and Safety Policy with the addition of clear organisational charts. He commented, on that basis, the policy was updated and amended and had been subject to consultation prior to consideration by the Lothian Health and Safety Committee.

117.3 Mrs Allan commented from a patient perspective whether new risks had emerged during the review. Mr Boyter commented the focus of the Health and Safety Policy was on NHS Lothian’s responsibility as an employer to its staff and, in that particular regard, no new risks had been identified. He commented, however, he was thoughtful about the points raised by Mrs Allan.

117.4 Mr Renwick questioned how requirements within the Health and Safety Policy applied to external contractors. Mr Boyter explained the process for engaging private contractors stressing in response to comments made by Mr Renwick and Mrs McDowell that the expectation would be that contractors would at least meet, if not exceed, NHS Lothian’s own internal requirements. Mr Boyter, through the Health and Safety Committee would amend the wording accordingly to emphasise this key point.

117.5 Dr Prowse questioned the position in respect of the non-mandatory retirement age and, in particular, issues around on-call commitments. Mr Boyter reported any employee over the 70 years of age was referred to the Occupational Health service on an annual basis and, at this point, consideration to any on-call aspects of their employment would be reviewed. The Vice-Chair commented there was a valid point to be considered in respect of the difference between people’s expectation of what they could undertake in terms of job opportunities.
and what they were actually capable of doing. He advised staff side colleagues continued to engage in a proactive and transparent manner in both the local and area Health and Safety Committees.

117.6 The Board agreed the revised NHS Lothian Health and Safety Policy.

118. **NHS Lothian Contribution to SEAT Work**

118.1 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 in driving forward work on a regional basis.

118.2 Mr Renwick commented future reports to the Board should follow the agreed Board template. He advised he was aware of a number of risks pertinent to other Boards, particularly in respect of emerging clinical strategies and the paediatric position which would potentially benefit from SEAT input. He felt the resource implications contained within the paper were bland and should be addressed in future iterations. Professor McMahon undertook to address the points raised by Mr Renwick.

118.3 The Vice-Chair commented it had been disappointing in respect of shared services work on corporate functions that NHS Fife intended to make savings through further local and national work and withdraw from the SEAT regional workstream on shared corporate services. He commented other colleagues had given up valuable time over a 12-month period only to reach a point where NHS Fife had decided not to participate in the workstream.

118.4 Mr Boyter commented that he would work with NHS Borders to see if any of the work undertaken could still be progressed following NHS Fife’s withdrawal.

118.5 The Board noted the report on NHS Lothian’s contribution to SEAT work.

119. **Presentation – Scottish Patient Safety Programme – Dr Nikki Maran, Consultant Anaesthetist, Royal Infirmary of Edinburgh**

119.1 The Board received a positive and informative presentation on the work of the Scottish Patient Safety Programme from Dr Maran, Consultant Anaesthetist, Royal Infirmary of Edinburgh. She advised the Scottish Patient Safety Programme focussed on critical care, the general ward and leadership and medicines management.

119.2 Dr Maran provided a question and answer sessions for Board members following which the Board thanked her for her contribution and invited her to provide a further update at a future Board meeting, the timing of which would be determined by Dr Farquharson.

120. **Communications Received**
120.1 The Board received a list of communications received from the Scottish Government Health Department.

121. **Resolution to Take Items in Closed Session**

121.1 The Chair sought permission to invoke Standard 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.

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

122.1 The next meeting of Lothian NHS Board would be held on Wednesday, 28 March 2012 at 9.30am in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
<table>
<thead>
<tr>
<th>Item</th>
<th>Action to be taken</th>
<th>By whom</th>
<th>Completion date</th>
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<tr>
<td>2.2</td>
<td><strong>MHRA Consultation on the Project to Consolidate UK Medicines Legislation</strong> – The Chair reported that the consultation was now closed and agreed to circulate the comments sent in from the Lothian Area Pharmaceutical Committee as there were implications for controlled drugs.</td>
<td>PM/CG</td>
<td>14/02/12</td>
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<td>2.3</td>
<td><strong>LAHSC: Life Sciences Review</strong> – The Forum noted that LAHSC were looking at how they could help to move things forward, reduce complications and reduce professional silos. The Forum agreed that Mr Mike Gray should be invited to the next Forum meeting to discuss progress and anything that the Forum may be able to help with.</td>
<td>DG/CG</td>
<td>06/02/12</td>
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<td>3.6</td>
<td><strong>Scottish Clinical Leadership Network Business Case</strong> - Dr Hendry stated that she would circulate the Business Case to Area Clinical Forums for feedback after the Business Group meeting to be held on 7 February.</td>
<td>CG</td>
<td>14/02/12</td>
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<td>4.</td>
<td><strong>CEL 01 (2012)</strong> – Dr McCallum would arrange for Healthy Working Lives representation to attend the next Forum meeting. Ms Roebuck asked if there was a contact for assistance in evaluation initiatives that were being introduced. Dr McCallum agreed to find out and pass this information back to the Forum.</td>
<td>AKM</td>
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<td>6.</td>
<td><strong>NHS Lothian Clinical Strategy “Our Health, Our Future”</strong> - It was agreed that the presentation given by Professor McMahon at the meeting be circulated and that he be invited to attend the next ACF to give an update on the Clinical Strategy and any implications.</td>
<td>CG</td>
<td>02/02/12</td>
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Minutes of the Meeting held on Thursday 02 February 2012 commencing at 8:30am in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Present:
Professor Pat Murray Chair, Lothian Area Pharmaceutical Committee (Chair)
Mr Graham Bell Representative Patient
Dr Stuart Blake Chair, Lothian Area Medical Committee (Vice Chair)
Mr David Gow Chair, Lothian Area Healthcare Scientists Committee
Ms Alison Meiklejohn Chair, Lothian Allied Health Professions Committee
Mrs Liz Roebuck Vice Chair, Lothian Area Dental Committee
Dr Alison McCallum Director of Public Health and Health Policy, NHS Lothian
Mr Norman Fraser Chair, Lothian Psychology Committee

In Attendance:
Mr Chris Graham Committee Administrator, NHS Lothian
Dr Anne Hendry National Clinical Lead for Quality, Scottish Government (Item 3)
Ms Alexis Burnett Communications Manager, NHS Lothian (Item 5)

Apologies:
Mrs Sally Egan Chair, Lothian Area Nursing and Midwifery Advisory Committee
Mr Robert Naysmith Chair, Lothian Area Dental Committee
Mr Kevin Wallace Chair, Lothian Area Optical Committee
Dr Simon Mackenzie Associate Medical Director, Acute Sector
Dr Anthony Moffoot Vice Chair, Lothian Area Medical Committee

1. Minutes of Previous Meeting ~ 17 November 2011 - The circulated minutes of the meeting were approved as an accurate account of that meeting, subject to the following correction –

   - Remove the sentence at 1.3 – “Mr Short added that all clinical and non clinical healthcare staff had been transferred over the NHS Lothian” as this statement was inaccurate.

2. Matters Arising [Action Checklist]

   2.1 Lothian Pharmaceutical Care Services Plan – Mr Bell reported that he had sent his comments on the plan to Aileen Muir, who had thanked him for his useful and constructive comments. The Chair informed the Forum that the Plan would be going to EMT and to the Board. The final version of the document would come to the next Forum meeting after it had been to the Board. The Chair thanked Mr Bell for his input into the plan.
2.2 MHRA Consultation on the Project to Consolidate UK Medicines Legislation – The Chair reported that the consultation was now closed and agreed to circulate the comments sent in from the Lothian Area Pharmaceutical Committee as there were implications for controlled drugs.

PM/CG

2.3 LAHSC: Life Sciences Review – Mr Gow reported that as part of the review Mr Mike Gray, Service Manager for Laboratory Medicine University Hospitals Division and Dr Alison McCallum had both given presentations at the last LAHSC meeting. The presentations had been on Progress on the laboratory medicine 4 year plan and Performance Standards and Minimising Variation. Mr Gow added that the Labs Review had appeared to be stalled and was being ‘killed by kindness’. The Forum noted that LAHSC were looking at how they could help to move things forward, reduce complications and reduce professional silos. The Forum agreed that Mr Gray should be invited to the next Forum meeting to discuss progress and anything that the Forum may be able to help with.

DG/CG

3. Quality Strategy / Infrastructure Delivery Group Update

3.1 The Chair welcomed Dr Hendry to the meeting.

3.2 Dr Hendry gave an update on the Quality Strategy and the Infrastructure Delivery Groups. Dr Hendry stated that it was a pleasure to see the increasing profile of the Area Clinical Forums. It was noted that all delivery groups now have ACF representation as part of the move towards more meaningful engagement.

3.3 There was discussion on the Workforce strategy and the ongoing development work which John Connaghan and Jill Vickerman from the Scottish Government Health and Social Care Directorates were involved with.

3.4 The Quality Alliance Board and Clinical Leadership were also discussed. The Forum noted that there was a Business Case being developed for the Scottish Clinical Leadership Network supporting a series for four master classes over a year and a web based accelerated programme of learning resources. Dr McCallum asked that if the Public Sector Leadership Master Class was to run again then it would be helpful if there could be ACF participation in this.

3.5 Dr Hendry stated that the intention was to have a programme of learning sitting under the Harvard Leadership programme which could be a sustainable and scale able model for Boards and allow more people access.

3.6 Dr Hendry stated that she would circulate the Business Case to Area Clinical Forums for feedback after the Business Group meeting to be held on 7 February.

CG

3.7 There was further discussion on training and education issues including measuring impact and fitness for purpose of training. Dr Hendry informed the Forum that there was a proposal to have a 90 day test of change between March and June this year, where 12-14 individuals from Boards will be involved in action research and be asked to test support, feedback, reflect and share their experiences as case studies. Dr McCallum stated that the leadership exercises
carried out through resilience under the justice directorate were usually of superb quality and brought together a range of people in the same room and it may be worth looking a linking in with this.

3.8 Issues around project management and redesign management were also mentioned. The Chair stated that it was critical to get basics right when redesigning services i.e. slicker, better and for less. There was discussion on the role and support of psychology in an educational way.

3.9 The Chair stated that there was a need for clarification of what is out there in terms of support for educational programmes. This was something that the ACF was keen to be involved with.

3.10 Dr Hendry stated that she would be happy for any further feedback and would continue to check in with the ACF twice a year.

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

4. CEL 01 (2012) – Health Promoting Health Service (HPHS): Action in Hospital Settings

4.1 The Forum noted the recently received CEL 01 (2012). Dr McCallum reported that this CEL builds on from CEL 14 (2008). Area Clinical Forums are considered a key route through which the HPHS agenda could and should be championed.

4.2 The Area Clinical Forum (ACF) forms a centre stage for delivery, professional skills and can reach across the organisation and out to patients. The ACF has a Leadership role as outlined in the CEL which complements the professional line management role. There is also an expectation of scrutiny of professional behaviour, ensuring that effective interventions are offered to all eligible patients. There will be a series of tasks for ACF to undertake in relation to ensuring that patients can access health improvement interventions and in the delivery of the objectives of the CEL. The Forum noted the implications for further improvements in the organisation and delivery of care at individual and organisational level.

4.3 Dr McCallum added that there was a clear need for this to happen and that it was an intention to also look at opportunities for improving staff health in parallel to this. There was close working with partnership to build support for this approach. In terms of delivery, there was a need to ensure interventions were of high quality, outcomes achieved and dealing with risks to health in a consistent manner. There was also the hearts and minds issue, addressing potential professional barriers to raising, recording and addressing social and behavioural risk. Dr McCallum stated that international evidence shows that vertical silo interventions do not lead to sustainable change. It was important that the delivery of key outcomes into how people work on a day to day basis was embedded ensure sustainability.

4.4 The Chair stated that the CEL was aspirational to an extent and welcomed the ACF champion role, however Lothian is at the forefront, with lots of the initiatives happening already through NHS Lothian’s excellent Pharmacy Strategy and it was about how the Forum can add value to this and make a difference in addition to what is already in place. There needs to be clarity if there is something outwith what is already happening which the Forum could actually champion.
4.5 Dr McCallum added that there are a lot of the equity aspects which Lothian does that others do not. These were the European Equity Standards with the aim to ensure that the health system is equitable, ensuring that those who are most vulnerable can enjoy the same health outcomes as those who are most affluent. It was important not to get too hung up on performance measures as ends in themselves as these were usually more modest and did not always capture all NHS Lothian does to improve outcomes.

4.6 There was discussion on information infrastructure; motivational interview technique training and the measurement of the success of subtle change.

4.7 The Chair stated that there was an issue of ownership and taking responsibility and how best to appropriate discussion with appropriate personnel to get appropriate changes. Mr Gow added that credibility was also important.

4.8 The Forum felt that it was important to get agreement on the best way to take this forward as a group. Dr McCallum referred the Forum to the section in the CEL on healthy vending as one possible area for involvement, given the expertise at the Forum’s disposal. There was discussion on the Healthy Working Lives initiative and it was agreed that Dr McCallum would arrange for Healthy Working Lives representation to attend the next Forum meeting.

AKM

4.9 Ms Roebuck asked if there was a contact for assistance in evaluation initiatives that were being introduced. Dr McCallum agreed to find out and pass this information back to the Forum.

AKM

5. Area Clinical Forum Communications Plan

5.1 The Chair welcomed Ms Burnett to the meeting.

5.2 The Forum discussed the draft communications plan and thoughts on taking it forward. The Chair stated that there needed to be reference to new initiatives such as the Quality Strategy and the recent CEL. The Members were asked to send any further feedback to Ms Burnett. The Plan was accepted as the ACF Communications Plan.

6. NHS Lothian Clinical Strategy “Our Health, Our Future”

6.1 Feedback from Meeting held on 19 January 2012 – Ms Roebuck and Mr Bell reported back from the recent meeting. It was agreed that the presentation given by Professor McMahon at the meeting be circulated and that he be invited to attend the next ACF to give an update on the Clinical Strategy and any implications.

CG

6.2 16 November 2011 Action Note – The Action note was noted.

7. Chair’s Business

7.1 ACF Chairs Group Update – No update was given.
7.2 Annual Reviews – Staff Meetings – The Forum noted the tabled paper from Malcolm Summers, Deputy Performance Manager (East), Health Workforce and Performance, Scottish Government. The Forum was happy to endorse the ACF Chairs’ comments and the Chair would feed this back to Mr Summers.

8. Board Issues

8.1 Lothian NHS Board Papers available at www.nhslothian.scot.nhs.uk

8.1.1 The Forum noted the minutes of the Board meeting held on 23 November 2011 and the agenda and electronically circulated papers from the 25 January 2012 meeting. The Chair added that it was hoped that Dr Nicola Maran, the AMD for SPSP would attend the next ACF to discuss SPSP. The presentation given to the Board had already been circulated.

8.2 NHS Lothian Service Redesign Committee - The Forum noted the minutes of the meeting held on 19 December 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 14/12/11
- Pharmaceutical Committee 01/12/11
- Healthcare Scientists Committee 07/12/11
- Allied Health Professions 15/11/11

10. Items for Information

10.1 No items were raised.

11. Any Other Competent Business

11.1 Patient Groups – Mr Bell reported that new patient group fora were being established at the Western General Hospital and Royal Infirmary of Edinburgh. There also remained groups at the Royal Hospital for Sick Children and St John’s Hospital. These were bodies of patients that the Forum may find useful to engage with on a hospital basis. The Forum noted that the Western Forum was being organised through Diane Loughlin, PFPI & Health Promotion lead at St John’s Hospital.

12. Date of next meeting: Thursday 17 May 2012, 8.30 – 11.30am, Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG (Deadline for receipt of papers is 3 May 2012)

13. 2012 Meeting Dates

- 16 August 2012
- 22 November 2012
<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>Corporate Governance (12 April 2011)</td>
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<tr>
<td>Minutes of the Operational Audit Sub-Committee held on 28 March 2011</td>
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<tr>
<td>• Management to investigate the risk of NHS Lothian staff performing duties relating to maternity medical services, that are already covered by the Primary Medical Services Contract.</td>
<td>DM</td>
<td>27/9/11</td>
<td>Discussions ongoing with Community Midwife Management about greater input from GP Practices in line with Maternity Medical Services. Will be discussed at PC Forward meeting on 7 February.</td>
<td>In progress</td>
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<td>Action Required</td>
<td>Lead</td>
<td>Due Date</td>
<td>Action Taken</td>
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<td><strong>Corporate Governance (21 June 2011)</strong></td>
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<td><strong>Formal Consideration of Resources Available to the Committee</strong></td>
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<td>• In recognition of the future changes in Board membership, succession plans</td>
<td>SGR/ AP</td>
<td>27/9/11</td>
<td>This process has started with an initial consideration of the requirements of</td>
<td>In progress</td>
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<td>should be developed to ensure that the Committee has the necessary skill set within its membership.</td>
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<td>the Scottish Government Audit Committee Handbook.</td>
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<td>The Corporate Governance team is preparing an Audit Committee induction pack</td>
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<td>for new members and this will be brought to the Committee on 5 April 2012</td>
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<tr>
<td><strong>Matters Arising from Meeting of 11 October 2011 (28 February 2012)</strong></td>
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<tr>
<td>• Mrs Goldsmith advised the Committee that discussions were ongoing on the transfer</td>
<td>SG</td>
<td>31/5/12</td>
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<td>of the staff lottery from the Board. It was agreed that there should be a deadline</td>
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<td>of 31 May 2012 for the transfer to take place.</td>
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<td>• To obtain legal advice on discussions with Consort proceeding in the absence of</td>
<td>SG</td>
<td>19/3/12</td>
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<td>a representative of the Board.</td>
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<td>Action Required</td>
<td>Lead</td>
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<td><strong>Minutes of the Operational Audit Sub-Committee held on 26 September 2011</strong></td>
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<tr>
<td>(28 February 2012)</td>
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<td>• The Committee to receive an update on the progress being made on Business Continuity Planning.</td>
<td>AMcM</td>
<td>5/4/12</td>
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<tr>
<td><strong>Internal Audit Progress Report</strong> (28 February 2012)</td>
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<tr>
<td>• The Committee to receive a briefing on the controls in place to prevent nursing registrations from lapsing or false registrations being presented.</td>
<td>AB</td>
<td>5/4/12</td>
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<tr>
<td><strong>Technical Brief</strong> (28 February 2012)</td>
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<td>• The impact of prison transfer financial liabilities to be clarified, and the matter to be referred to the Finance &amp; Performance Review Committee.</td>
<td>SG</td>
<td>5/4/12</td>
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<td>• The Top 100 earners in NHS Lothian to be identified, and a report to be presented to the Committee.</td>
<td>AB</td>
<td>5/4/12</td>
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Minutes of the NHS Lothian Audit Committee Meeting held at 9.00am on Tuesday 28
February 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1
3EG.

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

In Attendance: Ms J Bennett (Clinical Governance Manager) (attended for item 26.3); Professor J J Barbour (Chief Executive); Mrs S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting & Corporate Governance); Mr A Boyter (Director of Human Resources and Organisational Development); Mr A Perston (External Auditor - Audit Scotland); Mr D McConnell (External Auditor - Audit Scotland); Mr D Woods (Chief Internal Auditor); Dr C J Winstanley (Chairman); Mr A Payne (Corporate Governance & Value-for-Money Manager); and Mrs E O’Connor (Committee Administrator).

Apologies for absence were received from Mr B Peacock.

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. The Chair, as a new employee of the City of Edinburgh Council, declared an interest in shared services contracts and the transfer of Catering staff from the Council to the Board vis a vis catering for the Sick Children’s Hospital.

20. Minutes of the Previous Meeting

20.1 Minutes of the Previous Meeting held on 11 October 2011 – previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 11 October 2011 were approved as a correct record.

20.2 Update on the Previous Meetings held on 31 January 2012 and 21 February 2012 – The Chair gave a verbal update on discussion at the previous meetings held on 31 January 2012 and 21 February 2012. He informed the Committee that following the report by Dr David Farquharson to the Scottish Government on waiting times, the Board, through the Audit Committee, had commissioned PricewaterhouseCoopers (PWC) to conduct an audit on waiting times on 6 February 2012. A verbal report from PWC was given to the Board Review Group on 17 February 2012 with a summary of early themes. A letter was then received on 20 February 2012 from the Scottish Government stating that the audit should be carried out by the Scottish Government (as distinct from Lothian NHS Board). This was considered on 21 February by the Audit Committee and on 22 February 2012, it was agreed by the Board that NHS Lothian’s contract with PWC should be terminated. The Chair added that
PWC had advised that, in line with usual practice, PWC would retain the unattributable material already gathered, but not share it with any third party (including the Board or the Scottish Government). The Committee’s opinion is that the full findings from the review to be conducted by PWC on behalf of the Scottish Government should be made available to the Board whether in draft or final form.

20.2.1 The Chair highlighted the strong sense of commitment from the Board to maintain the internal efforts towards achieving waiting times targets. He highlighted that management actions originally identified as a consequence of Dr Farquharson’s report were progressing in order to ensure waiting times systems in NHS Lothian were fit for purpose. The Board’s Special Review Group was monitoring the progress.

20.2.2 Members raised concerns regarding a potential conflict of interest for a member of PWC’s review team – allegedly, while working on the audit for PWC, the team member was also employed by the Scottish Government in a function relating to waiting times management.

20.2.3 Mr Egan referred to the work of the Special Review Group of the Board and reported that an internal investigation was being taken forward to provide assurance that internal reporting to the Board was consistent. Mr Boyter and Mr Egan have agreed the terms of reference of the internal investigation and managers had been informed. The investigation would be taken forward with trade unions. This investigation is scheduled to conclude on 30 March 2012. Mr Boyter highlighted that this had been discussed with the Scottish Government and that this had been agreed as the appropriate way forward.

20.4 The Chair commented that this issue had been handled with diligence, transparency and rigour. He suggested that the lessons learnt from this incident should be discussed at the next meeting. Mr Martin added that this incident would need to be reflected through the Governance Statement which accompanies the Board’s annual accounts. Professor Barbour added that the reporting of waiting times data has been consistent across governance committees, with executive directors reporting figures as presented to them and understood by them. The Committee acknowledged this position.

21. Matters Arising

21.1 Matters Arising from the Meeting of 11 October 2011 – the Committee noted the previously circulated paper detailing the matters arising from the Audit Committee meeting held on 11 October 2011, together with the action taken and the outcomes.

21.1.1 Mr Payne gave a brief overview of the action note. Professor Murray referred to the concerns raised at the previous meeting regarding the gaps in the communication of risk to the Chair of the Healthcare Governance and Risk Management Committee. Professor Murray reported that this risk was now on the corporate risk register. Dr Winstanley suggested that the key points of this risk should be highlighted and broken down with information on how the risk would impact the Board.
21.1.2 Mr Payne reported that the new risk management policy and procedure were currently out for consultation and would be presented to the Healthcare Governance and Risk Management Committee for approval. Workshops to educate staff on the new policy and procedure had been delivered.

21.1.3 Mrs Goldsmith advised the Committee that discussions were ongoing on the transfer of the staff lottery from the Board. It was agreed that there should be a deadline of 31 May 2012 for the transfer to take place.

21.1.4 Mr Payne updated the Committee on the format of the annual committee reports, which would now have a "statement of assurance need". He confirmed that the authors of all Committee annual reports had been given the same timescale for completion.

21.1.5 The Committee discussed the Royal Hospital for Sick Children/Department for Clinical Neurosciences project and joint working with the Scottish Futures Trust. The discussion highlighted concerns that the Chief Executive of the Scottish Futures Trust had been in discussions with a General Manager from Consort without a Board representative being present. The Committee agreed that this was unacceptable and the Board should seek legal advice from the Central Legal Office (CLO).

SG

22. Operational Audit Sub-Committee

22.1 Minutes of the Operational Audit Sub-Committee held on 26 September 2011 – the Committee noted the previously circulated minutes of the meeting of the Operational Audit Sub-Committee held on 26 September 2011.

22.1.1 With regards to Business Continuity (158.4 of the minute), Mr Egan reported that conflicting information had been reported to the Healthcare Governance and Risk Management Committee in February, where it was noted that the Business Continuity Workshop had been cancelled due to a lack of staff engagement. It was agreed that an update on business continuity should be requested from Professor McMahon.

AMcM

22.1.2 The Chair highlighted that the Operational Audit Sub-Committee had requested more localised data and performance monitoring for dental services, community pharmacy and ophthalmic services.

22.1.3 The Committee agreed to adopt the minutes of the Operational Audit Sub-Committee meeting held on 26 September 2011.

22.2 Minutes of the Operational Audit Sub-Committee held on 28 November 2011 - the Committee noted the previously circulated minutes of the meeting of the Operational Audit Sub-Committee held on 28 November 2011.
22.2.1 The Committee agreed to adopt the minutes of the Operational Audit Sub-Committee meeting held on 28 November 2011.

23. Linkages with Other Board Committees

23.1 Finance & Performance Review Committee – Minutes of the Meetings held on 13 September, 12 October, & 14 December 2011

23.1.1 Mr Egan referred to the minutes of the 13 September meeting and pointed out that the City of Edinburgh council’s fuel department would not now be privatised. Professor Murray also clarified that the Local Reinvestment Plan in Pharmacy referred to in the minutes should read Local Reinvestment Plan in Medicine.

23.1.2 The Committee noted the Finance and Performance Review Committee minutes of 13 September, 12 October, & 14 December 2011 and the information therein.

23.2 Healthcare Governance & Risk Management Committee – Minutes of the Meetings held on 4 October & 15 December 2011

23.2.1 Mr Egan advised the Committee of a possible governance risk within the prison service – healthcare staff had been reported to be carrying out duties that they were not qualified for. Professor Murray advised that a full report on the prison service was on the agenda for the next meeting of the Healthcare Governance and Risk Management Committee in April. Professor Barbour explained that David Small was preparing a paper to the Executive Management Team (EMT) on all policies linked to prison healthcare that would need further scrutiny. It was noted that there had been an increase in complaints from prisoners.

23.2.2 Mr Woods drew attention to a comment made by the Director of Public Health & Health Policy regarding conduct of the Business Continuity audit. Mr Woods advised that the audit report was issued in July 2011, while the Director of Public Health & Health Policy had been referring to an issue raised by her team in October 2011 about problems uploading information to a database used by the Business Continuity team. As such, the comment recorded in the minutes did not relate directly to the internal audit.

23.2.3 The Committee noted the Healthcare Governance & Risk Management Committee Minutes of the Meetings held on 4 October & 15 December 2011 and the information therein.

23.3 Staff Governance Committee – Minutes of the Meetings held on 29 June, 31 August & 22 December 2011

23.3.1 Mr Boyter drew attention to the eKSF update – he highlighted that the target of 80% of staff having been on eKSF by March 2011 had not been met, however the target had been achieved by the end of May 2011.
23.3.2 The Committee noted the Staff Governance Committee Minutes of the Meetings held on 29 June, 31 August & 22 December 2011 and the information therein.

24. Internal Audit

24.1 Internal Audit Progress Report (January 2012)

24.1.1 Mr Woods spoke to the Internal Audit Progress Report (January 2012). He went through the report and highlighted that 4 final reports had been issued since the last Operational Audit Sub Committee. He also gave a verbal update on counter fraud. There followed some discussion on the staff nurse who had continued to work as a registered nurse despite letting her Nursing and Midwifery Council (NMC) registration lapse. The Committee noted that there was a framework in place to monitor registration, but in this case the nurse had falsified documents. Members remained concerned that this could happen and wondered whether this should have been detected earlier. It was agreed that Mr Boyter would liaise with Mrs Hornett and bring a paper back to the Committee on the present arrangements.

24.2 Draft Internal Audit Plan 2012/13

24.2.1 Mr Woods presented the Draft Internal Audit Plan 2012/13. He explained that the Audit Universe was listed in appendix 1, where all potential audits were laid out, with dates and opinions of the latest reports and indicating when the next audit would take place. Audits were risk rated as high medium or low. Appendix 2 detailed the mapping of the Audit Universe against the corporate risk register. The Committee supported the Draft Internal Audit Plan 2012/13 and commented that the plan was sensible and pragmatic. In response to a question from Mrs Douglas, Mr Woods explained that audits of CHP Governance, Change Fund and Prison Service were not included in the plan as structures within those areas were subject to change, but audits would be considered once frameworks had stabilised.

24.2.2 There followed some discussion on the integration of health and social care and members noted that work was being taken forward on this. Dr Winstanley questioned whether the CHCP model would only be used for older people’s services or applied across other areas too.

24.2.3 The Committee approved the Draft Internal Audit Plan 2012/13.

24.3 CFS Intelligence Alerts

24.3.1 The Committee noted the circulated intelligence alerts issued by Counter Fraud Services.
24.4 CFS Quarterly Reports – September & December 2011

24.4.1 Mr Woods presented the CFS Quarterly Reports – September & December 2011. The Committee noted that CFS reported an increase in referrals regarding non-clinical staff. Committee members questioned the appropriateness of CFS quoting staff members’ names following criminal convictions or professional sanctions. Mr Boyter reassured the Committee that NHS Lothian has regular contact with Lothian and Borders Police in relation to intelligence gathering. Professor Barbour commented that the most prevalent type of referrals to CFS continued to be overseas visitors.

25. External Audit

25.1 Priorities & Risks Framework (November 2011)

25.1.1 Mr McConnell introduced the Priorities & Risks Framework (November 2011). The report identified the areas seen as key risks and indicated the mitigation Boards may wish to put in place.

25.2 Review of Internal Audit 2011/12

25.2.1 Mr Perston explained that Internal Audit uses a risk based approach when developing the audit plan, with appropriate documentation standards and reporting procedures. In 2011/12, Audit Scotland would place formal reliance on the General Ledger & eFinancials audit. There would also be reliance on annual stock-taking work. Mr Perston concluded that Internal Audit operates in accordance with Government Internal Audit Standards. The Chair suggested that the reference in Audit Scotland’s letter to NHS Borders should be removed as not being relevant for NHS Lothian’s purposes.

26. Corporate Governance

26.1 NHS Scotland National Shared Services and Move to National Single Instance

26.1.1 Mrs Goldsmith spoke to the report to inform the Committee on the progress of the National Financial Shared Support Services Programme (NSSS), changes in the NSS consortium and the move to a National Single Instance (NSI). She reported that procurement would now be a part of the NSSS. In relation to the NSS Consortium, it was noted that Robert Stewart, Director of NHS24 had been appointed as Consortium Chair and David King, Head of Finance for NHS Lothian would be the consortium lead. At the national meeting, the Health Board Directors of Finance agreed to move to a NSI of the CEDAR eFinancial Ledger System. NHS Scotland would be using one updated version of the current ledger system. Dr Winstanley emphasised the requirement for NHS Lothian to have sovereignty over financial information. He reported that this should be considered in more detail before the NSI was taken forward. The Chair reported that this could be raised at the Operational Audit Sub Committee. SGR
26.1.2 The Committee noted the changes of services classified as ‘in scope’ to include Procurement, the change in key personnel in the NSS consortium and the decision by Health Board Directors of Finance to move to a NSI.

26.2 **Write-Off of Bad Debt**

26.2.1 Mrs Goldsmith advised that this case involved an overseas patient who had been admitted as an emergency to the Royal Infirmary of Edinburgh following a stroke. The patient was unable to pay due to financial hardship.

26.2.2 The Committee approved the request to write to the Scottish Government for approval to write off debt of £44,808. There was some discussion around the following statement in the paper: “the Board is required to treat patients with an urgent clinical need regardless of their ability to pay”. It was noted that there would be a point in the patient’s treatment that was no longer an urgent clinical need. The Committee noted the challenges in finding the right balance between urgent clinical care and continuing clinical care. The Committee commented that the template checklist from the Scottish Government asked for some information that would be inappropriate to provide.

26.3 **Corporate Risk Register**

26.3.1 Mrs Bennett presented the corporate risk register July –September 2011. She explained that the risk policy was out for consultation and would go to the April Healthcare Governance and Risk Management Committee for approval. Risk register workshops had been taking place across the acute division, primary care and hosted services. A corporate workshop was planned for 29 February 2012.

26.3.2 Mr Egan raised concern that actions were not always followed up once they had been added to the risk register. There were also a number of risks that were not listed on the risk register - he highlighted recent issues with health and safety and waiting times. Mrs Bennett reported that a revised risk register which would come to the October Audit Committee. The report to the October meeting would have more information on each risk, including the impact of the risk and ways to mitigate the risk. Dr Winstanley commented that the new section on the board report template should also provide further information on risks and ways to mitigate any risks. There were concerns regarding the escalation policy and the communication of risk to Board members.

26.4 **Audit Scotland: Overview of the NHS in Scotland’s Performance 2010/11**

26.4.1 Mr Martin summarised the key information in the report. Appendix 1 demonstrated the financial performance of NHS bodies 2010/2011. It was noted that of the leading Health Boards in Scotland, NHS Lothian had the highest percentage of GP outpatient referrals managed electronically.
26.5  **Technical Brief**

26.5.1 Mr Martin drew attention to the recent transfer of detailed information to individual Boards, and reported that effectively NHS Lothian was acquiring prior period net liabilities of publicly owned and private prison services relating to Saughton (Edinburgh) and Addiewell (West Lothian). The entries required would have an effect of a £0.5million reduction in the Board’s general fund as at 1 April 2012. The Committee agreed that this should be clarified by the Scottish Government. This issue should also be referred to the Finance and Performance Review Committee.  

26.5.2 Dr Winstanley asked about other ways the Board could demonstrate sustainability and reported that there had been a proposal to use local produce at St John’s Hospital. It was agreed that Mr Martin and Mrs Goldsmith would look into this and consider other areas in which the Board could demonstrate sustainability. Committee members asked about the situation in enhanced services and in prisons. It was agreed that James Glover, Head of Equality and Diversity should be involved in discussion around sustainability.

26.5.3 Mr Martin explained that Health Boards would need to disclose the median earnings of the workforce and the ratio of the highest paid Director’s earnings to the median earnings. The Committee noted that the highest paid Director’s earnings were not necessarily those of the Chief Executive. Furthermore the highest paid employees in the Board may not actually be Board directors. Mr Martin advised that he was seeking clarification on what was to be disclosed, and the matter would be confirmed when the Annual Accounts Manual for 2011-2012. The Scottish Government Technical Accounting Group (TAG) must approve this Manual. Mr Boyter agreed to compile a list of the top 100 earners in NHS Lothian and report back to the Committee.

26.6  **Introduction of Governance Statement**

26.6.1 Mr Payne introduced the report and explained the new Governance Statement which would replace the Statement on Internal Control in the accounts. He outlined the issues described in the report. It was agreed that the Audit Committee should receive details from the Chief Executive on the governance framework to discharge his Accountable Officer responsibilities. The Audit Committee would also receive summary information on what Executive Directors disclosed, with respect to any breaches of Standing Orders or Standing Financial Instructions or other significant control weaknesses or issues other than those to be disclosed within the Government Statement. It was agreed that the Committee did not wish to receive summaries of reports by Healthcare Improvement Scotland or other external review bodies, as relevant reports are already considered by governance committees which provide assurances directly to the Audit Committee. Mr Payne explained that guidance on how to complete the governance statement was explained in annex B of the report.
26.7 Assessment of Compliance with UK Code of Corporate Governance

26.7.1 Mr Payne gave a brief overview of the report and explained how the Board complies with relevant aspects of the UK Code of Corporate Governance. Mr Egan pointed out that non executive board members could be appointed for more than four years and could serve more than two terms. It was noted that for NHS Lothian there was no “Senior Independent Director” as described in the Code.

26.7.2 The Committee accepted this paper as a source of assurance that arrangements are in place to comply with the relevant aspects of the UK Code of Corporate Governance.

27. Any Other Competent Business

27.1 There was none.

28. Date of Next Meeting: Thursday 5th April 2012

29. Dates of future meetings in 2012

- Tuesday 26th June 2012
- Tuesday 9th October 2012
- Tuesday 11th December 2012
### Royal Hospital for Sick Children (12 October 2011)

- Include a detailed summary of the risks at the different stages in the paper to the Board
- Undertake work to mitigate the identified risks
- 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

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<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
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<tr>
<td></td>
<td>SG</td>
<td>30/01/12</td>
<td>OBC approved by NHSL Board 25 January 2012 for submission to Scottish Government. Paper on progress of OBC, including Consort sign-off, and project resources submitted to NHSL Board for private session on 28 March 2012.</td>
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### Financial Position (9 February & 13 April 2011)

- Include corporate income figures in the next financial update

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<td>SG</td>
<td>29/02/12</td>
<td>Draft Income summary being set up – due for completion for February results</td>
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### Shared Services (8 February 2012)

- Submit written reports to each meeting
- Raise the lack of formal commitments by both local and NHS partners to shared services at a SEAT meeting to see if NHS partners would consider how they could avoid abortive work in future

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<td><strong>Relocation of the Psychiatry of Old Age Ward from the Royal Victoria Hospital</strong>&lt;br&gt;<strong>to the Royal Edinburgh Hospital</strong>&lt;br&gt;(8 February 2012)</td>
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<td>• Submit a report to the next Committee meeting on whether the proposed solution fits in with the Clinical Strategy or whether the additional funding should be used to provide extra clinical capacity at the Royal Infirmary of Edinburgh.</td>
<td>SG/JKS</td>
<td>09/04/12</td>
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<tr>
<td><strong>Draft Financial Plan 2012/13</strong>&lt;br&gt;(8 February 2012)</td>
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<td>• Bring a paper to the April meeting on the inclusion of an income summary in future reports, as well as the issue of capital charges being included in the funding</td>
<td>SG</td>
<td>09/04/12</td>
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<td><strong>Emergency Access – 4-Hour Emergency Access Target</strong>&lt;br&gt;(8 February 2012)</td>
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<td>• Take a report seeking formal approval for the change from observation unit to surgical assessment unit to the Private Board meeting on 22 February before the unit was opened</td>
<td>JKS</td>
<td>09/04/12</td>
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<tr>
<td>• Remind Executive Directors that changes to Business Cases approved by the Committee require to be submitted to the Committee for approval before being implemented</td>
<td>JJB</td>
<td>09/04/12</td>
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<td><strong>Decontamination – Endoscopy Unit</strong>&lt;br&gt;(8 February 2012)</td>
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<tr>
<td>• Include priority rankings in papers seeking authorization for funding in future</td>
<td>JKS/SG</td>
<td>09/04/12</td>
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<tr>
<td><strong>Performance Management</strong> (8 February 2012)</td>
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<td>• Investigate how cases of failed suicides are handled and report to the Committee</td>
<td>DF</td>
<td>09/04/12</td>
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<td><strong>Workforce Efficiencies within NHS Lothian</strong> (8 February 2012)</td>
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<tr>
<td>• Provide an enhanced section in the next report on the forthcoming 2 year period</td>
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<td>09/04/12</td>
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<tr>
<td>• Include details of other payments in the next report to demonstrate that such costs were not being passed on to other parts of the public sector</td>
<td>AB</td>
<td>09/04/12</td>
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Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 8 February, 2012, 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; Mr R Burley; Councillor P Edie; Mr E Egan; Dr D Farquharson; Mrs S Goldsmith; Professor J Iredale; Mr P Johnston; Dr A K McCallum; Mr S G Renwick; Mrs J K Sansbury and Mr I Whyte.

In Attendance: Ms M Anderson; Mr P Gabbitas; Ms W Fairgrieve; Mr I Graham; Mr P Reith; Mr D A Small and Mr S Wilson.

Apologies for absence were received from Councillor J Aitchison; Mrs M Hornett; Professor A McMahon; Professor A McMahon; Professor M Prowse 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. Mr Renwick declared an interest in agenda item 2.1 “Shared Services” as he had taken up employment with the City of Edinburgh Council, one of the local authorities participating in the discussions on shared services and item 4.4 “Firrhill Partnership Centre” at which he was a patient. There were no further declarations of interest.

55. Minutes of the Previous Meeting

55.1 The previously circulated Minutes of the meeting held on 14 December 2011 were approved.

56. Matters Arising

56.1 Management of Drug Spend – Mrs Goldsmith advised the Committee that there would be a session on the management of drug spend at the Board Development Day on 22 February, 2012.

56.2 Shared Services – Mr Boyter advised the Committee that the scoping session on Estates would be held on 9 March 2012 and would be led by Mr J Forrest.
Sessions on transport and laundry had been held and a number of opportunities had been identified. Work was being undertaken on the preparation of fully costed proposals, which it was proposed would be brought back to the April meeting of the Committee. Mr Egan reiterated his previously expressed concerns over the lack of formal commitments by both local and NHS partners to shared services and the amount of time spent on an exercise that was still to show any return.

Professor Barbour advised that he would be happy as Chair of the South East and Tayside Group (SEAT) to raise this at a SEAT meeting to see if NHS partners would consider how they could avoid abortive work in future. At the end of the day, individual Health Boards were sovereign bodies and would decide whether or not to participate.

Mr Johnston commented that whilst he recognised the frustration at the lack of positive outcomes, local authorities could not undertake to sign up to proposals at the start of discussions and could only consider finalised proposals. Mr Egan indicated that his concern was that partners could randomly walk away from discussions and suggested that a commitment to remaining part of the process until final proposals were produced for consideration should be part of the code of practice. The Committee agreed to note the position and agreed that, in future, all reports should be in writing and circulated with the agenda, and that verbal updates would not be taken.

56.3 Relocation of the Psychiatry of Old Age Ward from the Royal Victoria Hospital to the Royal Edinburgh Hospital – Mr Egan reminded the Committee that approval of the Initial Agreement had been subject to compliance with the Clinical Strategy and he was not yet clear that the proposed solution fitted in with the Clinical Strategy. He questioned whether the additional funding should be used to provide extra clinical capacity at the Royal Infirmary of Edinburgh and was concerned that the whole picture was not being taken into account. It was agreed that Mrs Sansbury and Mrs Goldsmith would meet with Mr Egan outwith the meeting to discuss this matter and Mrs Sansbury would submit a report to the next Committee meeting.

56.4 Replacement of SPECT Dual Head Gamma Camera and Cardiology Catheterisation Laboratory at the Royal Infirmary of Edinburgh – Mrs Goldsmith advised the Committee that the proposals would lead to savings of £43,000 and were revenue neutral. The Committee agreed to note the position.

56.5 Hub Governance and Progress – Mr Graham gave a presentation to the Committee outlining the history, structure and governance of HubCo. The Committee noted that Mrs Goldsmith was Chair of the Territory Partnership Board and a representative to the Hub National Programme Board; Mr Small was an alternative representative on the Territory Partnership Board and Mr Graham was a public sector shareholder representative/director on the Hub South East Scotland Limited Board. Mr Renwick sought confirmation that the issue of the protection of officers serving as directors of a limited company had been addressed and Mr Graham confirmed that appropriate insurance was in place. Mr Burley expressed concern about potential conflicts of interest and the Committee had a full discussion about the governance of the partnership.
agreements required. Councillor Edie commented that different public sector agencies were progressing at different speeds and local authorities had some concern at the amount of time taken for NHS Lothian to move on joint issues because of the requirement to involve HubCo. Mr Gabbitas commented that he had been involved in a number of such joint projects and, in his experience, no one partner was responsible for these delays. The Committee agreed to note the position and the Chair thanked Mr Graham for his presentation.

57. Draft Financial Plan 2012/13

57.1 The Committee received a previously circulated paper providing an overview of the draft financial plan for 2012/12, which set out details of anticipated income, known additional costs, proposed investments, efficiency workstreams and the next steps to ensure budget sign-off by 31 March 2012.

57.2 The Committee also received two tabled appendices and spreadsheets summarising the NHS Lothian financial plan for 2012/12 and the five year financial plan for 2012/13 to 2016/17.

57.3 Mrs Goldsmith introduced the report and explained that the Scottish Government Health Directorates would not accept the draft financial plan until sufficient savings were in place for its achievement. A full report would be brought to the April meeting of the Committee as the current report merely dealt with incremental funding and costs. In addition requirements for increased activity and capacity were not yet incorporated.

57.4 Mrs Goldsmith expanded on various aspects of the report and confirmed that whilst there was currently a gap of £27,36m before implementation of the Local Reinvestment Plan progress on its implementation was already 50%-60% of the way there.

57.5 Mr Johnston queried references to additional paediatric/neonatology consultant posts to cover the reduction in trainee numbers and Dr Farquharson advised that interviews were being held in the first two weeks of March to recruit to the vacant posts and the Scottish Government Health Directorates were looking at longer term plans.

57.6 Mr Johnston emphasised the importance of the retention of a full range of services at St John’s Hospital and the importance of dispelling any doubts regarding such service provision.

57.7 Dr Farquharson confirmed that this was the intention as demonstrated by the continuing efforts to recruit staff to these posts.

57.8 Professor Barbour indicated that the Chairman had already determined that there would be a full discussion of this matter at a special private Board meeting in February, at which time a full progress report would be given. He emphasised that NHS Lothian would do all within its gift to ensure that paediatric services at St John’s Hospital were maintained. Mrs Sansbury reminded the Committee that the issue of the withdrawal of the trainees in paediatrics from St John’s Hospital
was different from the previous position in respect of orthopaedic surgery and recruitment of appropriate staff should help resolve the position.

57.9 Mr Whyte queried the progress in indentifying the outstanding savings, particularly in respect of the need for significant backlog maintenance and Mrs Goldsmith advised that a significant amount of work was being undertaken to resolve this issue.

Dr McCallum arrived at the meeting.

57.10 Mrs Goldsmith advised the Committee that progress on achieving financial balance was in line with previous years and backlog maintenance would be prioritised through the capital programme. Withdrawing from a number of older buildings would help the situation in respect of backlog maintenance.

57.11 Mr Renwick emphasised the need for an income summary to be included in future reports, as well as the issue of capital charges being included in the funding. Mrs Goldsmith advised that a paper would be brought aback to the next meeting of the Committee.

57.12 The Chair commented that it was important that further discussion on this matter be undertaken at the Committee.

57.13 Professor Barbour commented that the financial position showed a favourable movement and the additional NRAC funding was welcome. Mr Egan confirmed that the 3% savings target was achievable, although this would require effective targeting and implementation.

57.14 The Chair indicated his concern that the plan felt reactive rather than proactive.

57.15 Mrs Sansbury advised that a significant amount of work was being carried out on the implementation of the financial plan and indicated that more detail would be incorporated into the expanded paper.

57.16 Mr Renwick commented that a fuller report giving “the big picture” would be helpful.

57.17 The Committee agreed to note the anticipated additional recurring income of £24.2m; the unavoidable cost increases of £33.8m; the improvement in the local reinvestment plan requirements from 5% to 3% for 2012/13; progress made to develop speedy efficiency plans for 2012/13; the specific risks highlighted; the indicative position for the period 2012/14 to 2016/17; additional investment of £20.9m proposed to be funded through NRAC and efficiency targets and the next steps in the governance and approval process.

Mr Johnston left the meeting.
58. **Capital Funding**

58.1 Mrs Goldsmith gave a short presentation to the Committee on the position in respect of capital funding. It was noted that NHS capital funding would reduce from £488.2m in 2011/12 to £453.5m in 2012/13, £380.5m in 2012/14 and £323.9m in 2014/15. In the last 2 years revenue to capital transfers would increase these sums to £485.5m in 2013/14 and £359m in 2014/15.

58.2 It was noted that in Lothian, £33m would be spent on the Royal Victoria Hospital building, Royal Hospital for Sick Children/Department of Clinical Neurosciences and Wester Hailes. In addition, £22m would be spent on statutory compliance, medical equipment, eHealth, Healthcare Environment Inspections, decontamination and the Royal Infirmary of Edinburgh bed capacity with further sums to be confirmed being spent on revenue funding Hub projects.

58.3 The Committee noted that the draft capital plan would be submitted to the Scottish Government Health Directorates with the local delivery plan on 17 February, with a detailed capital plan report going to the Executive Management Team in early March. Following this there would be dialogue with Scottish Government Health Directorates colleagues regarding the project-specific funding and Hub during March with a further update being given to the Committee in April 2012.

58.4 Professor Barbour reminded the Committee that all the capital expenditure was linked to the development of the Clinical Strategy and there would be links into this in the report.

58.5 Mr Burley questioned progress on general practice replacement and Mrs Goldsmith advised that the Scottish Government Health Directorates were considering this and it was hoped to have a response at the next meeting. 

58.6 Mr Egan commented that the short-term requirements meant that money was still being spent fixing buildings that were no longer fit for purpose and suggested that NHS Lothian was over-provided with General Practitioners who were not necessarily located in the areas with highest demand. He suggested that the future strategy should be to provide fewer but larger General Practitioner premises. Mrs Goldsmith undertook to include reference to this in the capital plan paper for the next meeting.

58.7 The Committee agreed to note the position.

59. **Royal Hospital for Sick Children and Department of Clinical Neurosciences Project Delivery**

59.1 The Committee received a previously circulated report outlining the resource and facilities requirements for the Royal Hospital for Sick Children and Department of Clinical Neurosciences project delivery through the Non-Profit Distributing Procurement process and approval of the Full Business Case.
Mrs Sansbury spoke to the report emphasising that this was both to ensure the project team had the right level of resource as it moved into the delivery procurement phase and in response to the advice and guidance provided by the Scottish Government Health Directorates and Scottish Futures Trust during the Outline Business Case development.

Mr Renwick expressed concern at the number of people at arms length and sought assurance regarding the accountability and management of these staff. Mrs Sansbury advised that the staff concerned would sit within the project team and be managed by Mr Currie as Project Director. Staff would be seconded from existing posts rather than brought in.

The Chair commented on the lack of specific detail in the paper and Mrs Goldsmith advised that the original paper had contained additional detail but some of this had been lost in the simplification of the paper for the benefit of the Committee. Mrs Goldsmith undertook to circulate details of the costings to members of the Committee.

Professor Barbour advised the Committee that Mrs Goldsmith and Ms Ferguson would be providing an update on fund-raising options to the March Board meeting.

The Committee agreed to approve the recruitment of a commissioning manager, a communications manager, a contracts manager and a project accountant to the NHS Lothian project team; the secondment of a recognised public private partnership expert for the procurement phase of the project in a support role to the Project Director; the resource for dedicated project time for the Director of Capital Planning and Projects and the Associate Director of Finance during the procurement phase of the project and noted the establishment of a project office suitable for the procurement phase of the project, all subject to the costs being circulated and reviewed by the Chair. The Committee agreed to delegate authority to the Chair to confirm the appropriateness of these costs and it was agreed that future papers should detail the specific costs if approval was being sought.

Creation of a Teenage and Young Adult Cancer Unit at the Western General Hospital

The Committee received a previously circulated paper and Initial Agreement for the creation of a teenage and young adult cancer unit at the Western General Hospital.

Mrs Sansbury introduced the report and emphasised that the capital costs of around £1m would be met by the Teenage Cancer Trust and that as the unit would be embedded within an existing oncology ward and young people with cancer already had received care in treatment within oncology services, there would be no additional revenue costs.
60.3 Mr Renwick questioned the artificiality of the age limitations and Mrs Sansbury explained that such age ranges were already successfully in use in children’s services.

60.4 Dr McCallum advised that international evidence showed that 16-24 year olds had specific needs best addressed in dedicated units.

60.5 Mr Anderson commented that the seeking of the views of young people on the proposals was a good idea and should be standard practice.

60.6 Professor Iredale commented that the reconfiguration of the service would improve the safety outcomes and speed of the service and suggested that NHS Lothian was not always good at communicating this fact.

60.7 The Committee agreed to approve the Initial Agreement for the creation of a teenage and young adult cancer unit at the Western General Hospital; to support a formal agreement between NHS Lothian and the Teenage Cancer Trust who were fully committed to fund the capital costs associated with the creation of the teenage and young adult cancer unit to the sum of around £1m and to support an approach for the early release of enabling funds of around £94,000 to be provided by the Teenage Cancer Trust to take forward the design phase through to tender. This would allow identification of costs to inform the Full Business Case.

61. **Decontamination – Endoscopy Unit**

61.1 The Committee received a previously circulated report giving an update on the proposals to bring the decontamination processes within the endoscopy units at the Royal Infirmary of Edinburgh and Western General Hospital up to standard. Mrs Sansbury reminded the Committee that endoscopy decontamination facilities were provided on six sites; the St John’s Hospital, the Western General Hospital, the Royal Infirmary of Edinburgh, the Royal Hospital for Sick Children, Leith Community Treatment Centre and Roodlands Hospital. In recent years there had been a number of improvements to three of these facilities and only three sites required investment to bring them up to the required standards.

61.2 Mr Renwick commented that whilst he fully supported the principle, £60,000 of the costings was non-recurring and he questioned its affordability.

61.3 Mrs Sansbury advised the Committee that these proposals had been on the capital plan for some years and each phase would come back to the Committee for detailed approval.

61.4 Mr Egan commented that the Healthcare Governance & Risk Management Committee had expressed concerns at the time being taken to implement the improvements to the facilities.

61.5 The Chair commented that the paper should reflect the priority given to the plan and that such papers should include priority rankings in future. JKS/SG
61.6 The Committee agreed to support the principle of an upgrade to the current endoscopy units at the Royal Infirmary of Edinburgh and Western General Hospital providing compliance with Scottish Health Planning Note 13 Part 3, Chief Medical Officer Letter of 2006, BSEMISO 15883 Parts 1 and 4 and relevant Health Service Guidance in order to ensure JAG accreditation.

61.7 The Committee also agreed to support the Initial Agreement along with associated costs of capital of £3.17m (subject to market tests), non-recurring revenue of £60,000 and capital charges of £153,000. The Committee further noted that as these costs were indicative, full details would be included in the two separate Business Cases to be brought back to the Committee for approval. JKS

Dr McCallum left the meeting.

62. Tranent Health Centre Initial Agreement

62.1 The Committee received a previously circulated report and Initial Agreement for the extension to Tranent Health Centre and the development of the Standard Business Case.

62.2 Mr Small introduced the report and explained that the Initial Agreement set out to seek approval for the development of a Standard Business Case for the identified preferred way forward to address capacity issues at Tranent Health Centre. As the value of this project exceeded £750,000 HubCo would require to be involved in the process.

62.3 Mr Egan questioned who the new services proposed at the extended health centre would be provided by and Mr Small indicated that staff would be brought in from other locations and it was anticipated that general practices would increase in size in response to the increased population.

62.4 Professor Barbour highlighted the tendency for targeted bids to be submitted against NRAC funding and explained that there was no presumption that NRAC funding would be used unless against NRAC acknowledged priorities. Equally, he stressed the importance of budget holders getting best value from base funding, which greatly exceeded the marginal NRAC benefit.

62.5 The Committee agreed the Initial Agreement for the extension to Tranent Health Centre and the development of a Standard Business Case, that £1.2m of formula capital should be allocated to this project; to support the proposals to explore NRAC funding and LRP opportunities as solutions to the £0.062m revenue gap and noted that the Initial Agreement had been approved by the East Lothian Community Health Partnership Sub-Committee, the Lothian Capital Investment Group and the Executive Management Team.

Mr Small and Ms Anderson left the meeting.
63. **Firrhill Partnership Centre**

63.1 A previously circulated report seeking the approval of the Initial Agreement for the Firrhill Partnership Centre was received.

63.2 Mr Gabbitas introduced the report and advised the Committee that the Initial Agreement would follow the strategic case for the partnership centre and outlined the three main options for further consideration in the Outline Business Case. A paper on this project had been approved by the Executive Management Team in October 2007 which conferred priority within the Primary and Community Premises Modernisation programme for 2008/09.

63.3 The Committee noted that a sum of £820,000 from Hub South East Scotland capital enabling funds had been agreed in order to support the project.

63.4 The Committee noted that as the capital value of the project exceeded £5m, it would require to be submitted to the Scottish Government Health Directorates Capital Investment Group for final consent.

63.5 The Chair expressed concern at the timescale as there was a risk of additional financial outlays and the dislocation of general practice services for the local community if the project was not successfully completed by October 2014.

63.6 Mr Egan expressed concern that community physiotherapy services had been taken out of the brief and Mr Gabbitas explained that this was because the review of physiotherapy services had identified that there was not sufficient need to justify relocating physiotherapists from the existing service.

63.7 Mr Whyte commented that as the project had first been approved by the Executive Management Team in October 2007 there had now been a significant delay and questioned the reasons.

63.8 Mr Gabbitas explained that the capital availability had changed and the project had been re-prioritised. Further changes to the mechanism and vehicle for such projects had led to significant delays and the specifications had been amended for a good reason.

63.9 The Committee agreed to approve the Initial Agreement, subject to the concerns expressed, to give consent to the Edinburgh Community Health Partnership to issue a new project request to Hub South East Scotland for the production of a Hub stage 1 report that would support out Outline Business Case for the project. It was noted that if the stage 1 report presented a verifiable value for money solution and NHS Lothian then decided not to proceed with the project, a fee cost of up to £93,152 would be payable to Hub South East Scotland.
64. **Financial Position to 31 December 2011**

64.1 Mrs Goldsmith spoke to a previously circulated report giving an overview of the financial position of NHS Lothian for the first 9 months of the financial year 2011/12.

64.2 The Committee noted that an overspend of £1.03m was being reported for the first 9 months of the financial year, a favourable movement in the month of £1.27m, which reflected under-delivery of £1.053m against the local reinvestment plan programme and a slight underspend on other budgets.

64.3 The Chair commented on how well in-line University Hospitals Division now was with their local reinvestment plan target in comparison to previous years and also highlighted the positive overall position now being achieved by NHS Lothian as a whole.

64.4 The Committee agreed to note the improved financial position for the 9 months placing the Board on target to deliver a break-even financial position. The Committee also noted the continuing risks attached to the achievement of the balanced financial position in respect of the recurring local reinvestment plan target and minimising any carry forward into the next financial year.

65. **Performance Management**

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

65.2 Dr Farquharson introduced the report and commented that in line with the agreement with the Scottish Government Health Directorates, waits for upper and lower endoscopy and colonoscopy diagnostic tests would fluctuate between 4-6 weeks and work was continuing to ensure that surveillance patients were brought in for the investigations within the appropriate timescale.

65.3 Dr Farquharson commented that the ability of accident and emergency at the Royal Infirmary of Edinburgh to meet its targets were impacted on by delayed discharges as well as the difficulties being encountered by some local authorities in providing the necessary care packages timeously to enable patients to be discharged home.

65.4 The Committee noted that although accident and emergency attendances were still above the trajectory, NHS Lothian’s performance was better than all other equivalent Boards (except Grampian and Tayside) and was above Scotland’s performance level.

65.5 The Chair questioned whether steps were being taken to ensure that performance management figures were being appropriately monitored to ensure their accuracy.
65.6 Dr Farquharson confirmed that an Associate Director of Information would be appointed to ensure that the tributary data stream necessary was available and had been validated. He also advised that the Head of Strategic Planning had a lead role in Performance Management Information, as did individual Directors.

65.7 Professor Barbour reminded the Committee that the current format had been agreed by the Board in January 2011 and that further changes to the format would be brought back to the Board.

65.8 Mr Anderson queried whether there was any correlation between difficulty in obtaining General Practitioner appointments and attendance at accident and emergency.

65.9 Professor Barbour advised that an intensive survey of people attending accident and emergency had not supported such a link and some 30% of those attending were seeking an x-ray, something that would not be available at a general practice.

65.10 Councillor Edie questioned the availability of statistics on attempted suicides and whether there were protocols on how such cases of failed suicides were handled.

65.11 Mr Whyte commented that the police could not arrest someone who had not committed a crime and, therefore, such cases could only be dealt with on medical grounds.

65.12 Dr Farquharson undertook to investigate this and report back to the Committee.

65.13 The Committee agreed to receive the update and noted the actions being taken where performance was currently off trajectory or where no data was available. It was noted that responsible Executive Directors identified within the paper had provided and agreed the information on the actions being taken to address any shortfall against the agreed trajectories.

65.14 The Committee also noted that discussions had taken place with the Health Intelligence Unit regarding the source of the data provided in this routine performance report, and work was continuing to develop dash boards for Committees. It was anticipated that this data would form part of a suite that would be reported on.

66. **Workforce Efficiencies within NHS Lothian**

66.1 The Committee noted a previously circulated update on progress to date in regard to the planned workforce reductions.

66.2 The Chair questioned whether the report should include workforce planning and Mr Boyter advised that the Staff Governance Committee was already dealing with this aspect. Mr Boyter confirmed that it was accepted that NHS Lothian could not simply go on reducing staff numbers and that although further reductions would be required in the following year, these would be smaller. 


Boyter undertook to provide an enhanced section in the next report on the forthcoming 2 year period.

66.3 Professor Iredale advised that the Service Redesign Committee was keeping a watching brief on this and it should be possible to iron out local problems.

66.4 Mr Burley questioned whether any of the cost savings from the reduction in sickness absence had simply been transferred to other areas of public expenditure. Mr Boyter undertook to include details of other payments in the next report to demonstrate that such costs were not being passed on to other parts of the public sector.

66.5 The Committee noted the reduction of 570.7 whole time equivalent staff in post since 1 April 11 to 31 December 2011 against the annual target of 734 whole time equivalent posts, securing 77% of the annual target and 20 whole time equivalent posts ahead of trajectory.

66.6 The Committee also noted the reduction in sickness absence for April to November 2011 within a year-to-date average of 3.8% against 4.27% for the same period in 2010, equating to an annual saving of 86.4 whole time equivalent (£3.36m). The Committee also noted the reduction in managerial posts, in particular the 25% Scottish Government target which was 10 whole time equivalents ahead of trajectory and the position in regard to voluntary severance and pay-back of 0.88 years.

67. Emergency Access – 4-Hour Emergency Access Target

67.1 The Committee noted a previously circulated report giving an update on progress in improving care for patients treated as emergency attendances within NHS Lothian.

67.2 The Chair commented that in his experience some staff on wards did not seem to know about the 11.00am target for emptying beds and suggested that this required to be communicated to staff by managers more effectively.

67.3 Mrs Sansbury spoke to the report and explained that despite improvements made through the majority of 2011 as described to the meeting held on 14 December 2011, NHS Lothian’s attainment of the 4-hour standard continued to be variable.

67.4 It was noted that full data for 2011-12 for all Health Boards would not be available from the Information Services Division until June 2012 meaning that it was not possible to compare Lothian’s performance against equivalent Boards. It was noted that it was, however, known from the latest available validated ISD data that Lothian consistently performed above Greater Glasgow and Clyde and Lanarkshire but less well than smaller Boards.

67.5 Professor Barbour commented that this problem was a whole system issue and he emphasised the importance of local authorities being part of the whole system. Difficulty lay in the fact that whilst the NHS was held to account for A&E
performance, local authorities were not accountable in the same way for delays caused by an ability to provide sufficient appropriate assistance and accommodation to allow patients who were fit for discharge to be discharged from acute hospitals.

67.6 Mr Gabbitas re-assured the Committee that local authorities did see themselves as part of the system and significant additional investment was proposed by the City of Edinburgh Council in order to achieve its targets.

67.7 Mr Whyte commented on the lack of an emergency team in East Lothian to work jointly with the Community Health Partnership and the local authority while going into people’s homes to enable them to be discharged at as earlier stage as possible.

67.8 Mr Egan advised that the underlying issue was the lack of suitable accommodation to allow early discharges from hospital.

67.9 The Chair commented on the reference in section 6 of the report to changes to the agreed Business Case to the construction of an observation unit to a surgical assessment unit at the Royal Infirmary of Edinburgh.

67.10 Mrs Sansbury advised that the Improving Care, Investing in Change Board had agreed that the need was for assessment beds rather than observation beds and whilst the facility had been completed, recruitment of the necessary nursing staff was still underway and the unit had not yet opened.

67.11 The Chair reminded the Committee that an audit trail was required to show that formal agreement to the amendment to the Business Case received the approval of the Finance & Performance Review Committee.

67.12 The Committee agreed that the recruitment of nursing staff should continue but that a report seeking formal approval for the change from observation unit to surgical assessment unit be submitted to the Private Board meeting on 22 February before the unit was opened.

67.13 The Committee also agreed that Executive Directors be reminded that changes to Business Cases approved by the Committee required to be submitted to the Committee for approval before being implemented.

67.14 The Committee agreed to note the actions taken to date and the continuing work to consolidate the performance in the care of emergency patients within Lothian.

68. Inpatient and Outpatient Waits – A Progress Report

68.1 The Committee received a separately circulated paper from Mrs Sansbury giving a progress report on recent difficulties relating to inpatient and outpatient and cataract waiting time standards and patterns of suspension. Mrs Sansbury spoke to the paper and reminded the Committee that as soon as the issue had come to light on 25 October 2011, the decision to end the practice of offering patients treatment at hospitals in England other than in certain specialties only
available in national treatment centres had been taken on 27 October 2011. Dr Farquharson’s review of this practice had concluded that staff with responsibilities for managing waiting times according to the “New Ways” guidance had been trying hard to ensure that patients had offers of surgery as soon as possible and the additional capacity that was offered in surgery, urology and orthopaedics in Northumberland had been an initially well motivated attempt to provide an additional option for patients with routine clinical needs.

68.2 Mrs Sansbury advised that as a result of the requirement to offer treatment to those previously suspended because of unavailability to take up an offer of treatment in England, and the changing practice of suspension, there had been a marked impact on the number of patients on the active waiting list tripping the stage of treatment targets. Further guidance had been issued by Mrs Sansbury on 15 December in the context of the discussions around the national guidance and this too had an impact on NHS Lothian’s reported performance on long waits whilst simultaneously leading to a dramatic reduction in suspensions.

Mr Gabbitas left the meeting.

68.3 Mrs Sansbury advised that work was well underway to clear the substantial backlog through increasing theatre time and surgical sessions within Lothian, as well as increased used of additional capacity within adjacent NHS Boards and private sector facilities.

68.4 Mrs Sansbury emphasised that the review undertaken by the Medical Director had revealed that in some areas some administrative staff had diverged from the expected practice of consulting a supervisor who was able to book outwith in the standard timeframe. She confirmed that TRAK had now been set to stop the use of this work-around and had subsequently been altered to remove this restriction to booking.

68.5 Mrs Sansbury explained that with less than 9 weeks to the end of March, all patients who had to be treated to comply with the inpatient standard were now known. Of the 10,101 identified it had already been planned to treat circa 6,600 and thus the “additionality” equated to 3,500. This was the equivalent of approximately 4/5 weeks work. This was not an exact number because some of these patients would have been legitimately suspended from the standard waiting time, nor did it take account of urgent referrals. Mrs Sansbury advised the Committee that additional capacity could be provided subject to matching the specialties but that some difficulties would be encountered in some specialties including orthopaedics, urology and plastic surgery the end of March 2012. Mrs Sansbury emphasised that NHS Lothian had been working in close co-operation with the Scottish Government Health Directorates in resolving these difficulties. The result of these changes in our suspension practice had led to a temporary “bulge” of increased numbers and once this backlog had been cleared waiting time target should be achieved.

68.6 Mr Anderson questioned whether the use of external facilities was a good idea in clinical governance terms and Mrs Sansbury advised that where needed patients were being conveyed to and from other NHS hospitals whose facilities all met the appropriate clinical governance standards.
68.7 Mr Whyte commented there seemed to be nothing wrong with offering patients treatment in the north of England and suggested it should be a matter of patient choice.

68.8 Mr Burley commented that the change in definition did not appear to recognise the patients’ preferences.

68.9 Mrs Goldsmith advised the Committee that it was proposed to support the additional capacity requirement non-recurrently in 2012/13 with the resulting costs being factored into the Financial Plan for 2013/14 once the business case for the ongoing capacity was developed.

68.10 Mr Renwick commented that the lateness of the distribution of the 11-page report on a complex and important issue was regrettable and he advised he had been in Shetland on 15 December and would not have received the Medical Director’s report as stated in paragraph 3 of the report.

68.11 Mr Egan advised the Committee that he had been part of the review and could categorically reassure the Committee and the Board that there had been no misconduct at Executive Director level. He confirmed that Executive Directors had been as unaware of the problem as Non-Executive Board members.

68.12 Mr Egan commented that he believed there was not sufficient capacity in some of NHS Lothian’s hospitals and this required to be resolved at Board level. Mr Egan reminded the Committee that £1.3m had been spent on supporting orthopaedic services and in his view, local operational managers had not reported the issue to the Chief Operating Officer, who had in turn been unable to advise the Chief Executive of the problem and its scale. Mr Egan was therefore confident the PricewaterhouseCoopers audit was likely to find that Executive Management Team colleagues had done nothing wrong in their handling of the situation.

Mr Whyte left the meeting.

68.13 Professor Barbour advised the Committee that Executive Directors were cooperating fully with external auditors and there was a high likelihood that backlogs in all specialties, with the exception of orthopaedics, could be dealt with rapidly. As previously stated, there was a national Scotland-wide problem with orthopaedic services.

68.14 In response to a question from the Chair, Mrs Goldsmith advised that the numbers quoted in the report were based on the additional capacity required and the average of supply costs. Additional funding of £1.8m had been received from the Scottish Government and further year-end flexibility had been included.

68.15 The Chief Executive confirmed that this issue would not prevent NHS Lothian from achieving a financial break-even position by the end of the year.

68.16 Mr Renwick commented that a contract rather than a service level agreement would be required with Spire and Mrs Goldsmith advised that the clinical
governance requirements in respect of the arrangement with Spire would be incorporated into a contract.

68.17 The Chair thanked members of the Committee for their patience in dealing with a lengthy and complicated matter.

69. **Disbandment of the Primary and Community Partnership Committee**

69.1 The Committee noted a previously circulated report on its role with respect to independent contractors following the removal of the Primary and Community Partnership Committee from the Board’s governance architecture.

69.2 Mr Burley advised the Committee that more detailed recommendations with firm proposals were being drawn up and it was agreed to defer consideration of this matter to the next meeting.

The meeting closed at 12.55pm.
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<tr>
<td>• The Committee requested that an update report on the work carried out to reduce the number of maternal suicides come back to the Committee in 9 months.</td>
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<td><strong>Prison Healthcare Implementation Plan (October 2011)</strong></td>
<td>AMcM/AS</td>
<td>April 2012</td>
<td>On April agenda</td>
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<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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<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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<td><strong>Violence and Aggression training</strong></td>
<td>LK/MH</td>
<td>April 2012</td>
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<td>• The Committee noted that there were issues regarding staff uptake of the violence and aggression training. Mrs Khindria agreed to look into this and bring back a report to the next meeting with information on the numbers that required training and the areas that should be prioritised.</td>
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<td><strong>NHS Lothian Maintenance Issues</strong></td>
<td>GC</td>
<td>April 2012</td>
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<td>• Dr Winstanley requested a further paper with more information on the high risk areas and advice from the Director of Finance. Committee members also commented on the £120million funding needed for the other maintenance issues and asked for more information on how serious these issues were. Members also suggested that these issues should be linked to the clinical strategy.</td>
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- Mr Curley and Dr McCallum informed the Committee that there was another report on maintenance issues relating to healthcare associated infection. This report *would* come to the meeting in April.

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<tr>
<th>NHS Lothian Public Protection Services Update</th>
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<td>• The risk assessment would be delayed while the new structure for public protection was put into place. A report would be available for the June meeting.</td>
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<th>AKM/GC</th>
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DRAFT

NHS LOTHIAN

HEALTHCARE GOVERNANCE & RISK MANAGEMENT COMMITTEE

Minutes of the Meeting of the Healthcare Governance and Risk Management Committee held at 2pm on Tuesday 7 February 2012 in Room 7, Waverley Gate, and Edinburgh.

Present: Professor Murray (Chair); Ms M Anderson; Ms M McFarlane; Mrs S Allan; Professor M Prowse; Dr R Williams; Mr W Rae; Mrs I Garden; Mr I Whyte; Mr E Egan and Dr C Winstanley.

In Attendance: Dr D Farquharson (until 10am); Ms L Khindria; Ms L Falconer; Dr A McCallum; Mrs M Hornett; Dr S Mackenzie; Mrs P Dawson; Ms J Drysdale (item 64.2); Ms R Laskowski (item 65.1) and Mrs E O’Connor (Minutes).

Apologies for absence were received from Ms Sarah Ballard-Smith and Mr D Forbes

CHAIR’S REMARKS

The Chair welcomed members to the meeting.

62. RENAMING OF THE COMMITTEE & REVIEW OF CLINICAL GOVERNANCE IN UNIVERSITY HOSPITALS DIVISION AND CHPS/CH(C)P

62.1 Dr Farquharson spoke to the review of clinical governance in University Hospitals Division (UHD) and CHPs/CHCP. He highlighted that the Senior Management Teams (SMT) in UHD and CHPs/CHCP would report directly to the Board through this Committee. This would mean that the UHD Healthcare Governance and Risk Management Operational Group would be disbanded and the Clinical Management Group would take on the remit of this group and report to the UHD SMT. The Primary and Community Services Healthcare Governance and Risk Management Operational Group would also be disbanded as there would be direct representation on the Committee from each of the CHPs/CHCP through the General Managers/Clinical Director. The objective of these changes would be to ensure effective clinical governance was in place, to minimise duplication and to ensure clear accountability for clinical governance through existing line management structures. Mr Egan suggested inviting the CHPs/CHCP Chief Nurses and AHP Managers to attend meetings. Members asked for clarification on the aspects of the new process, and also requested more information on how issues would be fed back to the CHCP/CHPs and how the new arrangements would be evaluated.

62.2 The Committee welcomed the report and supported the recommendations set out in the report.
63. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF PREVIOUS MEETING: 15 DECEMBER 2011

63.1 The minutes of the previous meeting on 15 December 2011 were approved as a correct record. The Committee noted the updates to the December 2011 cumulative action note and the following points were picked up on:

- **Restraint Incident/Violence and Aggression training** - Mrs Hornett referred to the incident discussed at the previous meeting which involved a male patient being restrained by five members of staff. She reported that the patient required some degree of restraint to carry out personal care. She explained that he had a well documented care plan that had been formulated in conjunction with the patient’s consultant and the patient’s family. Mr Egan pointed out that some of the staff that had carried out the restraint had not received violence and aggression training. The Committee noted that there were issues regarding staff uptake of the violence and aggression training. Mrs Khindria agreed to look into this and bring back a report to the next meeting with information on the numbers that required training and the areas that should be prioritised.

  MH/LK

- **Suicide Review Process in NHS Lothian** – Ms McFarlane asked for more information on the Suicide Review Process in NHS Lothian. Dr McCallum and Ms McFarlane agreed to discuss this outwith the meeting.

64. MATTERS ARISING

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

64.1.1 Mr Curley spoke to the Decontamination Action Plan for the Royal Infirmary of Edinburgh and the Western General Hospital. He highlighted the associated costs – capital £3.17million, £60,000 non recurring revenue and £153,000 capital charges. This significant investment would ensure that NHS Lothian was compliant. It was noted that this would be discussed at the Finance and Performance Review Committee on 8 February 2012. The Committee supported the upgrade and the initial agreement and associated costs, although there was concern raised that work would not be carried out until March 2013. The Committee requested an update on progress.

64.2 NHS Lothian Maintenance Issues

64.2.1 Mr Curley spoke to the report on the backlog in maintenance issues in relation to the estate. He went through the report and reported that the backlog in maintenance costs presented in the State of the Estate Report for 2011 detailed a cost of £140million. The Committee noted that these issues had been growing steadily for the last 8-10 years. Mr Curley highlighted the areas with the highest risk:
• Western General Hospital – circa £8million – lift replacement, steam distribution, high voltage distribution, upgrade of fire alarm panel and water distribution

• St John’s Hospital – circa £8million – works including upgrade of flat roof, replacement of high level windows and high risk areas on first floor, boiler replacement and high voltage distribution and switchgear replacement

• Approximately £4million to sustain the infrastructure on the Royal Edinburgh, Astlie Ainslie and Roodlands Hospitals until the reprovisions of these sites are completed.

64.2.2 There followed some discussion on ways to resolve these issues. Members suggested seeking urgent disposals of land/assets. Dr Winstanley requested a further paper with more information on the high risk areas and advice from the Director of Finance. The Committee suggested that this be discussed at the next Board meeting in March and should be raised as AOCB at the Finance and Performance Review Group on 8 February. A further report was requested to come back to the Committee in April. Committee members also commented on the £120million funding needed for the other maintenance issues and asked for more information on how serious these issues were. Members also suggested that these issues should be linked to the clinical strategy.

64.2.3 Mr Curley and Dr McCallum informed the Committee that there was another report on maintenance issues relating to healthcare associated infection. This report would come to the meeting in April.

64.3 Liberton Hospital Inspection

64.3.1 Mrs Hornett gave a verbal update to the Committee. Liberton Hospital had been inspected on 8 and 20 December 2011. The initial feedback from this inspection had been very positive, however the written report was disappointing. She reported that she had written to the inspectors to ask for further information on the assessment and why the written report had been contradictory to the initial feedback. She explained that this was not good for staff morale and was counter productive. She highlighted that this was a test inspection so there was no further requirement to submit an action plan.

65. EMERGING ISSUES

65.1 Dr Farquharson updated the Committee on a recent incident involving the death of a patient. This incident was being investigated together with NHS 24 and the NHS Lothian Unscheduled Care Service (LUCS).
66. **SAFE CARE**

66.1. Healthcare Associated Infection Update

66.1.1 Dr McCallum spoke to the circulated Healthcare Associated Infection (HAI) update. She highlighted that NHS Lothian was receiving hand hygiene compliance of 95% and the most recent report had indicated 98% compliance. Mr Egan asked about the incident within neonatology that had been discussed at the previous meeting. Dr McCallum reported that the investigation was still continuing and a report would be ready for the next meeting in April. Mr Egan also asked about a recent outbreak of *Clostridium difficile*. The Committee requested that issues like this should be raised under emerging issues.

66.2 Prison Healthcare Implementation Plan

66.2.1 It was agreed that this would be discussed at the April meeting.

66.3 Sudden Unexplained Death in Infancy and Childhood

66.3.1 It was agreed that this would be discussed at the April meeting.

64. **EFFECTIVE CARE**

64.1 NHS Lothian Public Protection Services Update

64.1.1 Mrs Hornett spoke to the NHS Lothian Public Protection Services Update. The Committee noted the report. She reported that there had been an increase in the number of Multi Agency Public Protection Arrangements (MAPPA) cases. She also added that the risk assessment would be delayed while the new structure for public protection was put into place. A report would be available for the June meeting.

64.2 Business Continuity Management Update

64.2.1 Mrs Drysdale attended to speak to the Business Continuity Management (BCM) Update. The Committee noted the areas where there had been non compliance or only marginal progress made. She highlighted that this was a matter of concern. The Committee noted the key risks outlined in the report. Dr Winstanley suggested that this be referred to the Board and highlighted as a risk. Mrs Drysdale reported that the uptake for the planned BCM workshop was disappointing. It was agreed that the executive directors present would address the issues raised.

65. **PERSON CENTRED CARE**

65.1 Adults with Incapacity (Scotland) Act 2001

65.1 Ms Laskowski attended the meeting to speak to the report on progress made in relation to awareness and implementation of appropriate practice regarding duties and best practice surrounding the Adults with Incapacity (Scotland) Act (AWIA) – Part 5. Ms Laskowski went through the report and highlighted the key issues. It
was noted that there was a lack of robust information and education on the Act. She highlighted that Napier University were now delivering a reviewed AWIA module at Masters Level. This module would cost around £600 per participant. NHS Education for Scotland had also produced a National Learning Resource “Respecting and Protecting Adults at Risk in Scotland – Legislation and Practice”. This would require 32 hours of study. Ms Laskowski advised that AWIA training was not mandatory. The Committee noted that there were a number of issues with staff training and training courses for staff that should be mandatory for certain staff groups. It was agreed that a paper should come back to the Committee on training courses and what should be mandatory and what should be prioritised. Mrs Hornett and Ms Khindria agreed to take this forward.

65.2 Annual Complaints Report

65.2.1 The Committee noted the report with NHS Lothian complaints data for 2010/2011. Mrs Dawson spoke to the report. She reported that NHS Lothian had made improvements in its performance from the previous year – acknowledgement letters sent within 3 working days had improved from 95.6% to 97.3%. However response letters sent within 20 days had decreased from 82.4% to 72.3%. Dr Winstanley suggested changing the title as “complaints” was too negative. He also suggested other measures of performance other than speed e.g. quality and satisfaction.

65.3 Patient Quality Indicators (PQIs)

65.3.1 The Committee noted the report on the Patient Quality Indicators (PQIs) and the plan for implementation of PQIs and the Nursing and Midwifery Leadership Standards.

66. OTHER MINUTES: EXCEPTION REPORTING ONLY

66.1 The Committee noted the following minutes:

- Minutes of the Area Drug and Therapeutics Committee: 02/12/2011
- Minutes of the Mutuality and Equality Governance Committee: 13/12/2011
- Minutes of the Lothian Infection Control Advisory Committee: 07/11/2011
- Notes of the Primary and Community Services Healthcare Governance and Risk Management Committee meeting: 13/09/2011 & 29/11/2011
- Clinical Management Group Minutes: 13/12/2011

67. ITEMS FOR INFORMATION

67.1 The Committee noted the following items for information:

68. **DATE OF NEXT MEETING - 3 April 2012** to be held from **9am – 11am in Meeting Room 7 at Waverley Gate** (deadline for papers 19 March 2012)

**Other Dates for 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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| **Equality & Human Rights Scheme and impact of New Equality Act** (13 October 2010 and 31 May 2011)  
  • Circulate briefing to Committee | AB/JG | n/a       | Awaiting new regulations       | Ongoing |
| **Developing a Performance Monitoring “Dashboard” for MEGC**  
  • The Chair asked Dr McCallum to consult with Ms Gormley and to provide a paper on the definitions for the next meeting.  
  • 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/NG/AB | 29/05/2012 | Due at 29 May 2012 meeting |         |
| **Human Rights in Healthcare: Developing NHS Lothian’s Strategic Approach** (22 February and 31 May 2011)  
  • Liaise with The Scottish Commission on Human Rights | JG    | 31/05/11  | Ongoing                       |         |
| **MEGC Annual Report Timetable** (14 October 2011)  
  • Plan to produce a more substantive report by the end of the year. It was agreed to produce one report to fulfill 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 | AB/JG | 31/03/12  | Due at 31 March 2012          | Ongoing |
| **Equality & Diversity staffing roles and responsibilities in NHS Lothian**  
  • Mr Glover reported that the staffing structure would need a further update as a member of staff had recently retired. Discussions were ongoing to agree line management arrangements. An update would come to the next meeting in May. | JG/MH | 29/05/2012 | Due at 29 May 2012 meeting | Ongoing |
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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>
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<td>• Theme for either the September or November 2012 meeting.</td>
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<td><strong>Rapid Impact Assessment Performance Report</strong> (21 February 2012)</td>
<td>JG</td>
<td>29/05/2012</td>
<td>Due at 29 May 2012 meeting</td>
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<tr>
<td>• The Committee requested more information on the common themes and further data on the reports that had not been assessed. It was agreed that a further report on this would be available at the May meeting. Mr Glover explained that as part of the monitoring process, 6-8 RIA a year were also quality assessed.</td>
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<tr>
<td><strong>NHS Lothian Volunteering Services</strong> (21 February 2012)</td>
<td>SA</td>
<td>29/05/2012</td>
<td>Due at 29 May 2012 meeting</td>
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<tr>
<td>• Ms Garrod asked about volunteers assisting patients at meal times and whether this only covered older peoples’ services in NHS Lothian. Mrs Hornett explained that this covered a number of areas and was monitored thorough the Nutritional Care Strategy – Improving Patient Experience Group (NIPEG). Mrs Allan, the Chair of NIPEG agreed to look into this. Ms Gormley also referred to table 2 in the report – on Ethnicity, disability and gender and suggested including percentages.</td>
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<td><strong>Impact of Welfare Reform</strong> (21 February 2012)</td>
<td>JM</td>
<td>29/05/2012</td>
<td>Due at 29 May 2012 meeting</td>
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<td>• As the Board Committee with a remit to oversee NHS Lothian’s implementation of its responsibilities on mutuality and equality, the Committee noted its wish to draw attention to the potential impact that a reduction to this funding might have on health inequalities.</td>
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*Last updated 27/02/2012*
Minutes of the Meeting of the Mutuality & Equality Governance Committee held at 2:00pm on Tuesday 21 February 2012 in Meeting Room 4, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

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

In Attendance: Mr J Glover and Mrs E O’Connor

Apologies for absence were received from Mr S G Renwick;

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. Mrs Allan declared an interest in item 44.

36. Welcome and Introductory Remarks from the Chair

36.1 The Chair welcomed everyone to the meeting.

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

37.1 The Minutes of the Mutuality and Equality Governance Committee held on 13 December 2011 were approved as a correct record subject to the following amendments:

- Paragraph 28.3 to be reworded to read “Positive action was also discussed.”
- Paragraph 31.1 to be reworded to read “Ms Gormley noted that Scottish Government has considered the two terms and decided to use equality when referring to matters related to the Equality Act”

37.2 The Chair referred to the action note and asked about the following action relating to the performance monitoring “dashboard” – “proposed equity indicators to 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”. Mr Glover reported that discussions were ongoing with Dr McCallum to identify measures and confirmed that a report would be ready for the next meeting in May.

AKM/JG
38. **Matters arising.**

38.1 **Board paper template**

38.1.1 The Committee noted the revised board report template and the instructions for the preparation of board, committee and executive management papers. Mr Glover explained that the recommendations from the Committee had been reflected in the template. The section on inequalities would read – “Impact on Inequality, including Health Inequalities”. This would cover any impact of inequality for individuals with protected characteristics, or health inequalities in the wider population. Mr Glover explained that he would review all reports to ensure this section had been completed correctly.

38.2 **Update on discussions with the Archdiocese**

38.2.1 Mrs Hornett informed the Committee that a meeting had been arranged for 1 March 2012 to conclude discussions with the Archdiocese. She reported that the co-ordinator post had been disbanded as this work was now covered by the NHS Lothian chaplaincy. The Committee commented that this was a sensitive issue, but agreed that it needed to be resolved to ensure equality across the service. Ms Gormley pointed out that a similar situation had also arisen within the Prison Service.

38.3 **Equality & Diversity staffing roles and responsibilities in NHS Lothian**

38.3.1 Mr Glover reported that the staffing structure would need a further update as a member of staff had recently retired. Discussions were ongoing to agree line management arrangements. An update would come to the next meeting in May. JG

38.4 **NHS Lothian Equality & Human Rights Annual Report 2011**

38.4.1 James Glover reported that the NHS Lothian Equality and Human Rights Scheme Annual Report for 2011 which had been approved by the Committee at its October 2011 meeting would be distributed to the board with a covering letter. The Chair suggested that the report be entitled the NHS Lothian Equality & Human Rights Annual Report May 2010 – June 2011.

39. **Rapid Impact Assessment Performance Report**

39.1 Mr Glover spoke to the Rapid Impact Assessment (RIA) Performance Report. It was noted that there had been a steady increase in the numbers of RIA published across Lothian. The Committee referred to the impact assessment output by division. Mr Glover highlighted that there had been a reduction in the number of acute services RIAs as a number of clinical policies had been assessed retrospectively, whereas now large clinical policies were assessed at the point of governance. He also highlighted the rise in the number of multi agency RIAs - due to the submission of proposals to the Health Improvement Fund 3 year funding cycle. It was suggested that data from Royal Edinburgh Hospital and Associated Services (REAS) be included.
39.2 Mr Glover explained that the actions and recommendations from RIAs were monitored to ensure that actions were followed up and completed. There had been a significant improvement in compliance. The Chair requested that the compliance figures be presented by division. The Committee referred to the table that detailed the performance of a number of committees. The Committee requested more information on the common themes and further data on the reports that had not been assessed. It was agreed that a further report on this would be available at the May meeting. Mr Glover explained that as part of the monitoring process, 6-8 RIA a year were also quality assessed.

39.3 Ms Gormley asked whether the RIAs were available to the public. Mr Glover explained that this was work in progress and it was hoped to have all RIAs alongside the appropriate report available on the NHS Lothian website.

39.4 Mrs Allan asked for examples of when a RIA had had an impact on a policy or report. Mr Glover referred to the RIA on the child healthy weight policy. It was originally planned to address obesity in all areas in Lothian but following the RIA, it was agreed that it should focus on the 25% most deprived areas in Lothian. The Committee noted that this type of information would be useful for staff to demonstrate the importance of RIA.

39.5 The Chair noted the paper’s reference to a concern that financial decisions were not adequately assessed and asked for an explanation. Mr Glover explained that this was being taken forward and capacity building sessions had been arranged. Dr McCallum highlighted that this was a national issue for health services.

40. **Equal Opportunities in Nursing Career Development Report**

40.1 James Glover provided a brief verbal report on Equal Opportunities in Nursing Career Development. Mr Glover reported that investigation had identified that there was under representation of non white nurses in management positions. He reported that he had received verbal reports from candidates that the process was improving and good feedback had been provided following interviews. He highlighted that this was a cultural change so would take time to make an impact. A paper was circulated to members after the meeting.

41. **NHS Lothian Volunteering Services Annual Report**

41.1 Mrs Hornett presented the NHS Lothian Volunteering Services Annual Report 2011. The Committee welcomed the timely and informative report. Mrs Allan suggested having a brief summary at the end of the report detailing the benefits to the patient, the volunteer and to NHS Lothian. Ms Garrod asked about volunteers assisting patients at meal times and whether this only covered older peoples’ services in NHS Lothian. Mrs Hornett explained that this covered a number of areas and was monitored thorough the Nutritional Care Strategy – Improving Patient Experience Group (NIPEG). Mrs Allan, the Chair of NIPEG agreed to look into this. Ms Gormley also referred to table 2 in the report – on Ethnicity, disability and gender and suggested including percentages.
42. **NHS Lothian Advocacy Plan**

42.1 It was agreed that this should be deferred to the next meeting when it was hoped that Professor McMahon could attend to speak to the report. A written briefing was circulated.

43. **Involving People Action Plan Update**

43.1 The Committee noted the Involving People Action Plan Update.

44. **Caring Together Strategy and the Carer Information Strategy (CIS) Year Four Update**

44.1 Mrs Hornett went through the report on the Lothian spending plan under the Carer Information Strategy (CIS).

45. **Impact of Welfare Reform**

45.1 Dr McCallum spoke to the report on the UK Government’s reform of the welfare system and the potential implications of this reform for health services and health inequalities. She highlighted the main changes and reported that the two groups of people that were likely to be particularly affected were sick and disabled people and families with children. Ms Garrod asked about the potential impact this could have on mental health services and whether this could cause an increase in demand.

45.2 Dr McCallum referred to the statement in the report noting that due to financial pressures it was likely that the £56k contribution to funding the NHS Lothian Health Promotion Service is likely to be reduced and that this would result in fewer patients being able to access the service. As the Board Committee with a remit to oversee NHS Lothian’s implementation of its responsibilities on mutuality and equality, the Committee noted its wish to draw attention to the potential impact that a reduction to this funding might have on health inequalities.

46. **Any other Business**

46.1 There was none.

47. **Date of next meeting:** Tuesday 29 May 2012 2-5pm in Meeting Room 8, 2nd Floor, Waverley Gate. 2-4 Waterloo Place, Edinburgh EH1 3EG.

48. **Other 2012 Meeting Dates**

- 25 September 2012
- 27 November 2012
### Action Required

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<td><strong>Backlog of Maintenance Work</strong> (20 February 2012)</td>
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<td>• Write to Mr Walker, Chair of Finance and Performance Review Committee and Professor P Murray, Chair of Healthcare Governance and Risk Management.</td>
<td>JI</td>
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<td><strong>Lothian Health &amp; Lifestyle Survey</strong> (20 February 2012)</td>
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<td>• Bring forward a similar report for the Neighbourhood Partnerships.</td>
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<td><strong>April Agenda</strong> (20 February 2012)</td>
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<td>• Consider adding Workforce Plan and the Homeopathy Review to the April agenda.</td>
<td>JI/LT</td>
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Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday, 20 February 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Professor J Iredale; Dr B Agrawal; Ms J Anderson; Mr A Boyter; Mr R Burley; Mrs L D’Arcy; Councillor P Edie; Dr D Farquharson; Dr A K McCallum; Dr J Steyn and Ms L Tait.

In Attendance: Miss L Baird, Dr S Donald and Ms R Laskowski.

Apologies for absence were received from; Professor J J Barbour; Mrs S Egan; Mr J Forrest; Mrs S Goldsmith; Dr J Hopton; Mrs M Hornett; Dr S Mackenzie; Dr B McKinstry; Professor A McMahon and Mrs J Sansbury.

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.

48. Minutes of the Previous Meeting

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

49. Matters Arising from these Minutes

49.1 Backlog of Maintenance Works – the Chair explained that the previously discussed item in respect of the backlog of maintenance was out with the remit of the Service Redesign Committee. In his capacity as Chair he would write to Mr Walker, Chair of Finance and Performance Review Committee and Professor P Murray, Chair of Healthcare Governance and Risk Management to bring the concern about this issue to their attention.

49.2 ICIC Review of Remaining Programmes – Ms Tait advised that Professor McMahon had recommended that routine reporting would cease since the majority of the remaining programmes had been delivered. It was noted that the small number of workstreams requiring further consideration would be brought forward under the umbrella of the Clinical Strategy. The Committee agreed that no further routine reports were required.
49.3 St. John’s Hospital Paediatric/Neonatology Services Update

Dr Farquharson explained that as a consequence of the exceptionally high rate of maternity leave and other leave within paediatric trainees in South East Scotland there was an insufficient number of trainees to support the Paediatric/Neonatal Programme on all sites. Consequently the Postgraduate Dean has decided that trainees would be removed from St. John’s Hospital from April 2012 for a temporary period. He assured the Committee that the removal of the trainees did not affect the training status of Paediatrics and Neonatology Services at St. John’s Hospital, this change related to the current cohort of trainees only and was a temporary measure and a normal service could be resumed when trainee numbers increased to the normal level.

49.3.1 As soon as NHS Lothian and South East and Tayside Regional Planning Group (SEAT) had been advised steps to appoint 8 Locum consultants had been taken. Following advertisement it was considered that 3 appointments could be made subject to formal interviews and appropriate references being obtained. It was anticipated that gaps within the rota could be addressed by Advanced Nurse Practitioners, Agency Locums and the valuable support from existing Consultants at St. John’s Hospital.

49.3.2 Dr Farquharson assured the Committee that maintaining the service was a high priority and pointed our that 2,800 women gave birth at St. John’s Hospital each year and this activity could not be absorbed at the Royal Infirmary of Edinburgh maternity unit.

49.3.3 In response to Mr Burley’s query Dr Farquharson explained the viability of a number of services relied on trainee programmes and following Scottish Government initiatives to reduce the number of medical trainees throughout services, it was likely that similar issues in other areas would occur over the next 5 to 8 years. Dr Farquharson indicated that more services may have to move to 24/7 consultant presence over time in response.

49.3.4 The Chair commented that these arrangements were a consequence of circumstance rather than choice and the Committee should vigilantly monitor the progress of the service.

Ms Anderson entered the meeting.

50. Lanfine Review Report

50.1 Dr Donald spoke to the previously circulated report and gave a detailed presentation highlighting the personal nature of the service the Lanfine Unit provides to patients within the Lothian area. He went on to thank Mrs D’Arcy and Dr Agrawal for their recent visit to the Lanfine Service. Both acknowledged the visit had provided a better understanding of the information provided within the previously circulated report.

50.2 Members noted the importance of linkages with palliative care in developing the proposed network. The Chair offered Dr Donald his support in establishing the necessary links with palliative care.
50.3 Dr Agrawal proposed that Dr Donald should consider sharing knowledge with colleagues at other Health Boards either nationally or UK wide and explore the possibility of developing a pilot to determine the value of an outpatient day unit versus the current service provided by the short in-patient stay programme. The Chair noted that there was a precedent for sharing best practice with colleagues and supported Dr Agrawal’s suggestion of piloting a day service.

50.4 Mr Burley commented that the presentation conveyed the meaning of values based medicine and a person centre approach that was not apparent within the previously circulated report. He proposed that Dr Donald consider highlighting these compelling facts within any future report to the Board.

50.5 The Committee agreed to approve the recommendations detailed within the report.

51. Review and Redesign of Sutherland Ward – Amputee Service

51.1 Ms Laskowski spoke to the previously circulated report on the progress of the review and redesign of the amputee service delivered via Sutherland Ward at the Astley Ainslie Hospital. She went on to provide a detailed overview in respect of the current regional service, the impact of delays and the attached proposals for the transitional unit.

51.2 Dr McCallum commented that efficient future delivery of the service would rely on looking upstream and planning aftercare in advance. Ms Laskowski acknowledged that the majority of patients with peripheral artery disease who cannot go home could be planned for in advance however current processes and attitudes would required to change to achieve this.

51.3 The Committee discussed adapting services in respect of responding to the needs of the patients to alleviate pressure on delayed discharge. Members proposed looking into the use of NHS estates colleagues or private contractors to carry out the necessary works.

51.4 In response to Mr Burley’s query Ms Laskowski explained that there was no other example of a pre surgery transitional unit that could be approached to share information or best practice within the specialty however examples could be pulled from similar units for cardiology. The Committee agreed that Ms Laskowski needed to be mindful that the transitory arrangements did not become a permanent solution.

51.5 Mrs D’Arcy commended the refurbishment of the Sutherland Ward. She went on to suggest that Ms Laskowski should be mindful of opportunities during the redevelopment of the Astley Ainslie Hospital site and linkages to the development of the Lanfine in the process of developing a permanent solution for the service.

51.6 The Committee agreed to note the changes in practice informed by the lean event and associated improvements in care and that future reports on detail and implementation of the proposed new model of care could be reported to the Improving Care, Investing in Change Executive. The Chair requested that in
addition colleagues present maintain a watching brief over the service to ensure best practice.

*Dr Donald and Ms Laskowski left the meeting.*

52. **Lothian Health and Lifestyle Survey**

52.1 Dr McCallum gave a detailed presentation on the results of the Lothian Health and Lifestyle Survey, making reference to the similarities with the Scottish Health Survey whilst highlighting the benefits of the nurse lead approach in achieving comprehensive results.

52.2 Councillor Edie requested that Dr McCallum bring forward a similar report for the Neighbourhood Partnerships.

52.3 In response to Dr Agrawal’s query Dr McCallum advised that additional questions in relation to experiences of accessing health had been included in the boosted sample. She highlighted that Lothian was currently out performing other regions in some areas and overall services had been positively reviewed.

52.4 The Chair thanked Dr McCallum for her informative report and reminded the members present to think about how the data could be applied when considering service redesign.

*Councillor Edie left the meeting.*

53. **Clinical Strategy**

53.1 Dr Farquharson provided a succinct presentation on the progress of the clinical strategy highlighting progress to date and steps that would follow. He anticipated that the draft strategy would be available for consideration in May 2012.

53.2 Mr Burley commented that it would be useful to quantify how many of the over 65s fail to return home, whether this process was appropriate or an alternative could have been applied to enhance treatment and quality of life. Dr Farquharson advised the Committee the data would be there but was not currently collated. He assured members that NHS Lothian’s priority remained getting patients home expediently at the earliest opportunity.

53.3 Mrs D’Arcy queried whether the number of patients who experience a quick re-admission were recorded suitably. Dr Farquharson advised the Committee that this could be examined.

54. **Any Other Competent Business**

54.1 Site Visits – The Chair thanked Dr Agrawal and Mrs D’Arcy for their participation in the site visits. The Committee agreed that arranging site visits in advance of the meeting provided essential insight to proposals presented.
54.2 **April Agenda** - The Chair agreed to consider adding Workforce Plan and the Homeopathy Review to the April agenda.

JI/ LT

54. **Date of Next Meeting**

55.1 It was noted that the next meeting of the Committee would be held on Monday, 16 April 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, 29 February 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr E Egan (Chair); Mr A Boyter; Mr R Burley; Councillor J Cochrane; Ms L Falconer; Mrs J McDowell and Dr C J Winstanley.

In Attendance: Mr C Briggs; Dr D Farquharson; Mrs M Hornett; Mrs R Kelly; Ms C A Knox; Mr P Reith and Mr S Wilson.

Apologies for absence were received from Councillor J Aitchison, Dr C Kalman and Mr I Whyte.

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.

42. Minutes of the Previous Meeting

42.1 The Minutes of the previous meeting of the Staff Governance Committee held on 22 November 2011 were approved as a correct record.

43. Matters Arising

43.1 Retirement Award – the Chair commented that this issue had been ongoing for some time and had still not been resolved. He advised that the staff side had rejected the options of a retirement dinner, as part of the Celebrating Success awards. Mrs Kelly indicated that a bid had been submitted to the Trustees for funding for staff benefit to include celebrating success, retirements and other issues and this would be considered with other bids submitted. Dr Winstanley commented that the Trustees had already indicated support, in principle, for some sort of annual event and queried why Exchequer monies were not being used for this purpose. Mr Boyter indicated that the Chief Executive had made it very clear that Exchequer Funds were not appropriate for this use. Mr Boyter confirmed that some Boards in Scotland did use exchequer funds for such purposes that there was no current intention to replicate this in NHS Lothian. Mr Boyter indicated that those Boards using exchequer funds for this purpose might
well need to consider whether or not this was an appropriate use of NHS resources allocated for health care.

Mrs Hornett advised that she had written out to all charge nurses to remind them of the official procedures for the management of ward funds and, in particular, donations by patients for the benefit of staff. The Chair advised that the Director of Finance had confirmed that all funds should either be Endowment or Exchequer, although he stated that a number of wards had local cash funds. Mr Burley advised that the Endowments Review Group had noted that the Office of the Scottish Charities Regulator’s advice in relation to retirement awards was it was no longer appropriate for such awards to be made from unrestricted funds, but it was appropriate for use from restricted funds. The Central Legal Office had advised that such funds could be used for staff benefits and this was being checked with the Office of the Scottish Charities Regulator. The Chair undertook to discuss this issue with the Chief Executive and Chairman.

43.2 Prison Service – the Chair advised the Committee that he was aware of some significant governance issues following the transfer of the prison service to the National Health Service. Whilst the transfer was being carried Health Board by Health Board, there were a number of issues around health and safety and clinical governance and, in Lothian, these were being taken through the East Lothian Community Health Partnership as host for the service with Central Legal Office advice as required. Mr Boyter advised there were differences in standards of care between the prison service medical service and the NHS and, although Agenda for Change work had been done nationally by one particular Health Board’s HR Director, there were now some issues that individual Health Boards were having to pick up. Ms Falconer advised that the situation was more complex than had been originally thought and could not be fixed quickly. It was noted that the original timetable had been set by central Government. The Committee noted the position.

43.3 Employee Relations Case Review Update – Mr Boyter advised the Committee that a case review had been started and colleagues involved had been written to. Ms J Brown was undertaking structured interviews and would report back within the specified timescale. Any changes to be agreed would require to be presented to the Lothian Partnership Forum for signing off.

43.4 Financial Capability Project Update – Mrs Kelly advised that the project had been concluded and seminars on managing money and resources had now commenced. Information packs were expected from the Government and the option to have financial checks would be offered to staff. Dr Winstanley questioned whether it could be certain that NHS Lothian would not be endorsing staff being advised to come out of the pension scheme and Mrs Kelly confirmed that staff would be advised to remain within the pension scheme. Mrs Kelly explained that Staff Benefits dealt with such issues and staff were always advised that NHS Lothian did not endorse any particular advisor or product. Councillor Cochrane commented that credit unions, advice shops and Citizens Advice Bureaux were all widely available. The Chair indicated that the NHS Scotland Credit Union worked through NHS Lothian and could be better advertised. Mr Boyter advised that on the basis of the work in Greater Glasgow and Clyde NHS Board, the service being offered was felt to be beneficial for
employees and NHS Lothian, as a responsible employer, should have a range of measures in place. It would remain up to individual staff members to decide whether to avail themselves of the service. The Committee noted the position.

43.5 **eESS Systems Update** – Mrs Kelly advised the Committee the date of the implementation of the new Human Resources system had been delayed again as Atos Origin were continuing to have design problems. Mrs Kelly advised, however, that extensive work had now been undertaken to fix the issues and there was some confidence in eHealth that most of the obstacles had been overcome. The 30 April 2012 had been confirmed as the new go-live date and NHS Lothian would have two months overlap with the current provider. There were no major issues outstanding and Mrs Kelly was hopeful that Lothian would soon be in a position where the new system would be for benefit, although there would be some elements of the existing system that would not be carried over. The current system in NHS Lothian had been influential in what was contained in the new system and eHealth was now confident that the platform was workable. The Chair commented it should be made clear that the fault for the delays lay with Atos and not NHS Lothian. The Committee noted the position.

43.6 **Industrial Action** – the Chair commented that the recent industrial action had clearly shown the change in industrial relations in NHS Lothian over the past 10 years. Very few of those involved had taken industrial action previously and no patients were exposed to harm and no patient care was neglected. Mr Boyter commented that the business continuity planning had worked very well and guidance had been provided to some other NHS Boards. Mr Boyter indicated that the British Medical Association were now looking at taking some form of industrial action. Ms Falconer indicated that the Royal College of Nursing had still to decide its strategy. The Chair advised that Unison in NHS Lothian would not follow the UK line and would take the Scottish line. The Committee noted that a response was awaited from the Scottish Government. The Committee noted the position.

43.7 **Attendance Rates – Health & Safety Training** – Mrs Kelly advised she would be bringing a report to the Committee after the Health & Safety Committee had considered the issues and action required. The Chair expressed concern over the take-up rate of training on the management of aggression. In addition, problems with fire alarms and security systems at the Royal Infirmary of Edinburgh were being encountered, and he was keen to get as early a date as possible for a resolution to this problem. Mrs McDowell expressed disappointment that a paper had not been submitted to the meeting however it was noted it was a requirement that these reports went to the Health & Safety Committee first. The Committee agreed that in future papers should be provided for agenda items wherever possible. The Chair commented that it was unacceptable to have staff restraining potentially dangerous patients without having had appropriate training. Staff who had not received the proper training should not be undertaking those duties that required such training. It was agreed that the Chair should discuss this matter with the Director of Human Resources and Organisational Development outwith the meeting.
44. **Board Development Day**

44.1 The Chair reminded members that the Staff Governance Committee was organising the next Board Development Day and the Chair advised he had been in contact with the Board Chairman on this and a previously circulated draft timetable was received.

44.2 Mrs Kelly advised that the plan would be to start the session with some background presentations and then have separate sessions on specific elements of the Staff Governance Standard using both internal and external speakers.

44.3 Mr Burley agreed with the use of the Staff Governance Standards and emphasised the need for a dialogue around the Board itself and for some of the sessions to be interactive.

44.4 Mrs Hornett advised one of the 5x5x5 groups was reporting on staff and staff issues and through that elements of this could be included. Mrs Kelly advised that the staff survey would enable the Board to identify areas for improvement. The Committee agreed to note the position and provide any further thoughts or comments to Mrs Kelly outwith the meeting.

45. **Staff Governance Action Plan**

45.1 The Committee received a previously circulated report, detailing the progress on the Staff Governance action plan 2011/12.

45.2 Mrs Kelly introduced the report explaining it was an interim progress report and the summary column would be the most helpful.

45.3 It was noted that one of the 5x5x5 groups was looking at staff attitudes and engagement and there were some issues around Partnership Forums dealing with items as a priority.

45.4 The Committee agreed to note the interim report.

46. **Investors in People Update**

46.1 Mr Boyter gave an update to the Committee on progress in achieving Investors in People throughout NHS Lothian. Mr Boyter explained that NHS Lothian had initially been split into 24 business units, 19 of which had passed at the first time of asking and 5 of which had still to demonstrate that they had met the standard. Work was ongoing and 2 of the 5 had now been assessed and judged to have met the standard and the remaining three areas would be assessed between 19 and 24 March. The outcome would be known by the end of March and would be reported to the next meeting.
47. **Communications Strategy – Update on Implementation and Action Plan**

47.1 Mr Wilson presented a previously circulated report advising of the progress on the implementation of the existing NHS Lothian Communications Strategy and action plan and acknowledged that a refreshed strategy would be in place by the end of March 2012. Mr Wilson emphasised that internal communications was changing and changes would be made to team brief and Connection was being replaced by an electronic newsletter.

47.2 Dr Winstanley emphasised the need to be clear about what was being communicated and suggested that future reports should be more strategic.

47.3 Mr Wilson confirmed that it was planned that future reports would deal with strategic matters. Mr Boyter advised the Committee that the report would also be considered by the Lothian Partnership Forum.

47.4 The Committee agreed to note the position in respect of the Communications Strategy.

48. **Patient Complaints against Staff**

48.1 The Chair advised the Committee of his concerns regarding patient complaints against staff where staff members and their representatives had no access to case notes, either directly or through an independent reviewer or to cross examine the patient as a result of the confidentiality of patient records. Trades Unions now felt that staff were not getting a fair hearing and patients might now have to be cited to attend employment tribunals.

48.2 Mr Boyter commented that different standards of proof were required in different legal circumstances. Mr Boyter highlighted that in a criminal case the standard was beyond all reasonable doubt whilst in a civil case the standard was on the balance of probability and in our employment law context e.g. in a disciplinary case, the standard was that the manager needed a genuine belief that the alleged offence had been committed and that belief was based on a proper investigation. He indicated that as the Chair on behalf of the Trades Unions was querying whether or not a proper investigation could be demonstrated where patient confidential information was not available to the staff side for presentation at appeal, that he would explore this situation and take advice from the Central Legal Office.

48.3 The Chair commented that, in one instance, the investigating team did not speak to the patients themselves and, whilst the Trades Unions did not want to force patients to attend tribunals if the issue was not resolved, staff in areas where they might be at risk might have to insist on working only in pairs.

48.4 Mrs Hornett commented that patients had to agree to a number of other people being able to see their records and it did not seem unreasonable that they should be asked to provide such access.
48.5 Dr Farquharson commented that the precedent had been set for the General Medical Council and that some process should be in place.

48.6 It was agreed that the Chair, Mrs Hornett, Dr Farquharson and Mr Boyter should meet and discuss the options and report back to the next meeting of the Committee, when the Central Legal Office view was available.

AB/MH/DF/EE

49. Health and Safety Committee

49.1 The Committee received the previously circulated Minutes of the meeting of the Health and Safety Committee held on 29 November 2011.

50. Date of Next Meeting

50.1 It was noted that the next meeting of the Committee would be held on Wednesday, 20 May 2012 at 9.30 am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
58. **Welcome and Apologies**

   Apologies were noted as above.

59. **Minutes of the Previous Meeting Held 28th October 2011**

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

60. **Matters Arising / Action Note**

60.1 **Matters Arising**

   All business was covered via the meeting agenda.

60.2 **Action Note**

   The action note will be updated to reflect issues completed and updated.

61 **Items for Decision**

61.1 **Prison Healthcare Governance Agreement**

   A report was circulated to the meeting and the key issues were highlighted by Morag Barrow.
Responsibility for Prison Healthcare within HMP Edinburgh and HMP Addiewell had transferred to NHS Lothian on 1st November 2011 and this service is being hosted by East Lothian CHP.

An extensive planning process was used to bring about the transfer.

The paper detailed the governance arrangements and noted that the overarching governance would be via the East Lothian CHP Sub Committee.

The opportunities for improvements were highlighted – for example in the way addiction services can be managed.

£4.4 million has been allocated for 2012/13 for the budget for the service and an initial view is that this sum should be adequate, although there are uncertainties over the costs of out of hours medical cover and agenda for change implementation.

In the first month there had been 4 complaints against a previous average of 60 per month. It will be important to ensure that complaints are properly classified in terms of whether they relate to healthcare or prison management issues.

The key risks detailed in the paper were highlighted.

Iain Whyte asked what form of reporting the CHP Sub Committee would receive. Morag Barrow noted that this will develop over time but initially will be focused on finance and performance data.

Iain Whyte noted that he felt the hosting of this service prevented a big opportunity to address health inequalities by linking prisoners and their families to community based services that can provide support both during the serving of a sentence and on release from prison. One of the areas of opportunity is in relation to Health Promotions.

Dr Ian Johnston noted that the key issue for GPs is to ensure that the transition issues are successfully managed and the initial impressions have been very positive.

Decisions

The Risk Register is to be updated and tabled at the meeting of the CHP Sub Committee in February 2012.

The report was noted and the governance arrangements for Prison Healthcare in the service hosted by East Lothian CHP were supported.

62 Items for Discussion

62.1. 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 themes are the issues of shifting the balance of care, integration of health and social care and the challenging economic climate. The demographic challenges were also noted.

Any proposals for change brought forward to the Sub Committee in the future will need to be aligned to the main themes of the paper.

Dr Graham Alexander noted that to date in his view there had been very little shift in resource from Secondary to Primary Care. David Small commented that there had been significant investment in the GMs contract long term conditions and the change fund over recent years but Community Health Partnership’s should continue to promote investment in primary and community services.

Dr Ian Johnston noted there was evidence that despite the planned shift in the balance of care there had been an increase in the number of hospital based consultants but a decrease in the number of GPs.

Anne McCarthy noted that reports brought to the sub-committee over the course of this year showed a general downward trend in the number of CHP staff. David Small noted this was in line with well publicised actively managed manpower reduction plans.

Iain Whyte noted that at NHS Lothian level there had been an overall reduction in the number of hours worked but the level of activity had been flat and this represented a productivity gain in real terms of around 4% - 5%.

The opportunities presented by the recently announced changes to Community Health Partnerships in the integration announcement must be capitalised on with early planning for a review of how services are delivered.

Decisions

The report was noted.

62.2 East Lothian Community Health Partnership Sub Committee Group Diary Dates

A schedule of dates of meetings had been circulated in advance.

Decisions

David Small will contact members in relation to an alternative date for the meeting on 25th April 2012. DS

62.3. Older People’s Update

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

The paper highlighted the overarching principle of shifting the balance of care away from institutional and hospital care to care at home or in a homely setting and set out the range of actions taken in older peoples services that are aligned with these principles.

The paper referenced work being done with the Bellhaven and Edington hospital forums to plan future models of care. David Small noted that these are at different stages of development but firm proposals will be brought forward in the first half of 2012.

A project board has been established in relation to the proposed East Lothian Community Hospital to develop the business case.

Murray Leys noted the work being done to increase the number of respite beds in the area. Tony Segal noted that concerns raised over the quality of service are being addressed and that any increase in provision also has to be geographically balanced. Murray Leys noted that the data on current respite provision in East Lothian is understated as some people are buying respite privately and this is not shown in the officially published data.

Tony Segal commented that change fund submissions have been made which will seek to avoid emergency admissions to hospital being required due to issues with Carers.

Murray Leys noted the need to increase information on local capacity and commented that GPs can assist with the development of this.

**Decisions**

The report was noted. Change fund proposals will be discussed at the GP Forum in January and Murray Leys will attend this meeting.

62.4. **Payment Matrix in Primary Care**

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

Dr Graham Alexander asked if it was possible to have a report on the costs of the Payment Verification system to compare with the funds recovered as a consequence of the investigations undertaken.

It was noted by David Small that the level of monies clawed back for GPs is very low and is usually in relation to data errors, however some very substantial sums have been recovered from other independent contractors such as Dentists. The existence of the process also serves as a possible deterrent to false claims.

**Decisions**

The report was noted.
David Small will explore whether it is possible to obtain details of the costs and sums recovered and report back to a future meeting of the CHP Sub Committee.

63. **Performance Reports**

63.0. **General Managers Report**

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

**Delayed Discharges**

The November validated figure for East Lothian showed 12 East Lothian residents delayed with none breaching the national standards over 6 weeks in post acute and over 2 days in acute care. Murray Leys noted that the targets will become tighter over the next two years and he will be organising a meeting of the appropriate parties to ensure plan for delivery of these new targets.

**Capital Projects**

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

Planning work is now underway on the final re-provision of services from Edenhall Hospital following the recent transfer of some services to Herdmanflat Hospital.

Final costs for the Gullane Medical Practice have been received from Hubco and have been approved by the Hubco Board. Due diligence work is now underway.

It was noted that the Scottish Government had made positive announcements regarding the East Lothian Community Hospital project.

The proposal for the Tranent Health Centre is now being progressed by Hubco to the Standard Business Case stage.

**Review Groups for Bellhaven and Edington Hospitals**

The paper noted progress within these groups.

**Investors in People**

The CHP was successfully re-assessed for IIP accreditation between 5th and 7th December.

**Older Peoples Mental Health Services**

Admissions to Tantallon ward ceased on 7th November 2011 The last patient left the ward in the week beginning 12th December.

The report included details of usage of the bus between Haddington and...
Midlothian Community Hospital in the period from 8th November to 7th December. There has been very low demand for the service. A review of the service will take place on 16th December 2011. The costs are estimated at £37,700 per annum for the current service.

It was noted that the level of demand does not justify a commercial service and there are competition issues for existing commercial services using part of this route.

Decisions

The report was noted.

63.1 Staff Governance Report

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

The staff turnover rate in the 3 month period to 30th November was 1.7% (annualised rate of 6.84%).

The sickness absence rate for November 2011 was 5.95%. Of this, 3.88% was long term sick and 2.07% was short term.

David Small noted that the increase is a concern and the hotspots which are accounting for this increase will be targeted to get the performance back within the target level of less than 3.5%.

Decisions

The report was noted and David Small will report back to the CHP Sub Committee in February 2012 on the actions taken to reduce sickness absence levels.

63.2 Financial Report

A report was circulated to the meeting.

In the 7 months to 31st October 2011 the CHP had an overspend of £781k. Of this £481k related to Prescribing.

The element of the Prescribing overspend that relates to prices will be addressed corporately.

The CHP is on track to deliver LRP efficiencies in full for the year.

The CHP is taking management actions to address the overspend which will ensure that a break even position is achieved.

Decisions

The report was noted.

63.3 Clinical Director Report

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

*Roodlands Services*

The Junior Doctors pilot continues to run well. There have been no adverse incidents since the change. Dr Ian Johnson recommended that the pilot stage can be stopped and the changes mainstreamed.

Roodlands was noted as having rated well in a recent analysis of the quality of Junior Doctor training conducted by the General Medical Council.

The Clinical Director is working through issues with clinical support services including therapies and imaging.

**Decisions**

The report was agreed.

63.4. **Chief Nurse Report**

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

There were 65 children recorded on the Child Protection Register as at mid October 2011.

A steady increase in Adult Protection activity in line with growing awareness of adult protection issues was noted.

A number of mock Health Environmental Inspectorate audits have been conducted at Roodlands and Herdmanflat hospitals. Several issues have been identified and work is underway to address these. A senior Charge Nurse from Midlothian Community Hospital is currently working in Herdmanflat to guide, direct and support staff to improve standards.

The CHP has presented proposals for revenue and capital spend to address the key issues. Funding has been set aside in principle for this subject to confirmation of costs by the Estates Department. David Small noted that the costs for changes at Roodlands were in excess of £500k and planning for a decant of patients while the work is underway will be required.

There were 3 cases of clostridium difficile in the period from 1st October – 25th November 2011 – both at Roodlands.

There had been 4 cases of clostridium difficile in Community settings in the same period.

There have been 2 outbreaks of Noro-virus at Roodlands Hospital. Both wards have since re-opened.

Ronnie Hill noted that the role of the Public Protection Office is being reviewed by the Chief Executive of East Lothian Council.

The Sub Committee discussed the issues experienced by children in
households where substance or alcohol abuse is prevalent and the importance of holistic risk assessments was noted.

It was noted that the Children’s Act will be updated by the Scottish Government and also a new parenting strategy focused on the responsibilities of parents is to be brought forward.

**Decisions**

The report was noted.

63.5. **AHP Manager Report**

There was no business raised under this item.

63.6 **Hosted Services**

63.6.1 **LUCS**

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

LUCS sickness absence rate for October was 6.8%.

There were 5 complaints and 7 reported incidents in the two months to 30\(^{th}\) November 2011.

LUCS is projecting an overspend of £282k for the full financial year. This includes an on-going pressure of £163k in relation to pay enhancements for non clinical staff. £140k relates to sickness absence costs.

Jane Hopton noted the positive work done by the LUCs service on engagement with staff as this can be a challenging issue for the type of service managed by LUCS.

The actions being taken in relation to Quality Improvement were noted with the work being done on asthma, palliative care and stroke patients referenced as examples.

**Decisions**

The report was noted.

63.6.2 **Health Promotions**

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

The paper highlighted the need to raise awareness of the health needs for looked after children (LAC). There are about 210 such children in East Lothian.
The paper summarised the issues and detailed the proposed actions being taken both at a national and local level. Locally these include –

- Training of staff on the issues of looked after children
- Health promoting units
- Alcohol brief interventions
- Stop smoking
- Work with midwives

It was noted that looked after children who stay at home have been identified as doing less well educationally. This data will be used to influence future policy.

Ronnie Hill stressed the need for holistic views in case reviews to ensure that the key issues are addressed. The Change Fund for early interventions is seen as an opportunity to make very positive changes.

Murray Leys noted that he is preparing a paper on the governance issues for Adult and Children’s services and that he will table this at a future meeting of the CHP Sub Committee. The drafting of the papers will be discussed with Ronnie Hill and David Small.

Decisions

The report was noted.

63.7. PMS Expenditure by Community Health Partnership

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

It was noted that PMS expenditure relating to GPs is cash limited.

Payments for groups such as Dentists, Optometrists etc are not cash limited and a report on payments to these contractors would be helpful for the CHP Sub Committee.

East Lothian is broadly in line with Budget.

Decisions

The report was noted.

63.8. Single Outcome Agreement Annual Performance Report 2010

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

David Small noted this is a statutory report and it is important that it is seen by the CHP Sub Committee as part of the governance process.

The key areas were highlighted – e.g. ‘best start in life’. Health
Inequalities, delayed discharges, emergency admissions etc.

Murray Leys noted areas where further action was required such as Self Directed Support.

It was noted that some key data for 2010 – 2011 such as breastfeeding and obesity had not been available when the report was prepared.

**Decisions**

The report was noted.

**64 Carers Forum**

The Sub Committee received a verbal report.

Tony Segall noted that the local Change Fund submissions were aligned with the national target of allocating 20% of funding to support carers.

It is essential that during the planned integration of health and social care that the focus on carers issues is retained. Work being done to refresh some of the joint planning processes was noted.

Ian Whyte commented that he felt that the NHS was now much better informed about the work of the 3rd Sector.

Councillor McLennan noted the Scottish Government “Integration Announcement” and suggested the sub committee discuss this regularly.

**Decisions**

David Small and Murray Leys will liaise on the organisation of the Development Day.

**65 Public Partnership Forum**

The minutes of the PPF meeting held on 4th October 2011 were circulated in advance of the meeting.

The PPF is actively involved in the review groups for Bellhaven and Edington Hospitals and supports the initiative in relation to Polypharmacy.

**Decisions**

The Minutes were noted.

**66. Community Health Partnership Committee Appointments**

There was no business raised under this item.

**67 A.O.C.B.**
67.1. Care Inspectorate

Murray Leys reported that East Lothian Council was one of seven Local Authorities out of twenty eight to have achieved the highest score possible in the recent audit by the Care Inspectorate. This is a very good outcome and will result in a reduced level of scrutiny being required in the future.

68. Date of next meeting

It was agreed that the next meeting would take place on Thursday 23rd February 2012 at 2.00pm, The Council Chambers Haddington
<table>
<thead>
<tr>
<th>Topic</th>
<th>Decision</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>42.2 Matters Arising Not Covered on the Agenda</td>
<td>The Acting General Manager will update on prescribing waste at the next meeting of the CHP Sub Committee on 4th April 2012.</td>
<td>RA</td>
</tr>
<tr>
<td>44 Chairman’s Report</td>
<td>It was decided to invite Dr Nicky Moran to a future meeting.</td>
<td>BA</td>
</tr>
<tr>
<td>45 Acting General Manager’s Report</td>
<td>It is hoped to bring a joint presentation to a future meeting showing collaborative working to improve health through increased physical activity.</td>
<td>RA</td>
</tr>
<tr>
<td>46 Lanfine Redesign</td>
<td>The written report to be clearer re the outcomes and what the Service Redesign Committee is being asked to approve.</td>
<td>SD</td>
</tr>
<tr>
<td>47 Finance</td>
<td>Performance Management Group to review ECHP financial position at its next meeting.</td>
<td>BA</td>
</tr>
<tr>
<td>48 Pharmaceutical Care Services Plan 2012</td>
<td>Summary to be added to include background, aims &amp; contents should be added before going to EMT</td>
<td>AM</td>
</tr>
<tr>
<td>AOCB</td>
<td>Discussion on appointment systems and accessibility to be followed up.</td>
<td>BA</td>
</tr>
</tbody>
</table>
42. **Welcome/Introduction/ Declarations of Interest/ Apologies**

There were no declarations of interest.

Apologies were noted as above.

42.1 **Minutes of Previous Meeting held on 7th December 2011**

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

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

All business was covered via the agenda except for prescribing waste. Robert Aitken advised that work is ongoing on this; it is currently on the agendas for the PPFs and will be capped off on the April Agenda.
**Additional Agenda Item**

**Vitamin D deficiency in Scotland – Dr Helga Rhein** – (presentation e-mailed 2.2.12)

Dr Rhein highlighted the key messages and answers to questions around Vitamin D deficiency.

- 80% of Scottish population was deficient in Vitamin D
- Vitamin D important to immune system and bone health
- Geographical difference between Scotland and England in sunshine levels
- Pregnant women and babies particularly high risk group
- A solution would be to make it available on prescription which makes it credible or to target baby and antenatal clinics.

Dr Rhein was thanked for an interesting discussion and the group were encouraged to discuss through their network of connections.

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**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.**

- The Chair has relinquished his role on the NHS Lothian Staff Governance Committee and has taken on a new role on the Healthcare and Governance Risk Management Operational Group.
- Attended the Edinburgh Partnership meeting on 15th and particularly noted the Armed Forces covenant to support service and ex-service personnel and families in Edinburgh
- Attended a meeting pre Christmas at the Scottish Parliament with Angela Lindsay and Robert Aitken to discuss Podiatry which is hosted within ECHP.
- Attended two PPF meetings last week
- Attended the NHS Lothian Board meeting last week. Of note was Dr Nicky Maran from ERI re Scottish Patient Safety Programme.
- The Chair also attended the Scottish Association of Housing Associations conference last weekend where significant concerns were raised regarding welfare reform and the implications for housing benefit and the effect on inequalities. Scottish Federation of Housing Associations website was recommended.

Peter Gabbitas noted the effect that welfare reform may have on Council services. There could be an effect in the way that CEC receives income and a group is currently looking at the possibility of profound effects e.g. some of charges will no longer be paid direct to the Council. Difficult to predict at present as still working its way through parliamentary process and sections being rejected by the Lords.

**Decisions**

It was decided to invite Dr Nicky Moran to a future meeting.

The update was noted.
Acting General Manager’s Report

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

- Improving Primary Care stock of fit for purpose premises. Wester Hailes Healthy Living Centre is underway and is to be complete in late 2013. West End Medical Practice is also due for completion late 2013. Firrhill is to be combined with other capital schemes to allow it to progress. Ratho is covered separately on the agenda.
- Service and staff awards were noted
- Winter Plan – was working well
- Redesign – 6 areas were noted plus Lanfine which is covered separately on the agenda.
- Edinburgh Leisure – it is hoped to bring a joint presentation to a future meeting showing collaborative working to improve health through increased physical activity.

Lanfine Redesign

Presentation by Dr Stewart Donald, Consultant Rehabilitation Medicine

Lanfine Unit is part of Liberton Hospital and comes under Rehabilitation Directorate which is a Hosted Service under ECHP. Lanfine covers progressive neurological disorders including MS, Huntingdon’s disease, Parkinson’s spectrum & Motor neurone disease. Project has been ongoing for 18 months and a report will be submitted on 20th February to the Service Redesign Committee so any comment required by 6th February.

Current model was set up in the 1980s and is a planned short stay of 2 weeks consisting of assessment and rehabilitation. Additionally they manage patients outside of this 2 weeks and deal with crisis situations.

Have involved staff, users & carers and would rather stay with model that works than move to a respite and community care unit.

Report will state that they should preserve aspects that work well, adapt and meet gaps within resources available. Only at the start of implementation stage. Looking to develop networks and to have a gateway to make it easier to engage with networks.

Looking for services willing to engage and do things differently. Looking to prevent crisis admissions and provide more support at home.

Angela Lindsay offered support and involvement particularly around models for multiple long term conditions, home based networks, developing a virtual ward, telehealth/telecare etc.

Ella Simpson offered support via EVOC or Carers organisations and ‘Reshaping Care for older People’. Important to involve and support community capacity to keep social networks going. Day centres should also be brought into this.

Peter Gabbitas raised the issue of clarity required re boundaries and responsibilities between Health and Social Care & whether this differed across the country?

It was acknowledged that there are challenges from involving different services with different cultural backgrounds but not against blurring as long as carer and user knows who plays what role.
Peter Gabbitas also raised the move to person centred funding e.g. MS Society recently changing support from funding respite to personal budgets which provide flexibility.

It was agreed that personalisation could be discussed with carers but not sure what the response would be. There is also a need to recognise when losing cognitive abilities or tired of managing personal affairs and vulnerability kicks in.

Seb Fisher reported on the new Board which met approx 1 week age. Process was well done with stakeholder day as culmination. Fear amongst users and carers that funding released from modernisation will not still be available to be used in other ways for same client group.

Briefings for each of the work streams should be clearer within the month.

Advice from the group that the report needs to be crisper in what the Service Redesign Committee is being asked to approve. Need clarity in particular as to the end point you want to achieve.

Recognised that there is always anxiety and perceived threat when going through a change process. Perceived risk is that beds are got rid of and the end result is in disadvantaging groups of patients.

It was noted that Ian McKay has been a good support as Project Chair.

**Decisions**

The verbal report was noted. The written report to be clearer re the outcomes and what the Service Redesign Committee is being asked to approve.

47

**Finance**

**Finance Report to 31st December 2011**

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

David King explained that since the last report Peter Gabbitas, Robert Aitken and David had met with colleagues and some of the issues identified were now being resolved. As of December the position is improving and the projection is to break even.

Some of the larger LRP projects are not going to be able to deliver within the year and have been underpinned. LRP position is not particularly bad in the larger scheme of things.

Of the 6.1million overspend associated with prescribing 3.1 million is due to pricing assumptions that have proven to be incorrect & 1 million due to increased volume. 3.7 million has been released to support the prescribing position within the last couple of days. Figures are 2 months in arrears and position is considerably worse that we thought it was going to be.

**Decisions**

The report was noted and the challenges recognised. As the next meeting of the ECHP Sub Committee will be after the end of this financial year it as decided that the Performance Management Group will review the financial position at its next meeting.

48

**Pharmaceutical Care Services Plan 2012**

Aileen Muir spoke to the paper and plan that were circulated with the agenda.
This has not changed much since the April 2011 plan – now 1 less pharmacy. It is an expanded document meeting requirements providing a snapshot in time. This is part of a developmental process and after April next year colleagues from across Scotland will meet to discuss. Issues around an annual process when there is such minimal change but requires wide discussion. Some boards e.g. Fife have called this a ‘Provision of services’ document rather than a ‘plan’. Question for EMT on whether this is the direction that we might wish to take in Lothian? It is intended to publish this plan on the web which has the advantage of being in colour. The plan been sent to the PPFs for consideration. It will now go to EMT and then to the NHS Board.

It is felt that there are no major gaps in pharmacies across Lothian.

Aileen clarified that there was an Office of Fair Trading report that pharmacies were a shop and as such should be able to open anywhere. The Government refuted this and claimed that they are located based on need, the new pharmacy contract and the broader healthcare agenda. Requirement for plan was part of a ‘tweak’ to legislation describing provision of services and identifying gaps.

Maureen Reid raised the issue of patient safety in community pharmacies with high risk medicines under the chronic medication service as part of care management plans e.g. warferin, Lithium & interactions. Decided to bring information out at a later date if it is available.

Issue was raised about the national decision to move the supply of oxygen from community pharmacists to a single supplier managed through National Services Scotland which should be more cost effective. However there are challenges to managing this and concerns locally about the service. Professor McNee from Respiratory Managed Clinical Network has taken this on.

Decisions

The report was noted and the Sub committee agreed that calling it a plan was inappropriate. A summary to include background, aims & contents should be added before it goes to EMT.

Health Inequalities

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

- The Health Inequalities Standing Group has not met since the last Sub Committee meeting.
- Work has been ongoing to increase social capital and to support community health projects. There is now a model of core physical infrastructure agreed giving a menu / action plan to demonstrate core activities for funding to separate out core and other activities for funding e.g. outreach. There is now an action plan in place for most projects.

These are the 4 high level outcomes proposed for the new Single Outcome Agreement in Edinburgh:
• Edinburgh's children fulfill their potential
• Edinburgh's economy delivers increased investment, jobs and opportunities for all
• Edinburgh's communities are safer and have improved physical and social fabric
• Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health

Decisions

The update was noted.

50 Edinburgh Alcohol and Drugs Partnership Commissioning Plan

Peter Gabbitas introduced Nick Smith, Lead for Alcohol and Drug services to speak to the plan circulated with the agenda.

The plan has been ratified by Edinburgh Council with one change to the recommendations in that they wish to add elected members to the Partnership.

The plan is about delivering the right services to people in the right time frames, having clear links across the system & a multi agency response. Right services at right time will allow us to meet the HEAT target of 3 weeks. Communities are in place to support recovery.

Peter Gabbitas reported that in South East Edinburgh they have co-located all services and made access simpler with no requirement for an appointment. Procurement and commissioning may become more contentious & more discussion and sensitivity may be required at that stage.

Bob Anderson asked about drug prevention. This plan does not focus much on this area – the main plan for this will be the Children & Families Drug & Alcohol Plan & investment will go through that commissioning plan. This is due to be signed off by the Council in June / July after consultation. The numbers currently in treatment for alcohol are not as good as we would want them to be. A lot of people seem to be going around the system more times than necessary. Need to reduce the DNA rate to ensure people get the care they need to stop them going around the system. Ella Simpson noted that EVOC supports this and is happy to come to consultation meetings etc.

Decisions

The update was noted and the Recommendations approved.

51 Ratho Surgery Initial Agreement

Robert Aitken spoke to the paper circulated with the agenda. There are very limited opportunities. Ratho is a high priority due to current premises and population growth – 1,000 new houses expected locally. Small development proposed at Norwood Community Centre which will be used on a part time basis and will ease pressures particularly around access and estate. NHS can not request a developer to include a surgery within their plans in the way that a
Decisions
This was approved as a short term solution.

52 **Minutes from other Groups**

52.1 Edinburgh Alcohol and Drug Partnership – 21st December 2011.
A copy of the minutes was circulated to members and noted.

52.2 Primary Care Joint Management Group 10th December 2011 –
A copy of the minutes was circulated to members and noted.

52.3 Primary Care Forward Group – 7th December 2011.
A copy of the minutes was circulated to members and noted.

52.4 Edinburgh CHP Partnership Forum of 22nd November 2011.
A copy of the minutes was circulated to members and noted.

52.5 Edinburgh CHP Health and Safety Committee 22nd November 2011
A copy of the minutes was circulated to members and noted.

52.6 North Edinburgh PPF – 29th November 2011 –
A copy of the minutes was circulated to members and noted.

52.7. South Edinburgh PPF – 1st December 2011. –
A copy of the minutes was circulated to members and noted.

52.8 Edinburgh CHP Performance Management Sub-Group – 21st December 2011 -
Copies of the minutes were circulated to members and noted.

53 **LHP Reports**
There was no business raised under this item

54 **Questions from Members of the Public in Attendance**
There were no questions raised.

55 **Any Other Competent Business**

55.1 Jim Kendall raised an issue from the PPF around appointment systems for people with disabilities. This to be followed up after the meeting with Bob Anderson.

Ramon McDermott noted that work is ongoing on appointment systems led by Dr Nigel Williams

56 **Date and Time of Next Meeting**

56.1 The next meeting of the Edinburgh CHP Sub-Committee is scheduled for Wednesday 4th April 2012 at NHS Lothian, Waverley Gate, Edinburgh.
Note of the meeting of the Midlothian Community Health Partnership Sub-Committee held on Thursday 26 January 2012 at 2pm in Midlothian Council Chambers, Midlothian House, Dalkeith.

Present: Eddie Egan, Chairman
David Small, General Manager, Midlothian CHP
Michael Pearson, Director of Operations, UHD
Tom Welsh, Midlothian Council
Liz Cregan, Chief Nurse, Midlothian CHP
Dr Hamish Reid, Acting Clinical Director, Midlothian CHP
David King, Head of Finance, NHS Lothian
Morag Barrow, AHP Manager, Midlothian CHP
Thomas Miller, Lead Staff Side Representative, Midlothian CHP
Andrew Duffy, Pharmacy Representative
Mairi Simpson, Team Leader, Health Promotion
Sue Edmond, PPF Representative
Julie Gardner, Carers Action Midlothian, Carers Representative
Alistair Littlejohn, Clinical Services Development Manager, Learning Disabilities

Apologies: Dr Jane Hopton, Asst General Manager, Midlothian CHP
Councillor Jackie Aitchison, Midlothian Council Representative
Marlene Gill, PPF Representative
Vivienne Baird, PPF Representative

In Attendance: Sandra McNaughton, Associate Director Pharmacy Services, Minute 54.1
Tracy Sanderson, Learning Disabilities Service, Minute 59.1
Joanne Humphery, Carers Action Midlothian, Minute 60
Lyndsay Taylor, Edinburgh CHP – Minutes

52. **Apologies and Welcome**

Apologies were noted as above.

53. **Minutes of the Previous Meeting held 24th November 2011**

The minutes were agreed as being a true and accurate record of the meeting subject to the following change:

49. Public Partnership Forum
Paragraph 7 should read: Sue Edmond has been elected Chair of the PPF.

54. **Matters Arising / Action Plan**

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

54.1 **Pharmaceutical Care Services Plan**

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

Sandra McNaughton highlighted the key issues from the Pharmaceutical
Care Services Plan 2011/12 which outlines the provision of pharmacy services in Lothian. NHS Boards are required to publish and monitor the plans annually to reflect changes in service provision or service need. The plan includes local demographics, essential core services, additional services and recommendations.

The final draft will be presented to NHS Lothian Board for approval on 28th March 2012 and seeks support for the continued development of pharmaceutical care services.

Sandra McNaughton confirmed that although not included within the current contract, compliance aids will be reviewed. Extensive work has also been carried out to align pharmacy costs and to ensure a robust approach is factored in to financial planning.

Decisions

The report was noted and supported by the Sub Committee. It was agreed to look at providing a summary report for the purposes of PPF members, and an executive summary to report changes via the Sub Committee.

54.2 Neighbourhood Planning

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

Mairi Simpson provided an update on Neighbourhood Planning and highlighted the key areas for Midlothian. There are currently 7 Neighbourhood Planning Partnerships with another 3 to be established per year until 2014/15. These groups will continue to look at future links with Public Partnership Forums.

David Small noted that the CHP Management Team is broadly supportive of this work and would maintain links with Mhairi to support. It was noted that community planning issues could be taken through various groups and not necessarily the CHP. The Chair noted that support should be in place for staff working unsocial hours. Sue Edmond also highlighted the value in having a CHP member on the group to address health issues.

Mairi provided an update on the Armed Forces Community Covenant which was signed off in January 2012, being the second in Scotland. This aims at working jointly with the armed forces addressing issues such as social isolation. Liz Cregan noted that Health Visitors are also work closely with the armed forces supporting families.

A grant scheme is available to apply for funding for 1 year. It was noted there are pressures on various NHS services including GPs, Health Visiting, AHPs and Mental Health in supporting the MOD.

Decisions

The report was noted.
54.3 **Integration Announcement**

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

The Scottish Government paper dated 12 December 2011 reported the plans to integrate adult health and social care. The Council and NHS will work together to develop plans for a Health and Social Care Partnership which will be the joint responsibility of the NHS and local authority.

David Small confirmed that East & Midlothian CHP Sub-Committees will meet together to discuss this further on 6th February 2012 at 4.30 pm at Liberton Hospital.

**Decisions**

The paper was noted.

54.4 **Primary Care Contracts**

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

David Small noted the key issues affecting CHPs. A number of common themes are being addressed including the attempt to standardise the reimbursement arrangements for independent contractors attending meetings; working with community pharmacy on a proposal for the treatment of Chlamydia; and the financial recovery of Golden Hello payments where conditions have not been met.

**Decisions**

The papers were noted and the recommendations were supported.

55. **General Manager’s Report**

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

**Delayed Discharges**

The validated December census showed 3 Midlothian patients with none in short stay beds and no patients over 6 weeks in post acute beds.

**Investors in People**

East and Midlothian CHPs achieved Investors In People accreditation following the reassessment in December 2011. David Small thanked the Steering Group and all line managers and staff in the CHPs who worked hard to achieve the award.

**Older Peoples Mental Health Strategy**

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David Small noted that the single assessment ward in Midlothian Community Hospital is working well. Usage of the bus service running from Haddington to Midlothian Community Hospital has been very low. East Lothian CHP sub-committee has been asked to comment on the continuation of the service.

**Performance Management**

A template is being pulled together to map performance measures and will go back to managers for comment.

**Decisions**

The report was noted. The Chair extended his thanks to staff for achieving IIP award.

55.2 **Staff Governance Report**

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

The sickness absence rate for November 2011 was 5.02%. This represents the second highest sickness rate in Lothian. David Small will meet staff side to review HR support. It was noted that sickness absence requires to be reviewed to ensure prevention and support provided to staff. **DS**

**Decisions**

The report was noted.

55.3 **Finance Report to 30th November 2011**

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

Midlothian CHP is reporting a net overspend of £317k of which £191k relates to prescribing. The non prescribing element relates to pressures within community services and unmet LRP. £114k 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.

David King 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.

It was noted that Hosted Services are on target to break even at the end of the financial year.

The Chair noted that LRP targets should look at how to benefit patient services.

**Decisions**
The report was noted and supported by the Sub Committee.

56. **Clinical Director Report**

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

**Blue Badge Scheme**

Dr Hamish Reid noted there has been a national review of the Blue Badge scheme. Edinburgh CHP has a trained occupational therapist based at the SMART Centre, Astley Ainslie Hospital who will review forms and carry out clinical assessments. This service could be extended to all Lothian patients subject to suitable funding arrangements. Tom Welsh agreed to investigate further as to whether Midlothian Council plan to make changes to the assessment process.

Sue Edmond enquired about the closure of the Astley Ainslie Hospital and how this would impact on the SMART Centre. The Chair confirmed it was not planned to move the SMART Centre.

**QOF QP**

The QOF QP external review meeting with primary and secondary care was successful and received positive feedback. A similar event will be held again next year.

**GP Lead for Cancer & Palliative Care**

Dr Hazel McCutcheon has been appointed as the Lead GP for Cancer & Palliative Care and took up post on 1st October 2011.

**Home Oxygen Services**

A new national system is being implemented for the provision of oxygen in patients’ homes which will come into action on 1 April 2012. GPs will assess all patients receiving oxygen therapy and action as per new guidelines, by March 2012. This is being coordinated by Dr Ninian Hewitt, Clinical Lead Lothian Respiratory MCN.

Sue Edmond queried how this would be communicated to the public. Dr Hamish Reid and David Small confirmed that this was a national change and although numbers were low patients will be individually assessed directly with the GP and/or pharmacist.

**Decisions**

The report was noted.
56.2 **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 October 2011.

**Decisions**

The report was noted.

57. **Chief Nurse Report**

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

**Child Protection**

There were 160 children recorded on the Child Protection Register as at 30th September 2011 mainly due to drug and alcohol misuse, issues of neglect, domestic violence, and financial issues.

**Adult Protection**

Work is ongoing to ensure the accuracy of the new data collection system. Quarterly reports are available.

The Chair highlighted the importance of information sharing in relation to adult protection and supporting colleagues in the sharing of information around significant incidents.

**Community Nursing**

The report referenced School Nursing Service Redesign which is still ongoing; and the Midlothian Community Hospital and Healthcare Technician pilot. The report also referenced Community Mental Health Services.

**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 October 2011 – 10th January 2012 within Midlothian Community services.

The improved performance in relation to hand hygiene audits was noted.

Liz Cregan thanked Carol Horsburgh, Infection Control Nurse Specialist for all her support and confirmed Janette Richards will be taking over this role working to more geographical services. The Chair extended his thanks to Carol.

**Decisions**

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

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

The report provided an update on the Specialist Respiratory Service programme which has secured funding through the Change Fund. This is a fixed term investment for respiratory and anticipatory care.

The report provided an update on behavioural change training. Work has just started focusing on staff having more time with patients. Morag Barrow will report back at future meetings.

Morag Barrow noted that the CHP have been asked to present at an international telehealth conference in March 2012 regarding Falls.

**Decisions**

The report was noted.

59. **Hosted Services**

59.1 **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.

Tracy Sanderson reported the key issues from the report.

Approval has been given in principle for capital funding for the redevelopment of the Greenbank Centre into an Intensive Care Unit. This would ensure significant improvements to the service.

Tracy Sanderson and Alistair Littlejohn noted the staffing impact of work related injury, planned absences, maternity leave and retirement. This has resulted in using the nurse bank above normal levels. Despite this it was noted that a recent staff survey reported high levels of morale and positive feedback at Greenbank.

The Chair noted his appreciation to the Learning Disabilities Team for their contribution to achieving Investors in People accreditation and noted the teams’ dedication.

**Decisions**

The report was noted and supported by the Sub Committee.

59.2 **Substance Misuse**

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.

David Small reported the key issues in the report. The Substance Misuse
Directorate is currently working towards new waiting time targets with 90% of patients to be assessed within five weeks by March 2012. Current waiting time data is being uploaded with national data.

The report provided an update on in-patient services, harm reduction team, and Primary Care.

The Substance Misuse Directorate is reporting a break even position.

The Chair requested information on the prison healthcare service.

**Decisions**

The update was noted.

### 60. Carers Forum

The minutes of a meeting held on 13 December 2011 had been circulated in advance of the meeting and were considered by the Sub Committee.

Joanne Humphreys attended the meeting as CHP carer representative. The Chair welcomed Joanne and offered support to the role when required.

**Decisions**

The update was noted.

### 61. Public Partnership Forum

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

Sue Edmond reported the outstanding issues from the Midlothian PPF Patient Transport Group. It is unclear as to how transport is taken into consideration when decisions are made regarding services redesign. At present NHS Lothian or SAS are not involved in service redesign processes which can lead to consequences for travel for patients. The high number of wasted journeys made by the Patient Transport Service was noted and should be reported back to relevant groups. Sue agreed to look into how much is spent on private ambulances.

David Small agreed to contact Patricia Donald to arrange a meeting with PPF.

**Decisions**

The update was noted.

### 62. Community Health Partnership Appointments

No appointments noted.

### 63. AOCB
The Chair thanked Drew McErlean for his contribution to the group.

The Chair noted that he will be standing down as a Board member later in 2012.

64. Date and Time of Next Meeting

Thursday 29th March 2012 at 14:00 in the Council Chambers, Buccleuch Street, Dalkeith
Minutes of the West Lothian Sub Committee held on 26th January 2012 at 2 – 4pm in Bathgate Partnership Centre, Bathgate.

Present  
John Richardson (JR)  Public Involvement Representative  
Julie Cassidy (JC)  Public Involvement Coordinator  
Wendy Ramsay (WR)  SDO, Adult Protection (left after item 12)  
Margaret Douglas (MD)  Consultant, Public Health Medicine  
Claire Kenwood (CK)  Lead for Mental Health  
Sally Westwick (SW)  AHP Manager, West Lothian CHCP  
Marsha Scott (MS)  Manager, Tobacco, Alcohol & Drug Partnership  
Jane Kellock (JK)  Manager, C&F/Health Improvement  
Marion Christie (MC)  Head of Health  
Steve Faulkner (SF)  Primary Care Contracts Manager  
Lindsay Seywright (LS)  Assistant Principal West Lothian College  
Jennifer Scott (JS)  Interim Head of Social Policy, WLC  
John Reid (JRd)  Housing Strategy & Development Manager, WLC  
George Mackie (GM)  GP East Calder  
Jim Forrest (JF)  Director, West Lothian CHCP  
Theresa Douglas (TD)  Chair, West Lothian CHCP  

Apologies  
Lorraine Gillies (LG)  Life Stages Manager  
Gill Cottrell (GC)  Chief Nurse  
Sandra Mair (SM)  Director of Operation  
Mary-Denise McKernan (MMc)  Manager, Carers of West Lothian  
Jim Gallagher (JG)  Chief Executive, VSGWL  
James McCallum (JMc)  Clinical Director  
Jane Houston (JH)  Partnership Rep, West Lothian CHCP  
Ann Gee (AG)  Head of Housing and Building  

In Attendance  
Marjory Simpson (MSi)  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  
No other business notified
4. DECLARATION OF INTEREST

The Chair stated a declaration of Interest in the Mental Health Strategy consultation item being involved in the development of the document for health and social care education mentioned.

5. DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE

Andrew Jackson was in attendance at the previous meeting, to be added to attendance list

6. MATTERS ARISING FROM PREVIOUS MINUTES

There were no matters arising from previous minutes.

7. CONFIRMATION OF ACTION POINTS

Action to be added to action note from previous minutes.

Andrew Jackson to contact West Lothian Carers, Council Officers and PPFHC for input in the NHS Lothian Clinical Strategy.

8. MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING

The work of the mental health forum to be included in the next health link JC to contact NHS Communication department.

PPF minutes of 10.11.11 were noted

9. MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP

EG inquired if the osteoporosis directed enhanced service (DES) was adequate to meet demand.

SW to contact the falls co-ordinator to find out if numbers are available to ensure the resources are adequate.

PCJMG minutes of 10.11.11 were noted

10. MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT

CFMG Minutes of 31.10.11 were noted

11. MINUTES OF CHCP COMMUNICATION GROUP

Communication Group – last meeting in January has been re-scheduled

12. ADULT PROTECTION ‘SAFE AND SOUND’ EVENT
Wendy Ramsay talked to the paper informing the Sub Committee of the forthcoming event on the 14th March 2012. A brief background of the event was given and asked if the members could assist in the promotion. Attendance of the event will be split 70% service users and 30% support.

The paper was noted and given the Sub Committees support. MSi will assist in circulating information to relevant groups.

13. MENTAL HEALTH STRATEGY FOR SCOTLAND 2011 - 2015

CK talked to the paper firstly giving apologies for the delay in bringing this paper to the Sub Committee and not including the members at the first point of consultation.

JS and MC were involved in the consultation along with collaboration across a number of other areas.

CK ran over the questions and welcomed any feedback. Comments were made regarding the lack of knowledge among staff of the education framework mentioned in the consultation ‘Promoting Excellence’ and the requirement of raising awareness, knowledge and skills around dementia. Comments to be sent to CK by Monday 30th January for submission to the government on Tuesday 31st January.

MS highlighted the priority actions that could be taken around stigma and the scope for working with mental health. MS to make links with mental health.

The chair highlighted the requirement for wider and timely consultation with all partners around the Sub Committee.

14. PHARMACEUTICAL CARE SERVICE PLAN 2012

MD talked to the paper to recommend the Sub Committee review the updated NHS Lothian Pharmaceutical care services plan that will be published on the internet in April 2012.

The updated version gives more detail on the core services and how the services run. There is an issue around the needs of the patients but this will be covered in the future on a national basis.

The plan will be circulated to CHCP Board members and Public Partnership Forum for Health Care for comments.

15. HEALTH IMPROVEMENT AND HEALTH INEQUALITIES ALLIANCE (HIHI)

MD talked to the paper inviting the Sub Committee to note the review of the Health Improvement and Health Inequalities Group and the Terms of Reference for a reconstituted HIHI Alliance, approve the proposed areas of work for the alliance over the next year and agree to receive quarterly updates.

MD has taken over the chair of the HIHI alliance and will take forward priority areas for 2012. Priorities will be reset on a yearly basis. The HIHI Alliance will take over the responsibility of the Healthy Weight Project (T4H).
The HIHI alliance strategy requires to be linked to the CHCP workplan. Investment from West Lothian council was noted.

The Sub Committee noted the review and approved the areas of work and agreed to quarterly updates.

16. **TOBACCO, ALCOHOL AND DRUGS PARTNERSHIP (TADP)**

MS talked to the paper describing the process followed developing a draft joint commissioning plan for services and the intentions for the future consultation of the plan.

The partnership membership includes West Lothian Council, Lothian and Borders Police, NHS Lothian and numerous voluntary sector agencies which were all included in the development of the plan.

It has been highlighted that the TADP were good at providing a needs assessment and initial service but were poor at providing through put and relapse provision. An on line survey was sent to GP’s with a 50% return, further work is being carried out with JMc following consultation with GP’s. The chair highlighted the Sub Committee has the opportunity to enhance services and members can be contacted out with meetings to progress issues.

Health Inequalities impact assessment requires to be included.

The timescale for the new service is the 1st July 2012. Revised version of plan to be circulated. JS and TD to discuss further.

17. **ANY OTHER COMPETENT BUSINESS**

No other business was discussed.

18. **DATES AND VENUES OF FUTURE MEETINGS 2011**

8th March 2012        Bathgate Partnership Centre
26th April 2012        Strathbrock Partnership Centre
21st June 2012         TBC
30th August 2012       TBC
15th October 2012      TBC
6th December 2012      TBC

The meeting closed at 4pm
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH & CARE PARTNERSHIP BOARD held within STRATHBROCK PARTNERSHIP CENTRE, BROXBURN on TUESDAY 10 JANUARY 2012

Present - Theresa Douglas (Chair), Ellen Glass (Vice-Chair), Shulah Allan, Mike Boyle, John Cochrane, Janet Campbell; John Richardson (PPF)

Apologies - John McGinty

In Attendance - Jim Forrest (Director), Jennifer Scott (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), Alexis Burnett (Communications Manager, NHS Lothian) and Robert Naysmith (Clinical Director, Salaried Primary Care Dental Service)

1. OPENING REMARKS BY THE CHAIR

The Chair informed the Board that Jennifer Scott had been appointed on a permanent basis to the council post of Head of Social Policy and the Board members joined in congratulating her on her appointment.

2. MINUTE OF MEETING OF THE BOARD – 8 NOVEMBER 2011

The Board approved the minute of its meeting of 8 November 2011.

3. CHCP BOARD RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decisions
1. To agree the contents of the Note.
2. To delete as complete items 2, 3, 5-8, 10-13, 15, and 17-20.
3. To note that items 1, 4, 9, 14, and 16 should be carried forward.
4. To update the Note accordingly.

4. MINUTE OF THE MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP HELD ON 13TH OCTOBER 2011

The Board considered the minute of the meeting of the Primary Care Joint Management Group held on 13 October 2011.

Decisions
1. To note the minute
2. In relation to item 109.3 on page 3, to agree that a report should be brought to the next meeting of the Board on the polypharmacy pilot.

5. MINUTE OF THE MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP HELD ON 10 NOVEMBER 2011

The Board considered the minute of the meeting of the Primary Care Joint Management Group held on 10 November 2011.
Decisions

1. To note the minute.

2. In relation to item 131.3 on page 4, to note that the Head of Health Services would raise the matter at the group as an "action" and that the Clinical Director (Salaried Primary Care Dental Service) would raise the matter at a forthcoming meeting with other Health Boards

6. MINUTE OF THE MEETING OF THE CHCP COMMUNICATIONS GROUP HELD ON 4 OCTOBER 2011

The Board considered the minute of the meeting of the CHCP Communications Group held on 4 October 2011.

Decisions

1. To note the minute.

2. To note that all actions in the minute had been completed and that the next meeting was due to take place later in January.

7. MINUTE OF THE MEETING OF THE CHCP SUB-COMMITTEE HELD ON 13 OCTOBER 2011

The Board considered the minute of the meeting of the CHCP Sub-Committee held on 13 October 2011.

Decision

To note the minute.

8. NATIONAL DENTAL INSPECTION PROGRAMME FOR SCOTLAND REPORT 2011 PRIMARY 7 - REPORT BY HEAD OF HEALTH SERVICES

The Board considered a report (which had been circulated) by the Head of Health Services informing the Board of the recently published national report into the dental health of Primary 7 children in Scotland which showed that Lothian has now surpassed the national target for the dental health of this age group of children.

The report outlined how dental inspections were carried out across Scotland and the uses made of the information, and identified the national target and the performance of the Health Board as a whole in meeting that target. The trend in performance since 2005 was illustrated, which showed a steady improvement, reflecting the benefits of tooth brushing programmes.

In relation to West Lothian, the report advised that the dental health of P1 children had improved to be as good as that of other parts of the Health Board area, although P7 children continued to show poorer dental health.

Decisions

1. To note the contents of the report on the National Dental Inspection Programme (NDIP) for Scotland 2011.

2. To continue support for the Childsmile programme in schools and nurseries.
9. **UPDATE ON THE WORK OF THE WEST LOTHIAN CHCP FALLS CO-ORDINATOR - REPORT BY HEAD OF HEALTH SERVICES**

The Board considered a report (which had been circulated) by the Head of Health Services advising of the past work of the West Lothian Fall Co-ordinator post, and advising that the post had re-commenced with effect from October 2011.

The report outlined the policy requirements for the work of the post, and the steps being taken across the Health Board to complete and launch the Bone Health and Falls Prevention Strategy. It went on to list the key achievements to date and the future work plan.

**Decisions**

1. To note the key achievements resulting from the Falls Co-ordinator post and the future work plan for this post.

2. To agree that a further report should be brought to the April meeting of the Board to expand on the work of the post.

10. **PERFORMANCE MANAGEMENT IN THE CHCP - REPORT BY HEAD OF COUNCIL SERVICES AND HEAD OF HEALTH SERVICES**

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services updating the Board on performance management in the CHCP, and the integrated approach taken over the preceding year. The 64 high-level performance indicators which had been developed were contained in the appendix to the report, and work was ongoing to extend the range of indicators.

The report explained the background to performance management in the council, and advised of the work carried out to extend the same approach to the health side of the CHCP and develop comprehensive indicators for the whole of the CHCP.

The report advised that of the 64 indicators, 55 were on target or better and only two were below target, and that West Lothian was the first in Scotland to have incorporated the national community care outcomes within routine business processes and was the first area to be able to report on these regularly and consistently.

**Decisions**

1. To note the current performance across 64 key indicators, of which 55 are to target or better, with only 2 below target, both of which are being addressed by management action.

2. To support the continued progress of the integrated approach to performance management.

3. To agree that the presentation slides should be circulated to Board members.

11. **HEALTH & CARE GOVERNANCE**

(a) **CLINICAL GOVERNANCE**

The Board considered a report (which had been circulated) by the Clinical
Director summarising the governance arrangements supporting the review of deaths by suicide in West Lothian which new system has been agreed at Lothian Health Board level and was due to commence on 1 January 2012.

The report explained the new approach being taken in NHS Lothian to fit with national methodology, and outlined the steps taken so far and the steps to be taken in future to complete the introduction of the new practices.

Decisions

1. To note the drivers for change and the changes to the system for review of suicides alongside remaining challenges to its implementation.

2. To agree that a further report should be brought to a future meeting of the Board when the planned review of deaths by suicide in West Lothian not known to services was complete.

(b) CARE GOVERNANCE

The board considered a report (which had been circulated) by the Head of Council Services advising of the inspection of social work services between October 2010 and June 2011 by the Care Inspectorate. The report informed the Board of the purposes of the inspection, the methodology followed in carrying out the inspection, the findings from the Care Inspectorate and outlined the next steps. The Scrutiny Report was attached as an appendix.

Eight of the nine risk assessment areas inspected presented no significant concerns, and it was determined that:-

- there were clear established governance arrangements
- there was effective management of staff
- there was evidence of good quality assessment and care management
- there were effective risk assessment and management protocols but fewer risk management plans than there should have been
- there was rigorous and externally verified approach to self-evaluation
- there was evidence of established and effective partnership working
- there was a sound approach to addressing inequality including a detailed equality action plan, an annual diversity week of events and a number of services to meet the needs of marginalised groups
- there were no suspected or actual areas of unsatisfactory/weak performance that required urgent attention and improvement.

In the only area in which the level of risk was determined to be uncertain it was noted that Social Policy’s own self evaluation confirmed the view of the inspectors that more needed to be done to identify and measure the impact of services on outcomes for people who used services and their carers.

The report went on to advise that West Lothian Council was assessed as requiring level 1 scrutiny – low risk, good performance and good improvement work. Appendix 1 of the attached report contained the 10 scrutiny sessions that
had taken place, which was below the minimum scrutiny suggested for large local authorities and was indicative of the very low risk identified.

The report listed the recommendations for improvement and the next steps to be taken, and concluded by listing the comments made by the Care Inspectorate on the council's strong performance, as follows:-

- provided good information for the public, reflective of positive partnership working and integrated practice
- was very good at staff development, across community care, children and families and criminal justice, linking vision, national and local policy and strategy to staff training and support needs
- demonstrated that improvement through performance management was well embedded, using good systems, which identified staff management and staff performance as central to continuous service improvement
- provided robust evidence of effective governance at corporate and Community Health and Care Partnership (CHCP) levels
- provided clear evidence that Council's approach to assessment and care management was strong and underpinned by good monitoring arrangements
- had strong adult and child protection partnerships in place.

Decisions

1. To note the contents of this report.

2. To note the excellent performance of Social Policy as highlighted within the report.

3. To note that an action plan will address the recommendations for improvement detailed within the report.

4. To congratulate all staff on the excellent report.

STAFF GOVERNANCE

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services updating the Board on staff issues within the CHCP.

It provided information in relation to the industrial action on 30 November 2011, an incident of data loss in the Royal Infirmary in Edinburgh, and the award made to Sharon McMenemy (Charge Nurse, Mother and Baby Unit, St John's Hospital) in the Scottish Health Awards 2011.

Decision

To note the updates on the areas of staff activity.

2011/2012 REVENUE BUDGET - MONITORING REPORT AS AT 31ST OCTOBER 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 31 October 2011.

The report advised that the anticipated draft outturn for the CHCP as a whole was for an overspend of £4,000.

In relation to the overall Social Policy Budget, the forecast was for an underspend 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 report.

2. To note that service managers were taking management action to address areas of financial pressure within their own service area to ensure a balanced outturn is achieved.

3. To agree that a report should be brought to the next meeting of the Board on the Health Board's prescribing budget and budget pressures.

14. **RESOURCE TRANSFER MONITORING REPORT - REPORT BY HEAD OF COUNCIL SERVICES**

The Board considered a report (which had been circulated) by the Head of Council Services providing details of phased expenditure incurred in the period to 30 November 2011.

The report advised that the council had invested £4,220,000 of the total £6,300,000 resource transfer monies in that period, and that there had been a zero delayed discharge position.

**Decision**

To note the details of the monitoring report.

15. **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 use of the CHCP website; the appointment to the council post of Head of Social Policy; an update on Keep Well, the link developed to the West Lothian Licensing Board; and Scottish Government proposals for the integration of health and social care services.
Decision

To note:-

(a) The increasing usage of the CHCP website
(b) The appointment of Jennifer Scott to Head of Social Policy
(c) The progress of the Keep Well initiative
(d) The NHS Lothian link for the Council's Licensing Board
(e) The Scottish Government plans to integrate health and social care
CHAIRMAN'S REPORT

1. Internal

1.1 MSPs - briefings were held on 6, 10 and 24 Feb. The Vice Chair covered a further one on 12 March. There was particular interest in the future arrangements for paediatric trainees.

1.2 Board Recruitment - We are due to recruit six new board members during the course of this year. During this period I have spoken to five candidates seeking more information on non-exec roles. On 26 March I contributed to the long listing process for applicants.

1.3 Visits - On 6th March Morag Prowse joined me on a visit to the Princess Alexandria Eye Pavilion. We heard that the building is nearing the end of its useful life, and learned of emerging proposals to relocate inpatient services to the Royal Infirmary and outpatients to the Lauriston Building.

I visited East Lothian CHP visit 15 Feb. Iain Whyte and I saw round the new Musselburgh Primary Care Centre, which is truly magnificent. Later we visited the Emergency Care Services at Macmerry, an innovative and fast growing service to reduce acute admissions. We also saw round a Tele-health care house in Tranent.

1.4 Board Pilot - I was interviewed by Scott Greer of LSE in this period as part of the process of evaluation of the Board pilot. I was advised that the research findings will be available in June this year.

1.5 Ministerial Visit - On 20 March I hosted a seminar on adult ADHD attended by Health Minister Michael Matheson

2. External

2.1 Conferences - On 22 March spoke at a Sustainable Food conference in Edinburgh. On 16 March I attended a cycling conference with a focus on promoting travel to work.
2.2 Edinburgh Partnership Board - I attended a meeting of the Edinburgh Partnership Board on 8 March. We heard a presentation on the youth justice system, demonstrating the scope for joint working.

2.3 Time Capsule - Also on 8 March, I hosted the burying of a time capsule by school children at the new Musselburgh Primary Care Centre. The capsule will be opened on 8 March 2112, revealing the accuracy of the children’s predictions for future health care!

Charles Winstanley
Chairman
15 March 2012
charles.winstanley@nhslothian.scot.nhs.uk
1. Local Initiatives

1.1 Visits

I visited Midlothian CHP on January 20. The focal point of the visit was the Musselburgh Primary Care Centre, which is scheduled to be fully operational in May, 2012. The building is truly impressive and its completion will mark another important milestone in NHS Lothian’s strategy of investing in primary and community based services.

On February 3, I visited the Royal Infirmary of Edinburgh and met staff in our critical care ward. Staff are engaged in important work on infection control, and I heard presentations on the development of advanced Nurse Practitioners and home ventilation.

On February 10, I visited the Royal Edinburgh Hospital and met key clinical staff, who shared with me their work on suicide prevention, their work on risk management, links to prison healthcare and the care programme approach. I also heard a very encouraging presentation on Psychology service developments supporting our Child and Adolescent Mental Health Service led by Cathy Richards, and a powerful presentation from Sandra Ferguson on child sexual abuse. I also visited The Works, a project NHS Lothian has established to support vocational rehabilitation for people with mental health conditions. Alan Boyter is following up with them how we can link this innovative service to Occupational Health and to other major employers.

On February 29, I visited West Lothian Community Health and Care Partnership and was delighted to be able to tour the recently opened South East Scotland Regional Eating Disorders Unit. This is another example of new investment to support an important specialist service at St John’s. Colleagues providing the service were hugely positive about its benefits and capabilities and believe that it offered an opportunity to be truly world class in service delivery. I also visited the Pathways learning disability resource centre, which is a new purpose-built building opened by West Lothian Council. The multi-disciplinary interaction within a very well laid out building was very apparent.
1.2 Edinburgh BioQuarter – Scottish Partners Forum Meeting – I attended this meeting on February 2. Progress continues to be good with occupation of the No 9 incubator building now well underway. An accompanying marketing strategy for the BioQuarter is also well advanced and focuses on high quality research and facilities, a successful track record of industrial partnerships and creativity, the cost effective location with quality employees, and efficient and effective delivery.

1.3 Staff Successes – Board members will wish to know that Belinda Dewar, a senior nurse from our Compassionate Care Project has been successful in securing a prestigious Florence Nightingale Foundation travel scholarship enabling her to visit the United States to undertake a study on ‘Enhancing Dignified Care Throughout the Organisation within the USA’. I am sure this will be of benefit to our work in NHS Lothian in due course.

Dr Simon Mackenzie has also been successful in being awarded a Fellowship funded by the Health Foundation to spend a year in America at the Institute of Health Improvement. Again, we anticipate benefits for our own services in due course.

1.4 Meeting with MSPs – Along with the Chair and Vice-Chair and Executive Directors colleagues, I attended a meeting with Lothian and Borders MSPs on February 24. The topics discussed included paediatric rotas, which features elsewhere on the agenda.

2. Regional

2.1 I chaired a meeting of the South East and Tayside (SEAT) Planning Group on February 17. Matters discussed included the welcome opening of the Regional Eating Disorders Unit, a SEAT supported and funded initiative, and the annual report on Child and Adolescent Mental Health Services with continuing focus on the challenges affecting paediatric rotas across the region, as reported elsewhere on our agenda.

3. National

3.1 Scottish Leaders Forum – I attended the annual Scottish Leaders Forum at the Golden Jubilee Hospital on 2 March. The Forum this year had a particular focus on youth employment and our efforts in this area also feature elsewhere on the agenda.

3.2 I attended a meeting of the UK-wide Health Services Research Board meeting in London in January 25 and 26.

James Barbour
Chief Executive
15 March 2012
1 Purpose of the Report

1.1 The purpose of this report is to recommend that Board acknowledge the key benefits to integration; agree the minimum scope of coverage for the new partnerships; subscribe to the available evidence to support the development of the Lothian framework; agree that the key reason for integration is to improve shared outcomes, note the key links to current policy and commissioned reports, to be incorporated within the Lothian approach, and agree that the Joint Directors and the General Manager for East and Mid will lead the integration process for Lothian.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board to:

2.1 Acknowledge the key benefits to integration, paragraph 3.2

2.2 Agree that the minimum scope of coverage of the new partnerships for Lothian is stated as adult social care, including older people, mental health, disabilities and substance misuse, with careful thought given to children’s services as well, paragraph 3.3.1

2.3 Agree that the Joint Directors for Edinburgh and West Lothian, and the General Manager for East and Midlothian Community Health Partnerships, along with the Medical Director, will lead the integration agenda for Lothian, paragraph 3.3.2

2.4 Subscribe to the key lessons from the available evidence, which will support the approach for the development of the framework for application across the Lothian partnerships, paragraph 3.3.3.

2.5 Agree that the key reason for integration in Lothian is to improve shared outcomes, paragraph 3.3.3
2.6 Note the key linkages with the integration agenda and the current policy and commissioned reports, and that these will be incorporated within Lothian partnership approach to integration, paragraph 3.3.4

3 Discussion of Key Issues

3.1 The Emerging Integration Agenda
The Cabinet Secretary confirmed on 12 December 2011\(^1\) that legislation will be brought to the Scottish Parliament to formally integrate health and social care services. The Scottish Government has rejected the option of a new statutory body, and will instead base its plans on reforming the existing Community Health Partnerships, moving them towards Health and Social Care Partnerships.

3.2 The Key Benefits of Integration
As well as more effective use of the collective resource in fiscally challenging times, key benefits of the integration reform allows real opportunities to strengthen the quality of outcomes and experience that people have when using health and social care services across Lothian. This will be achieved through more integrated services being clinically led by our experts such as General Practitioners, Consultants, Nurses and Allied Health Professionals, to improve the health and well being of our population, and will include;

- people being supported within community settings for longer, receiving a wide range of comprehensive assessment, acute, rehabilitation and social care, on an integrated basis, from a wide range of flexible staff, founded through anticipatory care plans
- an increase in numbers of people being supported to end of life at home or in homely settings
- support for those in care homes, to prevent unnecessary hospital admission
- people only coming into hospital when required, with less unscheduled care and more planned interventions, with comprehensive geriatric assessment being a key focus at the front door
- an appropriate journey within hospital, with reduced boarding
- fewer delays within the journey and appropriate and timely discharge plans in place
- pathways being designed across the whole health and social care system, ensuring people have the most appropriate journey

The Board is recommended to agree that these are the key benefits to integration.

3.3 The Way Forward for Lothian
The Cabinet Secretary described the key objectives of the reform, when she discussed the proposals to Scottish Parliament on 12 December 2011\(^2\), which was to address “the consensus around the contention that separate and—all too often—disjointed systems of health and social care can no longer adequately meet the needs and expectations of the increasing number of people who are living

\(^1\) http://www.scotland.gov.uk/News/Releases/2011/12/12111418
\(^2\) http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=6627&mode=html
longer into old age, often with multiple, complex, long-term conditions and who, as a result, need joined-up, integrated services.\(^3\)

The Scottish government have adopted Kodner’s\(^3\) definition of integration;

Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration … to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings.

3.3.1 **Scope**
Lothian, and indeed Scotland, has a track record of providing services for those with complex, long term problems, cutting across multiple services, providers and settings not only in services for older people, but those of mental health, disabilities and substance misuse, in Lothian. There is a key risk of undermining the extensive work to date, if these social care services are not included. It is therefore recommended to the Board that the minimum coverage of the new partnerships in Lothian remains as stated in adult social care. Careful thought will also have to be given to the progress to be made across services for children as well.

3.3.2 **Governance**
Nationally, there requires to be agreement that the partnerships will be established as partnerships between the local NHS Board and the Local Authority with the NHS Board Chair operating as the equivalent to the Council Leader, as is currently the case, for example, in community planning. NHS Lothian Board currently exercises the full range of governance with accountability to the Cabinet Secretary. If this is altered for certain functions within the new Health & Social Care Partnerships, a much wider redesign of the governance of the NHS and Local Authorities will be required.

The Joint Directors and General Managers in Lothian, together with the Medical Director, are leading the integration process across the partnerships, and are drawing together key NHS stakeholders on the 3\(^{rd}\) April 2012, where a view will be formed on the range of governance options, and the associated opportunities to ensure the integration agenda in Lothian is not constrained. The agenda will also include forming views on;

- how to resolve any impasse within the partnerships that may occur
- how to ensure the scrutiny processes of each part of the partnership are maximised to best effect
- the future position for hosted services, which some partnerships manage on behalf of Lothian, regional and in some instances national partners

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developing an overarching governance and financial framework to progress integration across the Lothian partnerships, taking into consideration the agency and structural factors indicated below
relationships with ‘Our Health, Our Future’, being led by the Medical Director

It is recommended to the Board that the Joint Directors, General Manager and Medical Director, lead the integration process for NHS Lothian to ensure synergies between the integration and clinical strategy agendas.

3.3.3 Approach
In Lothian we should be seeking to integrate outcomes across the partnership, as opposed to focussing on structures and processes. The most important reason for any partnership to integrate is to;

○ improve effectiveness, including the reach and access of services, as well as equity, equality and outcomes being delivered.

This is supported by Williams & Sullivan (2009), who indicate that the other key driver for integration is to ensure efficient services are delivered in a sustainable manner, by the most appropriate people across the partnership.

There are key lessons from the available evidence on effective integration for Lothian, from the work undertaken by the Shifting the Balance of Care national work;

○ integrate for the right reasons
○ don’t necessarily start by integrating organisations
○ ensure local contexts are supportive of integration
○ be aware of local cultural differences
○ ensure that community services don’t miss out
○ give the right incentive
○ don’t assume economies of scope and scale
○ be patient
○ Leutz’s sixth law; all integration is local and success will hinge on strong local leadership identifying solutions to specific local problems.

Additionally, Williams and Sullivan (2009) indicate that there are structural and agency factors that require to be considered to successfully progress the integration agenda;

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5 www.shiftingthebalanceofcare.nhs.uk
As well as these factors for integration, the five domains identified by Williams and Sullivan include;
- clinical
- service delivery
- organisation
- administration
- funding

It is recommended that the Board subscribe to the key lessons from the available evidence to support the development of a framework for application across the Lothian partnerships, and agree that the key reason for integration in Lothian is to improve shared outcomes.

3.3.4 Key Linkages
There are key linkages with the integration agenda and the current policy and commissioned reports, and it is recommended that Board note that these will be incorporated within Lothian partnership approach to integration, including;

- Audit Scotland report *Review of Community Health Partnerships*\(^6\), with the report recommendations being wide ranging, whole system and inextricably linked to the emerging integration agenda

- Commission on the Future Delivery of Public Services\(^7\), *(The Christie Review)* are met through our strong joint working between the organisations to ensure new models of care and public services are planned and delivered.

- Reshaping Care for Older People\(^8\), through building on joint plans and strategies for older people, and the emerging achievements of the Change Fund with the development over the next year of Joint Commissioning Strategies.

3.4 Key Opportunities

There is an established pattern of working together through the joint planning structures for older people, the established and progressing work being undertaken on a joint basis in mental health, learning disability, drugs and alcohol across the partnerships in Lothian, which have delivered improved quality and outcomes, redesign of services, allowing efficiencies and reinvestments to be made.

Particularly for older people, which is the initial focus of integration, this will be achieved through the;

- implementation of the agreed Joint Strategies and Plans for Older People
- developing Joint Commissioning Strategies for Older People
- delivery against the Joint Transformation Plans


\(^7\) [http://www.scotland.gov.uk/Publications/2011/06/27154527/0](http://www.scotland.gov.uk/Publications/2011/06/27154527/0)

The Community Health and Care Partnership General Managers in East and Midlothian, and Edinburgh Community Health Partnerships, and the two Joint Directors of Health & Social Care in West Lothian and Edinburgh will be instrumental in ensuring the success of the integration of services and improved outcomes for service users across the whole health, and social care system to ensure consistency and equity of service provision, whilst reducing variation and improving quality, productivity and efficiency, and achieving the joint outcomes established through the strengthening Community Planning Partnerships.

The self assessment checklist for NHS boards, councils and other partners to improve joint working between health and social care ⁹, recommended in the Community Health Partnership Audit Scotland report, will be used to provide a consistent approach to generating collective discussions around governance and use of resources, as well as the good governance principles for partnership working ¹⁰ which highlights key principles for successful for partnership working, and describes features of partnerships when things are going well, or not.

Another key opportunity within Lothian is the development of, and the operational use within partnerships of the Integrated Resource Framework. Through the three year data and financial information that it will contain, from 2008-11, there will be the ability to benchmark information and note trends by the end of February this year. This information will be used in informing the joint commissioning plans across all our programmes of work.

The approach and philosophy in Lothian will be to continue to focus on the shared agreed outcomes that we want to achieve for the people of Lothian in line with the main thrust of the current thinking around the integration agenda, whilst strengthening whole system working and the relationships with general practitioners, other community practitioners and acute teams in an innovative way. These shared agreed outcomes, in time should also be extended to other elements of established partnership working, for example services for children, criminal justice and housing.

3 Key Risks

3.1 There is the potential for lack of ownership from many sectors and partners in this venture, much of which may be generated by the uncertainty that this agenda may bring. We need to be mindful of this and ensure we engage all key clinical groups, as well as our independent contractors and third sector, and users and carers appropriately. This will require consideration about how these crucial relationships within the Partnerships will be engaged from the offset, to maximise the opportunities for success.

3.2 Any developing governance mechanisms and how the partnerships agree how to use collective resources will require to ensure the ability of the Board and partner organisations to improve quality, productivity and efficiency on a sustainable basis.

⁹ http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp_ch.rtf
whilst not impeding the integration of services being wrapped around the service user.

4 Risk Register

4.1 The NHS Lothian corporate Risk Register already indicates two key related high risks, which were reported to Healthcare Governance and Risk Management Committee on 12 December 2011, along with identified leads who are managing the risks:

- Risk 2964; the Board does not achieve its financial targets each year on a sustainable basis.
- Risk 1083; Joint working with Council waiting times/discharges.

5 Impact on Inequalities and Health Inequalities

6.1 Each of the partnerships will undertake impact assessments on the development of integrated services, ensure equality and health inequalities are addressed.

6 Involving People

6.1 Each of the partnerships through the key programmes have established communication and involvement plans, and additional engagement will be developed through the agreed integration mechanisms.

7 Resource Implications

7.1 The resource implications will become evident when the scope of integrated services are developed and agreed. There will be a key focus on ensuring quality of service delivery is not compromised, whilst maximising productivity and efficiency against the agreed outcomes.

Dr David Farquharson
Medical Director
20 March 2012
David.Farquharson@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
28 March 2012

Medical Director (Executive Lead)

DEVELOPING THE CLINICAL STRATEGY
“OUR HEALTH, OUR FUTURE”

1 Purpose of the Report

1.1 The purpose of this report is to advise the Board of the engagement that has taken place to date, the high priority projects already underway which will form part of the strategy, and the plans to progress the development of the strategy.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Welcome the stakeholder engagement events already delivered (see appendix 1)

2.2 Support the key themes and principles which have been developed to date

2.3 Note that the draft clinical strategy will be considered the Executive Management Team in April 2012 and presented to the Board at its next meeting.

2.4 Note that existing service strategies, the current priorities within outstanding ICIC workstreams and the Lothian Efficiency and Productivity programme will underpin the clinical strategy and will be incorporated into the strategy document.

2.5 Note that the strategy will identify priority workstreams, project plan and timelines for service redesign in 2012/13.

2.6 Note that 5x5x5 teams and Napier Harvard students’ projects will be aligned to the implementation of the strategic priorities.

3 Discussion of Key Issues

3.1 Safe, effective, person-centred care is at the heart of NHS Lothian’s approach to providing healthcare and promoting positive health for the people of Lothian. In order to continue to achieve this in the years ahead we need to review what we do and how we do it, in other words, how we continue to improve health and deliver high quality healthcare to meet future needs.
3.2 NHS Lothian is currently operating within a challenging environment that will see:
- significant growth in the elderly population, with significant numbers having between 1-3 long term conditions to treat
- reductions in the numbers of medical specialty trainees as well as changes to the broader workforce;
- a financial climate that is unlikely to improve over the next 5-10 years.

3.3 The challenge for NHS Lothian, like all publicly funded bodies, is to be able to respond to these challenges in a manner that is considered, co-ordinated and effective to ensure that the organisation can continue to meet its responsibilities for the population’s health whilst maintaining the level of performance and clinical outcomes that would befit a world top 25 health care organisation.

3.4 Seven key themes have been identified and agreed with stakeholders as the basis for our Clinical Strategy which will underpin future models of care:
- Needs-based services
- Effective, seamless and safe care
- Efficient services, outcomes focused
- Innovative learning organisation
- Partnership working
- Health improving
- Addressing health inequalities

3.5 The Clinical Strategy (Our Health, Our Future) will set out our approach to deliver the redesign of our clinical services over the next five to ten years. In order to meet these challenges we must explore different service models and re-assess the locations for health and care delivery with a key focus on integration around patient pathways, partnerships, and greater emphasis on the development of primary care and community services. This will require NHS Lothian to make difficult decisions in relation to staffing, hospital and community sites and interventions provided whilst continuing to place quality, safety and patient outcomes at the centre of what we do. Appendix 2 summarises the overall context within which planning is taking place, and highlights the areas of pressure which must be addressed, along with the enabling factors including e-health and other technological developments.

3.6 The Clinical Strategy will be taken forward within the context of existing strategies and work programmes already in progress within NHS Lothian. The extant service strategies, current priorities within outstanding ICIC workstreams and the Lothian Efficiency and Productivity programme underpin the clinical strategy and will be incorporated into the strategy document.

3.7 There is also a need to ensure existing commitments are fully reflected in the work going forward, such as our commitment to 3 acute hospitals in Lothian and agreed re-provision of other parts of the estate. The Strategy is intended to co-ordinate and align work areas more effectively in order to support whole-system changes required across the organisation.

3.8 Our strategy for redesign of services will reflect agreed principles of system design. Set out below are those we have developed as part of the process to date, refined
through discussion with stakeholders and building on the strategic narrative for 2020 and the quality strategy ambitions of the Scottish Government:

- Care delivered in the site best suited
  - Shift what is appropriate from inpatient to outpatient/community
- Care delivered by the professional best suited
  - Skill task alignment and professionals practicing at the top of their skills
- Care standardised and specified
  - Reduce waste (in its many forms); evidence based pathways
- Separate elective and emergency care
  - Focus on delivering both in a planned and reliable way to meet patient needs
- Focus on prevention and early intervention
  - Shift care interventions to earlier in the patient pathway

3.9 The strategy will focus on the most challenging patient pathways with the goal of improving quality and value throughout the acute, primary, community and social care systems. On this basis, the proposed initial workstreams are:

- unscheduled care
- frail/elderly patients
- elective surgery
- primary care/secondary/social care interfaces

The programme of work will review the current clinical evidence base, and benchmark processes and performance against best practice to help shape service and pathway redesign.

3.10 The ethos behind the Clinical Strategy will be a cycle of continuous improvement and following the initiation of the workstreams noted above, further areas will be identified that would benefit from pathway redesign based on evidence from benchmarking and data-led management of performance.

3.11 The successful implementation of the clinical strategy will require more than just technical fixes to service specific issues and will necessitate adopting a whole-system redesign approach, requiring strong clinical and managerial leadership at both strategic and operational levels. A project board is in place to provide stakeholder engagement and oversight of the strategic direction.

3.12 The lessons from previous experience within NHS Lothian and advice from major US change programmes have been considered and these reinforce the need for commitment to a significant programme of intensive work, underpinned by a set of design principles and rigorous processes, with clinical engagement and ownership paramount. Robust redesign processes should involve as many clinicians and clinical groups as possible, and the Medical Director’s Medical Strategy Advisory Group will be a key reference point.

3.13 The wealth of experience and knowledge within NHS Lothian will be utilised to support the implementation of the work programmes, through alignment of 5x5x5 teams in 2012/13 and the 2012 Napier/Harvard Leadership Programme intake.

3.14 In summary, the NHS Lothian Clinical Strategy will:

- set out overall service models and principles
- be based on high quality data driven evidence based patient pathways
- drive integrated re-design of major patient pathways in 2012/13 and beyond
- engage staff and stakeholders to deliver excellent services
- embed a continuous improvement and patient centred culture
- improve quality while controlling costs
- drive our workforce planning, finance and asset utilisation

3.15 The draft Clinical Strategy will be considered by the Executive Management Team at their meeting in April and presented to the NHS Lothian Board for agreement at the meeting on 23 May 2012.

4 Key Risks

4.1 The key risks and actions to address are as follows:

- Risk that stakeholders are not adequately engaged: The Project Board involves stakeholder representatives, and continued engagement with stakeholders – staff, partners and public – is planned during 2012.
- Risk that project support is inadequate: Resources have been identified, including those already associated with the ICIC programme. Requirements will be reviewed as workstreams are agreed, and prioritisation will take place to ensure existing resources are directed to achieve maximum benefit.
- Risk that programme management is insufficiently robust to drive delivery of the agreed programme of work: The ICIC Executive is proposed as the senior oversight group for the work programme, and will be responsible for addressing barriers to progress through exception reporting against timelines and outcomes.
- Risk that clinical staff are unable to participate in redesign projects, resulting in sub-optimal outcomes: The Medical Strategy Advisory Group chaired by the Medical Director will have a key role in ensuring engagement with clinicians, and will identify measures to mitigate this risk.

5 Risk Register

5.1 The intended outcomes from this work will support the delivery of performance targets within the NHS Lothian Risk Register and will include a shift in the balance of care from institutional to community based settings, reduction in delayed discharge, deliver of waiting times’ targets and achievement of 4-hour target.

6 Impact on Health Inequalities

6.1 An impact assessment was undertaken in June 2010 when the strategy was high level, bringing together drivers and principles for taking forward the development of the strategy. It was recognised that as it was in early development the benefits of an impact assessment were limited, and as the detailed work programmes are developed impact assessments will be carried out.

7 Impact on Inequalities

7.1 As noted above, a further impact assessment on the detailed work programmes will be undertaken to ensure that inequalities can be positively impacted.
8 Involving People

8.1 The development of the clinical strategy has involved a wide range of stakeholders and this is detailed in Appendix 1. This high level involvement will continue and engagement plans will be developed for the detailed work programmes, along with consideration of communication mechanisms for sharing our vision with the wider public.

9 Resource Implications

9.1 There are no direct resource implications relating to this progress report.

Dr. David Farquharson
Medical Director
13 March 2012
David.Farquharson@nhslothian.scot.nhs.uk

List of Appendices:

Appendix 1: Stakeholder engagement events delivered up to March 2012
Appendix 2: Strategic context, drivers and enablers for clinical strategy deployment
NHS Lothian Clinical Strategy Engagement Events

- Strategic Planning Team
- Public Health and Health Policy Directorate
- UHD SMT
- Clinical Strategy Event - public / patient
- Area Clinical Forum
- East Lothian CHP Sub Committee
- Allied Health Profession meeting
- Staff Governance Committee
- Clinical Board
- Informatics Board
- Service Re-Design Committee
- Lothian Area Division of Psychiatry
- Directorate Governance Group
- Pharmacy Senior Management Team
- Midlothian CHP Sub Committee
- Faith Group
- Primary Care Forward Group
- Lothian Area Pharmaceutical
- Lothian Partnership Forum
- Lothian Area Medical Committee
- Nurse Directors Meeting
- West Lothian CH(C)P sub-committee
- Health Promotion Service
- West Lothian Community Planning Partnership
- East Lothian Community Planning Partnership
- Scottish Health Council
- Medical Staff Association
Strategic context, drivers and enablers for clinical strategy deployment:

**APPENDIX 2**

**Person Centred**  **Safe**  **Effective**

**Lifestages:**
- Early Years
- School Age
- Working Age
- Older People

**Programmes/ Factors:**
- Obesity
- Cancer
- Disabilities
- Long-term Conditions
- Substance Misuse
- Alcohol
- Mental Health
- Sexual Health
- Medicine
- Surgery

**Pressures:**
- Waiting Times
- Accident & Emergency
- Delayed Discharge
- Workforce
- LRP
- In-patient flow
- Prescribing costs

**Settings:**
- Home/Community
- Primary Care
- Acute Hospitals
- Long-term Care
- Community & Specialist hospitals

**External:**
- Inequalities
- Demographics
- Finance
- Integration
- Prevention
- Mutuality
- Patients Rights

**Enablers:**
- Staff
- Patients
- Public
- Partners
- Technology
- Pathways
- Redesign
- LEAN
- Resources
- Comms
1 Purpose of the Report

This report presents the updated Quality Report for March 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 and effectiveness measures for Coronary Heart Disease (with supporting technical appendix 1).

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 core measures 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>
<thead>
<tr>
<th>Measure</th>
<th>Aim/target</th>
<th>Summary Results at March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR</td>
<td>HSMR less than one.</td>
<td>HSMR remains stable at less than one for all three acute sites.</td>
</tr>
<tr>
<td></td>
<td>SPSP national target to reduce HSMR by 15% by December 2012.</td>
<td>Reductions from Oct-Dec 2007 baseline at RIE (7.8%), WGH (5.5%) and St. Johns (5.2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Figures 1a-1c.</td>
</tr>
<tr>
<td>Adverse Events</td>
<td>SPSP target to reduce by 30% by December 2012.</td>
<td>Significant sustained reduction in adverse events – 46% from baseline (2007).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Figure 2.</td>
</tr>
<tr>
<td>Hospital Associated Infection(HAI)</td>
<td>HEAT targets for SABs and CDI relate to episodes/acute occupied bed days.</td>
<td>S. aureus Bacteraemia - on HEAT target.</td>
</tr>
<tr>
<td></td>
<td>HEAT target for hand hygiene is 90% compliance. Local stretch target of 95%.</td>
<td>C. difficile Infection – on HEAT target.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hand Hygiene – achieving HEAT target and local stretch target.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Figure 3a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Figure 3b</td>
</tr>
<tr>
<td>Incidents with associated harm</td>
<td>Reporting of incidents with harm should not increase.</td>
<td>The reporting of incidents with associated harm remains stable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Figure 4</td>
</tr>
<tr>
<td>Complaints</td>
<td>National target to acknowledge 100% of complaints within 3 days and to respond to 85% of complaints within 20 days</td>
<td>The number of complaints remains stable – Figure 5a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3-day compliance 97% against complaints national target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-day compliance 78% (Scotland 2010-11: 67.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Figure 5b</td>
</tr>
<tr>
<td>General Practice – Person-centred</td>
<td>Report on Better Together Results</td>
<td>Over 80% of patients agreeing or strongly agreeing with each statement, with Lothian’s results similar to other NHS Boards in Scotland. See section 3.5.</td>
</tr>
</tbody>
</table>
Figure 1a - Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – September 2011.

Figure 1b - Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – September 2011.

Figure 1c - Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – September 2011.

Figure 2 - Rate of Adverse Events per 1000 patient days. November 2008 to March 2011.

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 (Apr 2010-Dec 2011).

Figure 5b – 20-Day Response Target across NHS Lothian, Quarterly (Apr 2009-Dec 2011).
Figure 5a – Formal Complaints per quarter across NHS Lothian (Apr 2009-Dec 2011)
3.4 The measures for this report are for General Practice Person-centeredness and clinical effectiveness measures for Coronary Heart Disease (CHD).

3.5 **Person-centeredness Measures**

3.5.1 **General Practice Result - Better Together Board comparison**

Questions that were relevant to person-centeredness were selected. The overall results for Lothian were compared with other “urban” Boards, a comparison that has also been made for the Better Together acute sector results.

The inter-Board comparison (Appendix 2) shows that the responses for all questions and all Boards were very positive, with over 80% of patients agreeing or strongly agreeing with each statement. (N.B. the vertical axis starts at 80%).

Responses about nurses were more positive than those about doctors. The largest difference is seen for the question that asks about whether the patient had enough time with the doctor or nurse. These differences are in part explained by the fact that nurses are likely to see a different group of patients, perform a different range of tasks and have longer consultations times than doctors. The differences are statistically significant (95% Confidence Intervals at Board level for each question are approximately +/- 0.5%).

3.5.2 The 2009 Better Together results demonstrate very high levels of agreement with statements which reflect person centeredness in primary care. There is, however, a suggestion that overall Lothian scores are slightly lower than other urban Boards, particularly for the questions relating to consultations with doctors. There is also some variation between practices. These results will be compared with 2011 survey results when they become available. The fast frequent feedback technique used in the acute setting is currently being tested in primary care: 20 general practitioners are asking 50 patients to give them feedback on their person centeredness after a consultation. The survey will be repeated after 2 months. Individual doctors will know how well they do for each aspect of person centeredness compared to their peers.

3.6 **Coronary Heart Disease (CHD)**

For Coronary Heart Disease (CHD), the effectiveness measures are as follows:

1. Achievement of cholesterol targets for patients with CHD in the community;
2. Achievement of blood pressure targets for patients with CHD in the community;
3. Survival for 30 days after emergency admission for acute myocardial infarction;
4. Time to emergency coronary revascularisation in the Royal Infirmary of Edinburgh with comparison to data from other contributors to the National Cardiac Benchmarking Collaborative;
5. Overall CHD mortality rates in Lothian;
6. Premature CHD mortality rates among the whole population and the most deprived 15% of the population rates in Lothian.
The first two measures reflect evidence-based approaches to the secondary prevention of CHD in primary care. Data from 2010/11 from Primary Care is unavailable due to a move to new ehealth systems. The 2009/10 data has, however, been represented in a new format to show changes over time plus variation. The measures related to hospital care are limited at this time; however Lothian now participates in several national (UK) audits and in future years it is anticipated that results from these can be presented in this report.

Effectiveness measures included in other parts of the Board’s effectiveness measures timetable are also of relevance to CHD; for example smoking cessation (included in cancer measures) and diabetes management.

1 and 2: Achievement of cholesterol and blood pressure targets among patients with CHD in the community

In 2009/10, there were 30,458 patients on the Lothian CHD QOF register. Lowering the cholesterol of a patient with CHD means that they have a significantly reduced risk of a range of adverse events including myocardial infarction, stroke, and death.

Taking Practice A as an example, since 2005/6 the % of their practice population with CHD whose cholesterol is less than 5 mmol/L has increased from 72% to 74% in 2009/10 (Figure 6).

Both these population values are above 70%, the upper threshold for payment, and the practice would have received maximum QOF points and payment for this indicator in both years. There is no additional financial incentive for practices to increase their achievement above 70%. However, many practices do so. It is in the interests of Lothian’s population that these curves move as far to the right and become as vertical as possible. However, population achievement will never be all the way to the right and vertical as there will always be patients who need to be “excepted”. Patients are excepted when, for example, they are extremely frail, do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

Overall, since 2005/6, for both Lothian and Scotland, more practices have achieved greater population coverage of their CHD patient population in terms of lowering cholesterol. Lothian’s improvement has, however, been more marked, with an increase in median achievement from 72% to 78%. Despite CHD prevalence falling since 2005/6, the number of patients with controlled cholesterol has increased by 407 from 23,001 in 2005/6 to 23,408 in 2009/10.
1. Patients with Hypertension

In 2009/10, there were 101,344 patients on the Lothian hypertension QOF register. Controlling blood pressure results in a significant reduction in risk of stroke and ischaemic heart disease.

Overall, since 2005/6, for both Lothian and Scotland, more practices have achieved greater population coverage of their patient population with hypertension in terms of lowering blood pressure (Figure 7). In 2009/10, the vast majority of Lothian’s practices achieved higher population coverage than Scotland as a whole, and the median value for Lothian was 79.5% compared to 78.5% for Scotland. The number of patients with hypertension with controlled blood pressure has increased by 12,360 from 67,462 in 2005/6 to 79,822 in 2009/10.
Exception Reporting

The QOF includes the concept of ‘exception reporting’ to ensure that practices are not penalised where, for example, patients do not attend for review or where medication cannot be prescribed due to contraindications or side-effects. Lothian practices’ exception reports are overall lower than Scotland’s for both CHD and Hypertension. Over time the higher levels of exception reporting for both CHD and hypertension has reduced and the number of lower levels has increased, meaning that overall fewer patients are excepted now.

2. Survival for 30 days after emergency admission for acute myocardial infarction or unstable angina

The percentage of patients surviving for 30 days after emergency admission with a main diagnosis of acute myocardial infarction or unstable angina in Lothian is greater than that in Scotland as a whole when the data are adjusted for age, sex and deprivation (Figure 8).

Figure 8 – Trends in 30-day survival after acute myocardial infarction or unstable angina for years ending 31st March 2001-2010. Number of patients surviving for 30 days or more after a first emergency admission for acute myocardial infarction or unstable angina.

3. Time to emergency coronary revascularisation

The Royal Infirmary of Edinburgh has the best call to balloon times and is in the top three for door to balloon times of other centres currently participating in a national (UK) collaborative. Whilst this does not include all centres in the UK, it does include other large tertiary referral centres.
Table 2 - ‘Call to balloon’ and ‘door to balloon’ times in minutes for the Royal Infirmary of Edinburgh (RIE) and for all centres participating in the National Cardiac Benchmarking Collaborative (2008/9 and 2009/10).

<table>
<thead>
<tr>
<th></th>
<th>2008/9</th>
<th></th>
<th>2009/10</th>
<th></th>
<th>2010/11</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RIE</td>
<td>All 16*</td>
<td>RIE</td>
<td>All 22</td>
<td>RIE</td>
<td>All 19</td>
</tr>
<tr>
<td>Call to balloon times (mins): Median for RIE and median and (range) for all centres</td>
<td>n/a</td>
<td>111 (52-180)</td>
<td>80</td>
<td>111 (54-147)</td>
<td>81</td>
<td>112 (81-149)</td>
</tr>
<tr>
<td>Door to balloon times (mins): Median for RIE and median and (range) for all centres</td>
<td>54 (30-111)</td>
<td>54</td>
<td>33</td>
<td>44 (23-75)</td>
<td>28</td>
<td>40 (22-85)</td>
</tr>
</tbody>
</table>

* Data were available for 17 centres for door to balloon times for 2008/9

4. Overall CHD mortality rates

Figure 9 shows that CHD mortality has decreased in Lothian over the last eleven years, as is the case for the Scottish population overall.

Figure 9 - Age and sex standardised heart disease mortality for Lothian and Scotland 1999-2010. Source: [http://www.isdscotland.org/isd/5766.html](http://www.isdscotland.org/isd/5766.html) [http://www.isdscotland.org/Health-Topics/Heart-Disease/Topic-Areas/Mortality/](http://www.isdscotland.org/Health-Topics/Heart-Disease/Topic-Areas/Mortality/)

5. Premature CHD mortality rates and rates by deprivation

Figure 10 shows that the trend of reducing mortality is also seen for premature (defined as under 75 years of age) CHD mortality for the whole population and that the target to reduce the mortality rate by 60% between 1995 and 2010 appears achieved. However for the most deprived parts of the population trends in premature mortality from CHD are less favourable in Lothian (Figure 11).
To investigate possible explanations for this pattern including data artefact, Public Health is leading a review of individual records. The small numbers of deaths in this population sub-group must be noted here; it is possible that a larger number of deaths among particularly young people in one year may have contributed to this finding or that there has been a chance increase in numbers. Aside from further work to understand the data, programmes of work such as Keep Well are addressing the high risk of CHD mortality in deprived populations.

Figure 10 - European Age Standardised Mortality Rates per 100,000 population for Lothian for those under 75 (1995-2010) with trend against target (60% reduction in mortality by 2010)
3.6.1 McKinsey Cardiac Improvement Network

During 2011, NHS Lothian participated in a Global Cardiac Improvement Network, with other health organisations, which included Queensland and Victoria (Australia), Singapore, NHS South England and Pais Vasco (Spain).

The measures used are standardised using Organisation for Economic Co-operation & Development (OECD) standardised populations. The scope of this population is different from the European Standard Model routinely used for measuring UK and European activity. As a result, cardiac rates are quite different and are not directly comparable with European data. The data generated from the deep dive by the network is operational in nature and is being considered at service level.

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 The General Practice Better Together survey was developed nationally in partnership with patients.

8.2 The Cardiac Network has active patient involvement at a planning and service level.

9 Resource Implications

9.1 There are no resource implications associated with this report.

Dr David Farquharson  
Medical Director  
20 March 2011  
david.farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Technical Appendix  
Appendix 2: Better Together GP Survey 2009/10
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 (OBTD). 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.

Population coverage figures – Primary Care cholesterol (Figure 6) and Blood Pressure Targets (Figure 7)

- The vertical axis represents the % of practices achieving that level of achievement or less: e.g. in figure 3, in 2009/10, 0% of practices achieved less than 65% compared to 2005/6 when 0% achieved less than 48%.
- The horizontal axis represents the level of population coverage or achievement for that indicator. Population coverage means that no patients are removed from the denominator; the % achievement refers to all patients with CHD who are relevant for that indicator.
- The two vertical lines representing QOF upper and lower bounds which refer to the lower and upper levels at which practices receive payment for achieving these levels of
coverage: e.g. in figure 3 practices start receiving payment for CHD08 when 40% of
their population has their cholesterol controlled.

- The lines represent the cumulative distribution of practice levels of achievement for
  Scotland and Lothian in 2005/6 and 2009/10. Each point on the line represents a
  practice with a certain level of achievement.
- The diamonds on the horizontal axis represent the median values for achievement for
  each line. E.g. in figure 3, in 2009/10, 50% of Lothian practices achieved 78%
  coverage or more, compared to 72% in 2005/6.
Better Together - GP Survey 2009/10
Average percentage of patients giving a positive response

The doctor listens to the patient

The nurse listens to the patient

Patients feel that the doctor has all the information they need to treat them

Patients feel that the nurse has all the information they need to treat them

The doctor shows consideration for the patient's personal circumstances when treating them

The nurse shows consideration for the patient's personal circumstances when treating them

The doctor talks in a way that helps the patient to understand their condition and treatment

The nurse talks in a way that helps the patient to understand their condition and treatment

Patients have confidence in the doctor’s ability to treat them

Patients have confidence in the nurse’s ability to treat them

Patients have enough time with the doctor

Patients have enough time with the nurse

Patients are involved as much as they want to be in decisions about their care and treatment

Key:

1. Fife
2. Grampian
3. Greater Glasgow
4. Lanarkshire
5. Lothian
6. Tayside
PRISON HEALTHCARE GOVERNANCE

1 Purpose of the Report

The purpose of this report is to advise the Board on Governance arrangements for Prison healthcare.

2 Recommendations

The Board is recommended to:

2.1 Support the governance arrangements already in place.

3 Discussion of Key Issues

3.1 The responsibility for prison healthcare within HMP Edinburgh and HMP Addiewell transferred from The Scottish Prison Service to NHS Lothian on 1 November 2011. This service is hosted by East Lothian CHP. This was agreed at the CHP Sub Committee meeting on 27 October 2011.

3.2 HMP Edinburgh is operated by Scottish Prison Service (SPS) and has an average daily prison population of 900 prisoners, which now includes 114 women offenders. HMP Addiewell is a private prison operated by Sodexo Justice Services (SJS), with a population of 796 prisoners, all of whom are male.

3.3 The national memorandum of understanding between the Scottish Prison Service and NHS Scotland, ‘Healthcare for Prisoners’, which has recently been updated, clearly sets out responsibilities of the NHS, the SPS and those which are shared, as well as the role of the Scottish Government Health Department (through the Primary Care Directorate) and the Scottish Government Justice Department (through the SPS Director of Prisons). This document also sets out the framework for accountability and governance which includes a Joint Steering Group on Prisoners’ Healthcare.

3.4 Operational service delivery is through a “Health Centre Manager” in each prison who is responsible for all day to day provision of healthcare. Management of medical staffing is currently through the Edinburgh CHP Access Practice. Both
report to the East and Midlothian CHP Allied Health Professions Manager who in turn reports to the East and Midlothian CHP General Manager. Lead Director responsibility lies with the Acting Director of Strategic Planning.

3.5 Governance is through East Lothian CHP Sub-Committee.

3.6 The CHP has developed a specific risk register for prison healthcare and has included an overall risk on the CHP risk register.

3.5 A Lothian overarching joint steering group, which first met on 8 February, is chaired by the General Manager of the CHP. Membership includes the Governor of HMP Edinburgh and Director of HMP Addiewell, AHP Manager, CHP Prison Healthcare Managers, Strategic planning and Partnership representation. This will ensure alignment between the CHP and prison management and avoid duplication by building on existing reporting mechanisms. The group will focus initially on areas of shared responsibility, e.g. critical incident review processes and incident management.

3.6 Professional accountability has been assumed by professional leads within the CHP (the Chief Nurse for Nursing and the Clinical Director for medical staff) and single system Pharmacy Directorate (the Associate Director of Pharmacy).

3.7 Financial governance is through East and Midlothian CHP AHP Manager. Resource allocation of £4.4 million for 2012/13 has been included in the financial plan for NHS Lothian.

3.8 The focus for NHS Lothian prior to 1st November 2011 was primarily on strategic and key operational issues relating to transfer. Since transfer, more detailed operational work streams have now been identified and are underway. This includes review of policies and procedures.

3.9 During the period between 1st November 2011 to 31st March 2012, work is underway to ensure policy alignment that is fit for purpose. This work is led by the NHS Lothian Clinical Governance team. This will be complete by 31st March 2012. Complete adoption of all NHS Lothian Clinical Governance and Health & Safety policies will take place from 1st April 2012.

3.10 Particular focus is being given to policies on medicines management. It is anticipated that this work will be completed by April 2012 in order to fit the timescale in 3.9.

3.11 There are 13 pre-existing health care standards that SPS previously monitored with an annual timetable for internal and external reporting of compliance.

3.12 The 13 standards covered the range of health care services provided to prisoners as well as processes for medicines management, healthcare associated infection, facilities and records. The responsibility for these standards transferred from the Prisons/Healthcare directorate of the Scottish Government to Healthcare Improvement Scotland (HIS) on 1 November 2011. HIS is mapping these standards to NHS Scotland standards through the recently established National...
Prisoner Healthcare Network of which NHS Lothian is a member. Implementation will follow established NHS Lothian procedures.

3.13 In considering the prison healthcare transfer overall, it is difficult to determine and assess what the impact has been at such an early stage in the process. The view from the senior management teams within the prisons has been very positive and there has been no significant incidents involving healthcare and prisoners as a direct result of NHS Lothian providing the care. As outlined in 3.9 above, the establishment of NHS Healthcare Standards for prisons will be an important development and these will support wider performance management processes.

3.14 In the interim, it is worth noting that in terms of complaints received from prisoners regarding healthcare, there have been 33 for the 4 month period from 1 November to 29 February. The previous numbers of complaints received by healthcare prior to transfer were in the region of 60-80 per month, therefore there has been a significant reduction in the overall number of complaints.

3.15 A visit to each of the prisons by the Chief Executive of NHS Lothian is planned for 21 and 23 March in order to meet healthcare staff and the prison governors. This will also provide the opportunity to see and hear how the prison transfer has been progressed within Lothian.

4 Key Risks

4.1 Key risks associated with policy review are transitional and it is anticipated they will be removed from the prison service Operational Risk Register within 12 months, as the services become fully embedded within NHS Lothian.

4.2 Other risks to note include a potential financial risk for 2012/13 since this will be the first full year of operation and since Agenda for Change assimilation of the staff is not complete.

4.3 Both these risks are being actively managed.

5 Risk Register

5.1 Identified risks associated with the transition are included and managed through the Operational Prison Healthcare Risk register and East Lothian CHP has an overall risk regarding the prison service on its risk register.

6 Impact on Health Inequalities

6.1 The NHS Lothian Impact assessment toolkit has included prisoners since 2002. 29 impact assessments (out of 90 carried out across the organisation between February and December 2011) have been identified as having a potential impact on either prisoners and/or prison healthcare staff. These include policies such as the Adult Protection Policy, Death in Hospital Policy and Risk Policy, and plans including the Arts & Health Strategy and Clinical Strategy. In each case actions
have been recommended and followed up as appropriate. In addition to these, an impact assessment has been carried out to examine the overall range of plans and policies affected by the prison healthcare transfer programme.

7 Impact on Inequalities

7.1 The findings of the impact assessment identified the need to ensure there is robust information gathering processes in place to capture information on patient ethnicity and age – this will be supported through the implementation of the Vision IT system in May. There are also potential issues over access to healthcare within the prison setting for particular prisoner groups, such as those requiring protection and sex offenders, which require further investigation. The impact on staff was, in the main, very positive, with far greater access to information, support and professional development.

8 Involving People

8.1 All work has been completed in partnership. Prisoner forums exist in both prisons and any future service development or policy consultation will make use of this existing infrastructure.

9 Resource Implications

9.1 There are no immediate resource implications of the issues covered in this paper.

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20 March 2012
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NHS LOTHIAN

Board Meeting
28 March 2012

Director of Finance (Executive Lead)

FINANCIAL POSITION TO 31 JANUARY 2012

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 ten months of the financial year 2011/12.

1.2 Any member wishing additional information on the detail of this paper should be raised with the Executive Lead prior to the meeting.

2 Recommendation

2.1 Members of the Board are recommended to

- Note the continued forecast of breakeven for the financial year 2011/12
- The continued actions to deliver increased level of recurrent savings from the 2011/12 targets and minimising the carry forward into 2012/13’s financial plan

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an over spend of £0.22m for the first ten months of financial year 2011/12, a favourable movement in the month of £0.81m This reflects under delivery of £2.172m against the Local Reinvestment Plan (LRP) target (also referred to as efficiency target) offset by a £1.95m under spend on other budgets.

3.2 Breakeven performance on core and non-core expenditure is anticipated for the financial year to 31 March 2012, however a review of the position to the end of January indicates that there may indeed be an under spend for the year. A weekly review of the position is being undertaken by the Director of Finance, as we approach the end of the financial year.

3.3 The month 10 results are summarised in Table 1 below:
### Table 1 – Financial Position to 31st January 2012

<table>
<thead>
<tr>
<th></th>
<th>Total £k</th>
<th>Outstanding Efficiency Savings £k</th>
<th>Net of Efficiency Savings £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospitals Division</td>
<td>753</td>
<td>6</td>
<td>747</td>
</tr>
<tr>
<td>CH(C)Ps</td>
<td>(2,574)</td>
<td>(1,501)</td>
<td>(1,073)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(794)</td>
<td>0</td>
<td>(794)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>207</td>
<td>(677)</td>
<td>884</td>
</tr>
<tr>
<td>Non recurring flexibility</td>
<td>2,190</td>
<td>0</td>
<td>2,190</td>
</tr>
<tr>
<td>Under/(Over)spend</td>
<td>(218)</td>
<td>(2,172)</td>
<td>1,954</td>
</tr>
</tbody>
</table>

3.4 In looking toward 2012/13, the Draft Financial Plan was considered by the Finance & Performance Review Committee during February. This was shared with the Scottish Government Health Directorates, in line with the timetable for submission of the Draft Local Delivery Plan. A response has been received from SGHD on the Draft Financial Plan; the comments are largely seeking clarity on assumptions and minor presentational issues. These will be considered as part of the ongoing refinement of the Financial Plan, which will be resubmitted to the Finance & Performance Review Committee for final sign off in April, with Board approval being sought in May.

**University Hospitals Division**

3.5 The University Hospitals Division is reporting net expenditure of £0.753m under budget for the first ten months: an under spend of £3.048m against baseline budgets; over achievement of £0.006m against the agreed LRP target; a shortfall of £1.921m against local Divisional savings, and an overspend of £0.380m in relation to Waiting Times. The month included one off reductions in monthly pay costs which reflects the November 2011 strike action.

3.6 Work is ongoing to manage financial performance, particularly the impact of the waiting times and capacity issue.

3.7 The Division has delivered £18.34m (68%) of its annual efficiency target after 10 months. However, significant additional work remains in progress to secure more substantial recurrent delivery of these savings.

3.8 Subject to the LRP and the continuing Waiting Times target risks that have attracted increasing senior management focus, the Division anticipates being able to deliver breakeven against the baseline budget by the year end.

**Primary and Community**

3.9 The CHPs / CHCP / Primary Care services are reporting a net overspend of £2.574m for the period, an adverse underlying movement of £0.237m in the month. Consistent with previous months, this predominantly relates to prescribing, with the balance in core and hosted services across all CHP/CHCPs, with the exception of West Lothian which has balanced its prescribing overspend with HCH underspends.
3.10 The prescribing recovery plan in place across the CHPs concentrates on tackling the remaining issues of unmet savings and increased volumes. The pricing position has been supported by additional non recurring flexibility agreed as part of the Mid Year Review process. The CHPs are also providing additional support from their own resources arising from their month 10 reforecast.

3.11 The overall HCH position continued to improve in the month. However there remain issues relating to community premises’ costs and mental health staffing.

3.12 Slippage on the LRP target is largely attributable to the Edinburgh CHP and Prescribing. Within all CHP/CHCPs there is still £2.78m 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 75% of the current plan slippage.

**Corporate Budgets**

3.13 Corporate Budgets are underspent by £0.207m for the period; whilst absorbing slippage of £0.677m on LRP schemes.

3.14 As highlighted in previous months, the main issues with baseline budget performance are continuing overspends within Estates (particularly Facilities Management for rent, rates and transport costs). These and the LRP slippage are currently offset by the financial impact of departmental underspending in Pharmacy, Planning and Nursing related principally to unfilled staff vacancies. Some in month unanticipated variability in telecoms costs was experienced by e-Health during the month.

3.15 In relation to delivery of LRP savings targets, the Mid Year Review forecast indicates full achievement in all areas, with the exception of Facilities and HR (combined £1m anticipated slippage). It should be noted that the shortfall on HR savings relates entirely to the Occupational Health Service. Work is continuing within these areas in particular to identify additional schemes to meet the in year shortfall on a non recurring basis and to address the potential impact of targets carrying forward into 2012/13.

**Strategic Budgets**

3.16 There is a £0.794m overspend against Strategic Budgets for the period to date, which is largely related to UNPAC costs of the high cost psychiatric / learning disability cases (£2.182m), offset by a number of non recurring benefits including extra recoveries on clinical claim legal costs (£1.235m).

**Efficiency & Productivity**

3.17 As highlighted below, £32.5m of savings have been achieved for the year to date. The full year effect of the schemes generating these savings is in the region of £44.5m, and this is underpinned by 427 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 - Jan Target £000</th>
<th>April – Jan Actual £000</th>
<th>Slippage £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHD</td>
<td>26,840</td>
<td>25,840</td>
<td>18,339</td>
<td>18,345</td>
<td>6</td>
</tr>
<tr>
<td>CH(C)Ps/PCCO</td>
<td>14,514</td>
<td>14,507</td>
<td>9,478</td>
<td>7,977</td>
<td>(1,501)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>7,005</td>
<td>7,005</td>
<td>5,407</td>
<td>4,730</td>
<td>(677)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>1,771</td>
<td>1,771</td>
<td>1,476</td>
<td>1,476</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>34,700</strong></td>
<td><strong>32,528</strong></td>
<td><strong>(2,172)</strong></td>
</tr>
</tbody>
</table>

Capital

3.18 Expenditure of £55m has been incurred to the end of January 2012 against the capital investment programme for the year. Major areas of core spending include: the Royal Victoria Building (£21.1m); Musselburgh Primary Care Centre (£9.8m); Chalmers Sexual Health Centre (£1m); Dalkeith Medical Centre (£2.2m); Medical Equipment (£4.3m); the birthing suite at the Royal Infirmary of Edinburgh (£2.2m), and development expenditure of £5.6m on the new Royal Hospital for Sick Children at Little France. Details of the expenditure and year end projection are on Appendix 2.

Prompt Payment Performance

3.19 Payments within 30 days by volume and value for the 10-month period to 31 January were at 89% (unchanged from last month) and 79% (down 3%) respectively. Payments within 10 days by volume and value are at 62% (down 1%) and 52% (down 1%) respectively. Average period of credit taken remained steady at 23 days.

Activity Information

3.20 Activity information is now being separately reported, in line with EMT request.

4 Key Risks

4.1 The key risks in relation to the delivery of the break even forecast are:

- delivery of recurrent LRP schemes to minimise carry forward into the 2012/12 planning cycle
- Management of the financial effect of any recurrent shortfall in LRP delivery through non-recurrent savings’ and cost recovery plans
- Continued management of the financial exposure on waiting times’ related additional activity delivery

These issues are highlighted in the reports on Divisional areas and within the section on Efficiency and Productivity and are the subject of specific delivery workstreams and action by local clinical management teams.
5 **Risk Register**

5.1 There are no further implications for the Board Risk Register which already includes management of the Board financial position and the mechanisms for management of these risks.

6 **Health and Other Inequalities**

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 **Involving People**

7.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

8 **Resource Implications**

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith  
Director of Finance  
6 March 2012

**List of Appendices**

Appendix 2: Capital Expenditure Analysis
NHS Lothian Expenditure Summary April 2011 - January 2012
APPENDIX 1

<table>
<thead>
<tr>
<th>Division</th>
<th>Annual Budget 2011-12</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNIVERSE HOSPITAL DIVISION</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Medical</td>
<td>121,434</td>
<td>99,356</td>
<td>100,433</td>
<td>(1,077)</td>
</tr>
<tr>
<td>REAS &amp; MOE</td>
<td>66,419</td>
<td>54,483</td>
<td>54,966</td>
<td>(483)</td>
</tr>
<tr>
<td>Surgical</td>
<td>75,536</td>
<td>62,698</td>
<td>63,069</td>
<td>(371)</td>
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<tr>
<td>Labs, A&amp;T, Critical Care, HDSU</td>
<td>116,990</td>
<td>97,354</td>
<td>96,322</td>
<td>1,032</td>
</tr>
<tr>
<td>Women &amp; Children &amp; Neuroscience</td>
<td>89,359</td>
<td>73,028</td>
<td>72,265</td>
<td>762</td>
</tr>
<tr>
<td>Radiology, Cancer &amp; Head &amp; Neck</td>
<td>97,755</td>
<td>81,067</td>
<td>79,906</td>
<td>1,161</td>
</tr>
<tr>
<td>Corporate</td>
<td>20,141</td>
<td>9,912</td>
<td>10,183</td>
<td>(271)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>587,633</td>
<td>477,897</td>
<td>477,144</td>
<td>753</td>
</tr>
<tr>
<td>CHCP/CHPs/PCCO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>63,005</td>
<td>54,373</td>
<td>54,931</td>
<td>(558)</td>
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<td>Edinburgh CHP</td>
<td>244,474</td>
<td>205,981</td>
<td>207,652</td>
<td>(1,672)</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>69,289</td>
<td>58,429</td>
<td>58,790</td>
<td>(362)</td>
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<tr>
<td>West Lothian CHP</td>
<td>96,015</td>
<td>77,761</td>
<td>77,760</td>
<td>1</td>
</tr>
<tr>
<td>PCCO</td>
<td>10,948</td>
<td>(4,292)</td>
<td>(4,307)</td>
<td>16</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>483,730</td>
<td>392,252</td>
<td>394,826</td>
<td>(2,574)</td>
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<tr>
<td>STRATEGIC BUDGETS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLAs/UNPACs/Non Contract Activity</td>
<td>10,104</td>
<td>8,477</td>
<td>10,658</td>
<td>(2,182)</td>
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<tr>
<td>Capital charges and Asset Impairments</td>
<td>52,564</td>
<td>31,842</td>
<td>31,841</td>
<td>1</td>
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<tr>
<td>Provisions for Pension Costs and Claims</td>
<td>14,547</td>
<td>4,371</td>
<td>3,136</td>
<td>1,235</td>
</tr>
<tr>
<td>Commissioning from 3rd Sector</td>
<td>12,968</td>
<td>11,984</td>
<td>11,947</td>
<td>37</td>
</tr>
<tr>
<td>Reserves and Uncommitted Allocations</td>
<td>13,246</td>
<td>(2,011)</td>
<td>(2,126)</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>103,430</td>
<td>54,662</td>
<td>55,456</td>
<td>(794)</td>
</tr>
<tr>
<td>CORPORATE BUDGETS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive's Department</td>
<td>532</td>
<td>437</td>
<td>425</td>
<td>12</td>
</tr>
<tr>
<td>Medical Director</td>
<td>997</td>
<td>515</td>
<td>436</td>
<td>80</td>
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<tr>
<td>Consort</td>
<td>43,535</td>
<td>36,366</td>
<td>36,459</td>
<td>(93)</td>
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<td>Communications</td>
<td>600</td>
<td>498</td>
<td>505</td>
<td>(7)</td>
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<tr>
<td>Ehealth</td>
<td>25,948</td>
<td>18,609</td>
<td>18,663</td>
<td>(54)</td>
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<tr>
<td>Facilities Management</td>
<td>77,505</td>
<td>63,386</td>
<td>64,432</td>
<td>(1,045)</td>
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<tr>
<td>Finance and capital planning</td>
<td>10,928</td>
<td>9,056</td>
<td>8,904</td>
<td>153</td>
</tr>
<tr>
<td>Human Resources &amp; OH&amp;S</td>
<td>10,467</td>
<td>8,086</td>
<td>8,065</td>
<td>21</td>
</tr>
<tr>
<td>Nursing</td>
<td>4,669</td>
<td>2,644</td>
<td>2,477</td>
<td>166</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12,246</td>
<td>9,957</td>
<td>9,431</td>
<td>527</td>
</tr>
<tr>
<td>Planning</td>
<td>3,223</td>
<td>2,550</td>
<td>2,277</td>
<td>273</td>
</tr>
<tr>
<td>Public Health</td>
<td>3,933</td>
<td>3,050</td>
<td>2,882</td>
<td>167</td>
</tr>
<tr>
<td>Other</td>
<td>(348)</td>
<td>(427)</td>
<td>(435)</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>194,235</td>
<td>154,727</td>
<td>154,520</td>
<td>207</td>
</tr>
<tr>
<td>Non recurring benefits</td>
<td>3,660</td>
<td>2,190</td>
<td>0</td>
<td>2,190</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,372,689</td>
<td>1,081,727</td>
<td>1,081,945</td>
<td>(218)</td>
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</table>
### Schemes with Specific Funding

<table>
<thead>
<tr>
<th>Scheme</th>
<th>2011/12 Expenditure Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital</td>
<td>£23.623</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>£11.574</td>
</tr>
<tr>
<td>Dalkeith Medical Centre</td>
<td>£2.186</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>£1.000</td>
</tr>
<tr>
<td>Pharmacy Modernisation</td>
<td>£0.013</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>£0.349</td>
</tr>
<tr>
<td>Radiotherapy - Phase 6</td>
<td>£0.052</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>£1.649</td>
</tr>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>£0.290</td>
</tr>
<tr>
<td>Radiotherapy-Other</td>
<td>£0.032</td>
</tr>
<tr>
<td>Gullane Medical Centre</td>
<td>£0.830</td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>£0.060</td>
</tr>
<tr>
<td>Specialist Services and Genetics</td>
<td>£0.252</td>
</tr>
<tr>
<td>Purchase of Items for Cancer Treatments</td>
<td>£0.265</td>
</tr>
<tr>
<td>Prison Transfer of Assets</td>
<td>£0.021</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>£4.467</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£46.662</strong></td>
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</tbody>
</table>

### Formula Programme

<table>
<thead>
<tr>
<th>Programme</th>
<th>2011/12 Expenditure Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Compliance</td>
<td>£2.086</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>£5.049</td>
</tr>
<tr>
<td>E-Health Strategic Priorities</td>
<td>£2.356</td>
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<tr>
<td>National PACS Refresh 2007-17</td>
<td>£0.129</td>
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<tr>
<td>Traffic management</td>
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</tr>
<tr>
<td>Expansion of renal capacity RIE</td>
<td>£1.050</td>
</tr>
<tr>
<td>Chemotherapy e-Prescribing &amp; Administration System (CePAS)</td>
<td>£0.133</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>£0.302</td>
</tr>
<tr>
<td>Observation Ward A&amp;E Rie</td>
<td>£0.213</td>
</tr>
<tr>
<td>Management of Finance Leases</td>
<td>£0.432</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>£6.799</td>
</tr>
<tr>
<td>Birthing suite (RIE)</td>
<td>£2.052</td>
</tr>
<tr>
<td>MCH Equipment</td>
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<td>MCH Capital Grants</td>
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<td>Maternity Unit (SJH)</td>
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<td>Tranent</td>
<td>£0.100</td>
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<tr>
<td>Speech Recognition</td>
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<tr>
<td>HEI</td>
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<tr>
<td>Completed Schemes under Review</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>£21.655</strong></td>
</tr>
<tr>
<td>Other sources of funding</td>
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</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>2nd Breast Cancer Theatre Unit WGH</td>
<td>0.377</td>
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<tr>
<td>Specific Allocations</td>
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<tr>
<td>Chalmers</td>
<td>1.147</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>2.051</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>70.367</strong></td>
</tr>
</tbody>
</table>
1 Purpose of the Report
1.1 The purpose of this report is to update the Board on the current situation with waiting times in Lothian.

Any member wishing additional information should contact either of the Executive Leads in advance of the meeting.

2 Recommendations

It asked that the Board:

2.1 Accept this update on the current position; and

2.2 Support steps being taken to support ongoing recovery.

3 Inpatient Waiting Times in Lothian

3.1 As reported to the Board previously, the number of inpatients waiting over 9 weeks for treatment increased following the change in the practice of applying suspensions that occurred once the offer of treatment in England was ended by Deputy Chief Operating Officer in October and following the review carried out by the Medical Director.

3.2 The reported trend in the total size of the waiting list, suspensions and those waiting over 9 weeks is outlined in the following figure.
3.3 Board members will note that at aggregate level while the overall size of the list has reduced, the number of patients waiting longer than 9 weeks has increased until the end of January, reaching 3327. Provisional information show that the numbers over 9 weeks dropped in February and are anticipated to fall further by the end of March.

3.4 At January’s board meeting the Chief Operating Officer indicated that this number could fall to 1800 by the end of this month. This is not now expected as the level of capacity required to address the change in suspension practice is much greater than was anticipated.

3.5 In November 2011 as waiting times reported in Lothian lengthened leading to breaches of the inpatient and outpatient targets, the Chief Operating Officer and the Assistant Director of Strategic Planning made an assessment of the capacity required to recover the position ensuring that patients were treated within appropriate timescales and in line with the standards set out by the Scottish Government. The change in suspension levels went beyond that which was anticipated leading to a larger volume of patients needing to be treated.

3.6 Contemporary suspension levels shifted from 30% of patients (3632) in September to 12% (1383) provisionally in February with those waiting over 9 weeks increasing to 3142. A suspension rate of 12% is below that reported by any Board in the most recent ISD publication.
4 Activity to Date

Internal Activity
4.1 Additional sessions were established across sites to support the required activity. The plans included opening up an additional theatre on both WGH and RIE sites as well as bringing a vanguard theatre on site to St John’s and running additional weekend sessions on each site.

4.2 The use of this capacity is supported through local teams focusing on 6-4-2-1 to maximize the use of facility. This process is used to minimise the impact of lost sessions caused by consultant leave by offering them to other operators initially within that speciality before offering them to other specialities. These increased sessions are anticipated to have supported an additional 1000 patients by the end of March.

External Capacity
4.3 Between November and March, NHS Lothian was engaged with a number of external hospitals to provide capacity. NHS Borders, Fife and Dumfries and Galloway were able to provide some capacity to allow some NHS Lothian patients to be seen. Furthermore Golden Jubilee National Hospital in Clydebank increased the number of patients able to be seen from Lothian to allow waits to be reduced.

A number of independent hospitals also provided capacity to bring down waiting times - Spire Murrayfield in Edinburgh and Ross Hall and Nuffield Hospitals in Glasgow. In order to ensure that appropriate clinical governance checks are in place to be assured that patients receive appropriate care, UHD’s Associate Director of Nursing has undertaken to visits to the establishments where NHS Lothian has not had a relationship recently.

Jackie Sansbury
Chief Operating Officer, UHD
21 March 2012
jackie.sansbury@nhslothian.scot.nhs.uk

Susan Goldsmith
Director of Finance
susan.goldsmith@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
28 March 2012

Medical Director (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 January and February 2012 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 (non-x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>107</td>
<td>60</td>
<td>47</td>
<td>13</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>February</td>
<td>113</td>
<td>68</td>
<td>45</td>
<td>6</td>
<td>3</td>
<td>26</td>
</tr>
</tbody>
</table>

3.3 At census point in January, NHS Lothian reported significant improvements in reducing the number of patients delayed with 60 patients delayed overall, which is a reduction on the 80 reported delays in December. The local target of 66 delays was achieved. With 13 delays, the national target of no delays over 6 weeks was not achieved across the Lothian Partnership area; however it is a significant improvement on the 27 delays over 6 weeks reported in December.
3.4 Unfortunately, this good performance in January was not sustained in February, with 68 patients delayed overall. However, there was a reduction in the number of Lothian patients delayed over 6 weeks to six, down from 13 in January.

3.5 The table below sets out the performance across the Partnership areas for January and February. 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>Jan</td>
<td>Feb</td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td>Overall</td>
<td>46</td>
<td>48</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Over 6 weeks</td>
<td>12</td>
<td>&lt;5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Short Stay</td>
<td>≤5</td>
<td>≤5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

3.6 In Edinburgh the local target of 48 was achieved in January and February with the partnership reporting 46 and 48 respectively. In terms of patients delayed over 6 weeks, Edinburgh reported 12 patients in January and five in February. Edinburgh continues to drive forward a range of actions and they are in the process of recruiting additional home care staff (by end of April) that will deliver an additional 1,400 hours on top of the 48,000 hours a month currently provided.

3.7 Whilst performance on the overall number of delays is still variable across East Lothian and Midlothian, there continues to be consistent progress being made in East Lothian and Midlothian in tackling delays of over 6 weeks. This has resulted in both areas delivering against the national standard of no delays over 6 weeks since April 2011.

3.8 West Lothian continues to have no patients delayed in both January and February.

3.9 Whilst performance based on ISD reporting processes has shown improvements, there are still significant pressures within the hospital system due to increased numbers of patients delayed. The graph below presents the information relating to the number of overall delays within the hospital system and the number of delays which are reported to ISD based on the national reporting rules.
3.10 It is clear from the graph there are significantly more patients delayed than is reported each month and this is due to the application of the ISD reporting rules. This allows for exclusions for the following reasons:

- Patients who have been declared a delay within three working days of census
- Patients who are due to be discharged up to three days after census
- Patients who are temporarily ‘unwell’ for more than three days on census day
- Patients who require NHS long term care
- Patients on a ward affected by infection control restrictions such as norovirus

3.11 NHS Lothian and Council partners continue to work collectively to reduce the overall number of delays, recognising the pressures being placed across the health and social care system.

3.12 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 January and February.

<table>
<thead>
<tr>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>Feb</td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td>Complex Codes</td>
<td>29</td>
<td>27</td>
<td>≤5</td>
</tr>
</tbody>
</table>

3.13 Overall, the number of patients coded complex remains high and work continues to find discharge solutions. There are currently 17 patients for whom guardianship orders are being sought, in order to move them onto the next stage of care. All these cases are being tracked to ensure the relevant paperwork is filled in as quickly as possible and then presented to the courts in a timely manner.

**National Picture**

3.14 NHS Lothian does continue to perform above the Scottish average on its overall delays, compared as a ratio per 100,000 population. The latest national comparative figures are from January 2012 and as can be see from the following table Lothian sits 4th of the mainland Boards.

<table>
<thead>
<tr>
<th>NHS Board area of treatment</th>
<th>Number of delays per 100,000 population</th>
<th>Number of &gt;5 week delays per 100,000 population</th>
<th>Population</th>
<th>Total</th>
<th>Number outwith the six week discharge planning period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>0.0</td>
<td>0.0</td>
<td>22,400</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>2.0</td>
<td>0.0</td>
<td>148,193</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Western Isles</td>
<td>3.8</td>
<td>0.0</td>
<td>26,190</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Orkney</td>
<td>5.0</td>
<td>0.0</td>
<td>20,113</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Orkney</td>
<td>6.7</td>
<td>0.0</td>
<td>550,820</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Borders</td>
<td>7.1</td>
<td>0.0</td>
<td>112,873</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Lothian</td>
<td>7.2</td>
<td>1.6</td>
<td>806,711</td>
<td>60</td>
<td>13</td>
</tr>
<tr>
<td>Highland</td>
<td>9.3</td>
<td>2.3</td>
<td>310,830</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>16.0</td>
<td>0.9</td>
<td>582,477</td>
<td>56</td>
<td>5</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>16.1</td>
<td>0.0</td>
<td>368,860</td>
<td>37</td>
<td>3</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>16.6</td>
<td>0.0</td>
<td>299,368</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>Scotland</td>
<td>16.9</td>
<td>1.0</td>
<td>5,222,100</td>
<td>57</td>
<td>54</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>15.2</td>
<td>1.3</td>
<td>1,200,370</td>
<td>183</td>
<td>16</td>
</tr>
<tr>
<td>Tayside</td>
<td>15.4</td>
<td>0.5</td>
<td>402,841</td>
<td>62</td>
<td>2</td>
</tr>
<tr>
<td>Fife</td>
<td>17.5</td>
<td>2.7</td>
<td>364,345</td>
<td>64</td>
<td>10</td>
</tr>
</tbody>
</table>
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.

Dr. David Farquharson
Medical Director
9 March 2012
David.Farquharson@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note and support the recommendations below.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Support the continuation of the weekly Planning Group Meetings mentioned below.

2.2 Support the implementation of recommendations and actions from these meetings.

2.3 Support the additional efforts to recruit consultant paediatricians to permanent posts at St John’s.

2.4 Support the employment of NHS Lothian medical and nursing staff as internal locums at enhanced rates of pay as per the relevant Terms and Conditions of Service.

2.5 Support the employment of agency medical staff when required and available to support the middle grade paediatric rota at St John’s.

2.6 Support internal communication with the staff affected at St Johns about the action being taken to sustain the service.

2.7 Support a programme of communication and business continuity planning with the Scottish Ambulance Service (SAS) and NHS 24.

2.8 Support business continuity planning involving the Royal Hospital for Sick Children (RHSC), neonatal and obstetric services at the Royal Infirmary of Edinburgh (RIE), the Lothian Unscheduled Care Service (LUCS) and West Lothian Community Health and Care Partnership.
3 Discussion of Key Issues

3.1 There have been serious staffing challenges in medical paediatrics across Scotland and the United Kingdom (UK) since 2008. These have been caused by a number of factors including the full implementation of the European Working Time Directive (EWTD) in 2009, a high level of maternity leave among trainees, less than full time working, out of programme training and the number of sites requiring 24/7 cover by resident middle grade (experienced registrar) paediatricians. Within the South East Scotland and Lothian these pressures have been managed by close collaboration between Boards and the Deanery to maximise the available staffing. Measures taken include

**January 2009** A bid was submitted to the NHS Lothian Planning Group for funding to recruit Specialty Doctors to contribute to the middle grade rota at St John’s was supported, but there were no applicants.

**Spring 2009** With the support of the Postgraduate Dean, trainees worked extra hours and carried out some out of hours shifts on a different site from their training location. This was prior to prior to full implementation of the EWTD in August 2009.

**March 2009** Approval to appoint an additional consultant paediatricians at St John’s and one at the Royal Hospital for Sick Children (RHSC).

**2009** St John’s consultant paediatricians’ job plans were changed to include a 16.00 – 20.30 hours evening session, Monday to Friday.

**July 2009** A new consultant paediatrician took up post at St John’s. Further Specialty Doctor advertisements placed. No applicants.

**September 2009** Paediatric Nurse from St John’s funded to attend John Moore’s University, Liverpool for Advanced Nurse Practitioner (ANP) training.

**January 2010** Further job plan changes so that consultant paediatricians at St John’s could run a ‘consultant of the week’ rota, to improve continuity of care given the gaps in middle grade staffing.

**Spring 2010** Further advertisements for Specialty Doctors at St John’s. No suitable applicants.

**April 2010** The University Hospitals Division Senior Management team supported a proposal to develop an advanced neonatal nurse practitioner (ANNP) model to cover the Special Care Baby Unit (SCBU) at St John’s and an advanced nurse practitioner (ANP) model to support the Children’s’ Ward.

**August 2010** Advertisement for three ANNP trainees. Two were recruited (one later withdrew because of ill health).

**2010 – 2011** National Delivery Plan investment in training for nurses at St John’s to enhance skills in continuous positive airway pressure (CPAP) respiratory support and associated care of acutely ill children

**Summer/Autumn 2011** Advertisements for two Specialty Doctors to work at St John’s. No suitable applicants. National advertisements placed for four fully trained ANNPs – no applicants.

Throughout this time, the service has also used internal and external locums to cover unfilled middle grade shifts and has relied heavily on some of the consultants at St John’s to ‘act down’ and provide resident on-call cover for the middle grade rota (paid at treble time).
3.2 Children’s Services in West Lothian comprise

**Children’s Ward at St Johns**

Fourteen inpatient beds and a six bedded bay used as assessment unit for ambulatory patients referred from A&E, primary care or the LUHS.

**Activity**

**General acute paediatrics**

Paediatric surgical day case activity ENT and plastics; general surgery planned

**Programmed investigations on a day case basis**

<table>
<thead>
<tr>
<th>Activity</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>% change 2007/08 to 2010/11</th>
<th>2011/12 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Inpatients</td>
<td>3741</td>
<td>3268</td>
<td>2741</td>
<td>2436</td>
<td>-35%</td>
<td>1574</td>
</tr>
<tr>
<td>Elective Inpatients</td>
<td>144</td>
<td>212</td>
<td>178</td>
<td>52</td>
<td>-64%</td>
<td>45</td>
</tr>
</tbody>
</table>

Emergency inpatient numbers are inflated by Assessment Unit patients- real number c1000 in 2010/11

Average length of stay in 2011 was 0.8 days.

GP Assessment Unit - 2010/11 1447 medical paediatric patients. Analysis by the Health Intelligence Unit shows that these 1447 patients are a subset of the emergency inpatients, meaning that the true number of emergency inpatients admitted to St John’s Children’s’ Ward is approximately 1000.

The GP Assessment Unit function has developed significantly over the last two years and with consultant paediatrician presence on the Ward from 08.00-20.30, this has allowed rapid access to senior medical assessment and decision making and has reduced the number of children being admitted. These patients would be more appropriately coded as ambulatory and not as inpatients as this inflates the number of emergency admissions.

The unit is supported by RHSCE which provides surgical care, sub-specialty medical paediatric care, high dependency care and intensive care. The paediatric intensive care retrieval service transfers those children requiring intensive care and many of those who require high dependency care.
Outpatients

There is a significant paediatric outpatient work load at St John’s which includes outreach of medical and surgical specialties from RHSCE. There is also provision of outpatient clinics in surrounding health centres by the Department. This activity is unaffected by staffing challenges.

Community Child Health Department

The Community Child Health Service forms part of a combined Lothian wide service. Two Consultant Community Paediatricians and a team of eight Community Child Health Doctors are based in the Department of Community Child Health at St John's Hospital. Specialist services led by consultants within the Community Child Health Department include:

- Child Development
- Physical Impairment including Neurodisability
- Communication Disorders including Autistic Spectrum Disorders
- Child Protection
- Looked After and Accommodated Children
- Learning Disability
- Visual Impairment
- Hearing Impairment
- Children with complex and exceptional healthcare needs

This service is unaffected by the current staffing challenges.

Activity for medical paediatrics and community child health delivered at St John’s Hospital and community sites is shown below;

<table>
<thead>
<tr>
<th></th>
<th>2010-11 (to end January)</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2011-12</td>
</tr>
<tr>
<td>Medical Paediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New outpatients</td>
<td>989</td>
<td>941</td>
</tr>
<tr>
<td>Return outpatients</td>
<td>3338</td>
<td>2610</td>
</tr>
<tr>
<td>Total</td>
<td><strong>4327</strong></td>
<td><strong>3551</strong></td>
</tr>
<tr>
<td>Community Child Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New outpatients</td>
<td>225</td>
<td>229</td>
</tr>
<tr>
<td>Return outpatients</td>
<td>269</td>
<td>225</td>
</tr>
<tr>
<td>Total</td>
<td><strong>494</strong></td>
<td><strong>454</strong></td>
</tr>
<tr>
<td>Combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New outpatients</td>
<td>1214</td>
<td>1170</td>
</tr>
<tr>
<td>Return outpatients</td>
<td>3607</td>
<td>2835</td>
</tr>
<tr>
<td>Total</td>
<td><strong>4821</strong></td>
<td><strong>4005</strong></td>
</tr>
</tbody>
</table>
Respite Care

Sunnadach is free standing accommodation, comprising 9 rooms, in Livingston providing inpatient respite care in the community for children with complex disabilities. Nurse led service unaffected by current staffing challenges.

Special Care Baby Unit

The Special Care Baby Unit (SCBU) has seven staffed costs with an average admission rate in 2010/11 of 10 per month. The SCBU is suitable for infants over 34 weeks gestation as there is no neonatal intensive care or invasive ventilation. Neonates requiring this are resuscitated, stabilised and transferred to RIE. The unit is supported by the regional neonatal transport service.

3.3 NHS Lothian is part of the South East Scotland training programme which treats paediatrics and neonatal services on a regional basis. During the late summer and autumn of 2011 it became apparent to the Postgraduate Dean and Training Programme Director that by the spring of 2012 there would be an unprecedented number of paediatric trainees temporarily unavailable to work in South East Scotland for reasons such as maternity leave and out of programme training to gain additional training elsewhere. It is anticipated that throughout the UK 10 to15% of trainees at any one time will be unavailable for a variety of reasons. However, the figure for South East Scotland is now 33% - more than double the UK average. This has led to 14-16 gaps in the middle grade (experienced registrar) rotas across the region. The planned reduction in the number of paediatric trainees in Scotland as a consequence of Modernising Medical Careers has not yet started. Current predictions are that the number of paediatric trainees in the SEAT regions will drop from 62 WTE to 47.25 WTE between 2012 and 2014.

On 18th January 2012 Professor Reid, Dean of Postgraduate Medicine NHS Education for Scotland SE Region decided to allocate those trainees who are available across fewer sites in the region and to remove middle grade paediatric trainees from St John's. The initial date of implementation for this measure was 01 February 2012 but after discussion with Dr Farquharson the date was put back to 11 April 2012. Professor Reid has discussed this proposal with the Scottish Government and it has the support of the General Medical Council which has overall responsibility for the governance of postgraduate medical training in the United Kingdom.

3.4 In November 2011 the South East and Tayside Regional Planning Group was informed of the situation and the Chief Executives directed that immediate efforts be made to recruit four fixed term consultant paediatricians and four fixed term consultant neonatologists for St John's to work in the middle grade resident rota and sustain the service. The posts would subsequently be made substantive. The posts closed in January 2012. There were no applicants for the neonatologist posts and three suitable applicants were short listed for the paediatric posts which were interviewed on 15 March 2012. An update on further progress on the recruitment of consultants will be available at the meeting. The consultant posts have been re-advertised on the SHOW website and in the British Medical Journal. The recruitment internet site remains active. In the event that one or more of these
applicants are appointed none are available before late summer. Appointing four would still leave gaps in the middle grade rota but with support from an ANNP and APNP already in post, previous experience suggests that these gaps would be manageable using internal locums.

3.5 Since 2009 there have also been several advertisements for specialty doctors to work in the middle grade paediatric rota at St Johns. This was repeated in late 2011. One suitable person applied and was short listed for interview but subsequently withdrew.

3.6 A number of posts for advanced neonatal nurse practitioners (ANNP) to work at St Johns as part of a combined medical and nursing rota were advertised in late 2011 with no applicants. The posts are currently being readvertised.

3.7 A number of posts for advanced paediatric nurse practitioners (APNP) to work at St Johns as part of a combined medical and nursing rota are currently being accelerated through the manpower approval process.

3.8 A Planning Group chaired by Mrs Fiona Mitchell Director of Operations for Women’s Services, Children’s Services and Neurosciences meets weekly to manage the issue of staffing the unit. The Group comprises the Associate Divisional Medical Director, the Chief Midwife, the Chief Nurse for Children’s Services, the Clinical Director of Paediatrics, the Clinical Director of Gynaecology, the Clinical Director of Obstetrics, consultant paediatricians from St John’s, a consultant neonatologist from RIE and the Clinical Nurse Managers for neonatology at RIE and St Johns.

3.9 Robust plans are now in place to maintain services at St John’s over the coming months. Work has commenced on rotas over the summer. A relatively small number of people – six consultants, an associate specialist, an advanced neonatal nurse practitioner and an advanced paediatric nurse practitioner and junior trainee – are covering the whole inpatient and outpatient service at St John’s and it is vulnerable to unplanned absences. We anticipate that as the summer progresses the number of people available to provide cover will reduce and the rota will become more vulnerable to any absences.

3.10 An opt out from the European Working Time Regulations (EWTD) to allow medical to work in excess of 48 hours a week to support the middle grade rota at St John’s has been put in place. HR colleagues are dealing with the technical aspects of this. The extra out of hours work involved will reduce day time availability of staff and in particular the number of outpatient appointments that are available.

3.11 We have obtained a Variation Order from Agenda for Change to allow ANNPs to work overtime to support the middle grade paediatric rota at St John’s. HR colleagues are dealing with the technical aspects of this.

3.12 Following a recruitment exercise, one consultant so far has been appointed with completion of training (CCT) date in mid July and we are now working on bespoke job plans for trainees who have CCT dates over the next six months in order to match them wherever possible with consultant vacancies.
3.13 At times of peak pressure and annual leave it is possible that we will find staff to cover the neonatal service 24/7 with help from medical and nursing staff at RIE but it is possible we may not be able to cover the paediatric service continuously.

4 Key Risks

4.1 An inability to staff the middle grade rota at St Johns for every shift with someone who has the necessary competencies to cover the paediatric service and the neonatal service.

4.2 Consideration should therefore be given to business continuity planning for a number of anticipated and short notice possibilities. These include closing the paediatric inpatient ward for weekends to concentrate the available resources from Monday to Friday, closing the paediatric inpatient ward and providing a five day or seven day ambulatory and assessment service from 08.00-20.00 and, in the event of not being able to cover the neonatal service, reducing the number of births at St John’s and their risk profile to a level compatible with a midwife led unit.

4.3 The patient safety risks inherent in the use for out of hours cover of external locums of unknown quality who are unfamiliar with the unit.

4.4 Loss of financial balance in Children’s Services if the service relies heavily on internal locums employed at enhanced rates and agency locums.

5 Risk Register

5.1 These risks need to be reflected in the NHS Lothian risk Register. Efforts to recruit consultants, locums, and nurse practitioners will continue throughout the Spring and early Summer to secure solutions to mitigate against the risk of disruption to paediatric & neonatal services at St John’s.

6 Impact on Health Inequalities

6.1 Given the nature of this paper there is not a requirement for an Equality and Diversity Impact Assessment. The action plans that may be required to address the areas of risk identified within this paper may require to undertake an assessment, in line with NHS Lothian policies.

7 Impact on Inequalities

7.1 Not applicable.
8 Involving People

8.1 It is the intention to put in place an opt out from EWTD to allow medical staff to work in excess of 48 hours per week.

9 Resource Implications

9.1 Four new consultants posts are costed at £480K, ongoing costs for internal and external locums have been in the region of £200K in recent years, ANNPs and APNPs at Band 8a are costed at £63,426. These costs will be partially offset by the saving on trainee bandings of £120K.

David Farquharson
Medical Director
21 March 2012
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NHS LOTHIAN LOCAL DELIVERY PLAN 2012-13

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the NHS Lothian Board approve the attached NHS Lothian Local Delivery Plan 2012-13, which has been developed with Executive Directors and Lead Officers responsible for the delivery of each of the targets.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Agree the attached Local Delivery Plan (LDP) 2012-13 for submission to the Scottish Government by 31 March 2012; and

2.2 Note that the work ongoing in relation to the finance and efficiency targets is being led by the Director of Finance and will be submitted to the Scottish Government separately.

3 Discussion of Key Issues

3.1 The NHS Lothian Local Delivery Plan 2012-13 has been developed by the Lead Officers and Directors responsible for the delivery of each of the targets. Discussions have also taken place at the Executive Management Team meetings in February and March.

3.2 Following the amendments suggested at the February EMT meeting, the draft submission was sent to the Scottish Government on 17 February. We have now received feedback from individual leads on the specific targets, which has been considered by the NHS Lothian leads and has been incorporated as appropriate into this final draft.
3.3 The following sections are included as part of the overall NHS Lothian Local Delivery Plan:
- LDP HEAT Risk Management Plans (Appendix 1)
- LDP HEAT Delivery Trajectories (Appendix 2)
- Summary of main workforce issues facing the NHS Board (Appendix 3)
- Single Outcome Agreements (x4) (Appendix 4)
- Outcomes Approach (Appendix 5)

3.3 Work is ongoing on the LDP Financial Plans and Efficiency Savings section, led by the Director of Finance.

3.4 NHS Lothian continues to support the development and delivery of the Single Outcome Agreements across the four Community Planning Partnerships. In line with previous years Local Delivery Plans, NHS Lothian has been asked to evidence the contribution to tackling critical issues linked to the social policy areas of:
- Health inequalities
- Early years
- Tackling socio-economic inequality
- Economic recovery

Appendix 4 contains the four Single Outcome Agreements for NHS Lothian council area.

3.5 The Local Delivery Plan covers a three year period, though there is an opportunity each year to review and adjust future years’ plans. For 2012/13 there are 15 targets, as detailed in the Key Risks section below.

4 Key Risks

4.1 Each of the targets identified within the Local Delivery Plan have risks associated with them as outlined in the Risk Management Plan at Appendix 1. Actions to manage each of these risks are also outlined within this document. Each Executive Director (identified in the Risk Management Plan) has responsibility for ensuring appropriate plans are in place to manage identified risks.

4.2 The following outlines the key risks and mitigation plans for each of the targets. It is important to note however that further risks associated with each of the targets are detailed in the Risk Management Plan at Appendix 1.

4.2.1 TARGET: To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

<table>
<thead>
<tr>
<th>KEY RISK</th>
<th>MITIGATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key risk is associated with: measurement (the absence of nationally agreed data definitions)</td>
<td>To allay these risks in particular we are working closely with ISD and cancer clinical audit to resolve measurement issues nationally and improve the capture, reporting and use of data locally; utilising the evidence base on socio-economic inequalities in</td>
</tr>
</tbody>
</table>
and approach to measurement)  
• achieving penetration of the programme to hard to reach groups, and to the most deprived communities and groups in Lothian  
• monitoring the impact of national social marketing campaigns on demand for diagnostic and treatment services across NHS Lothian and developing a clear picture of the anticipated changes in activity  
cancer survival to guide the development of service initiatives to be delivered as part of the Lothian Detect Cancer Early Programme\(^1\); and undertaking referrals analysis, linking closely with lead GP colleagues and Scottish Government colleagues, to assist in predicting changes in demand and the development of activity assumptions.

<table>
<thead>
<tr>
<th>4.2.2 TARGET: At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12(^{th}) week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEY RISK</strong></td>
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</table>
| Women from quintiles 4 & 5 and the hard to reach groups (e.g. vulnerable women, families, teenage pregnancy, substance using parents, women from areas of high deprivation who may not present to GP/ Midwife) who self pregnancy test may not always know or appreciate the importance of early booking within the 10-12 week window. | The following actions are underway to mitigate against this risk:  
• Increased publicity in NHS Lothian and the four Local Authority Areas, e.g. leaflets/posters re early booking and centralised bookings in all shops, environments, etc. who stock pregnancy tests. Liaison with Children and Family Centres.  
• Continue to work with GPs to improve referral before 12 weeks.  
• Education of all groups of staff and other agencies statutory and voluntary on the target and importance of early booking before 12 weeks.  
• Incorporate into Children and Young Peoples Integrated Children’s Services Priorities – “Best Possible Start” within local SOAs.  
• Education of young women within family planning services, schools and colleges / universities in the importance of early booking and antenatal assessment and care.  
• Explore the use of drop in clinics in hard to reach areas/access points. |

4.2.3 **TARGET:** Reduce suicide rate between 2002 and 2013 by 20%

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| Not all people who attempt or complete suicide are known to health services. | - The Lothian Joint Mental Health and wellbeing team draws together work to reduce suicide and to increase the range of individuals and communities with a greater understanding of risks to mental health.  
- The lack of contact with services for some who attempt or complete suicide has been built into our revised policy and review process as agreed by our Healthcare Governance and Risk Management Committee.  
- Implemented a suicide review for every suicide in Lothian regardless of contact with health services. This is an opportunity to learn from and improve practice.  
- Ensure appropriate capacity for Alcohol and Drug Liaison services. |

4.2.4 **TARGET:** To achieve 14,910 completed child health weight interventions over the three years ending March 2014

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| **Treatment:** during 2011 the number of complex referrals to the Get Going programme has increased substantially. This includes children, young people and parents / carers with psychosocial problems and other comorbidities. These complex cases were not witnessed in the initial piloting of the Get Going programme. | - The dietician and clinical psychologist supporting the ‘Get Going’ programme have had their hours increased to provide more support to families and coaches, including debriefing sessions. Clinical support is essential for safe delivery of the programme.  
- The referral and care pathways and supporting documentation for the Get Going programme are being revised to allow for screening and triage of referrals.  
- Enhanced child protection training is being provided for Get Going coaches through the clinical psychology team. |
| **Health improvement:** Of the schools and nurseries recruited to take part in the Healthy Families, Healthy Children programme, mainly in multiply deprived areas of Lothian, it is anticipated that around 25% of these children will be overweight or obese. Inclusion towards the HEAT target requires | - The “opt out” rather than “opt in” approach has been used in other parts of Scotland and is likely to maximise uptake. An “opt out” letter was agreed with local authority leads and has been sent out by each of the participating schools two weeks before the measurements are due to be taken.  
- Preparatory work with schools, through the involvement of Public Health, Health Promotion, School Nursing, and local authority leads, has ensured a good relationship with schools, a relationship that has developed |
participation in six out of eight of the sessions, and height and weights recorded at the start and completion of the programme. Parents can opt their children out of the height and weight measurements. If substantial numbers of overweight and obese children are opted out or do not take part in the required number of sessions, then that could impact on the ability to meet the HEAT target.

Further through the delivery of CPD sessions by Health Promotion staff.

- The school-based programme has been developed to meet Curriculum for Excellence Health and Wellbeing Experiences and Outcomes and sent to each class teacher on a CD ROM. The resources have been developed in close collaboration between Health Promotion and teaching staff. Schools have been confident to deliver classes that meet the requirements of the curriculum and they have been given the freedom to use their own approaches as long as they meet the overall requirements of the eight session programme. This has ensured a high level of trust between schools, local authorities and NHS Lothian and has led to an excellent level of uptake.

### 4.2.5 TARGET: NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014

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| Services may not attract the numbers of clients required to achieve the target. As prevalence reduces it becomes increasing challenging to attract smokers. Additionally, the impact of the economic downturn on tobacco misuse may change aspects of people’s lifestyle in unpredictable ways and have a direct impact on self-esteem, mental health and general well-being. | • NHS Lothian plans to continue with its strategy of increasing accessibility to its stop smoking services and in particular targeting services to those most in need, e.g. pregnant women, those with mental health issues and chronic disease.  
• NHS Lothian continues with an advertising strategy that includes leaflets and posters, press and bus advertising. We also carry out recruiting activity in local shopping centres and supermarkets, targeting those used most frequently by those form disadvantaged groups with high smoking rates.  
• We continue to provide raising the issue of smoking training to all healthcare professionals and local authorities to encourage referrals to the service. |

### 4.2.6 TARGET: At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014

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<tr>
<th>KEY RISK</th>
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<tr>
<td>Ensuring GDPs embrace the Childsmile element of the SDR and apply varnish at the anticipated rate.</td>
<td>Childsmile Co-ordinators to work closely with GDPs to support, encourage and facilitate participation in programme.</td>
</tr>
</tbody>
</table>
4.2.7 TARGET: NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009

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<tr>
<td>The key risk with these targets is the time to deliver as this is a 20 year programme which is linked to the Climate Change Bill; this states that by 2050 Scotland will decrease its Carbon Footprint by 80%.</td>
<td>To support the delivery of this programme we are identifying measures to reduce our carbon emissions; we will also be developing a suitable investment programme to align with the timescale and a suitable performance measure to ensure we remain on track.</td>
</tr>
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4.2.8 TARGET: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

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<tr>
<td>The key risk for the delivery of this target is to ensure there is sustained increase in service capacity.</td>
<td><strong>Statutory and 3rd sector services were engaged in redesign process through local ADPs and will be involved in planned service developments to ensure that model is owned by services and is sustainable.</strong>&lt;br&gt;<strong>Clinical leadership capacity was increased in 2010 to drive redesign and ADPs are sustaining this capacity.</strong>&lt;br&gt;<strong>Additional CPN capacity funded to support current workforce to redesign service to improve efficiency.</strong>&lt;br&gt;<strong>Additional capacity in 3rd sector services to match increases in demand. This funding will be sustained in 2012.</strong>&lt;br&gt;<strong>Inefficiencies in existing services have been identified using a LEAN approach. These have been removed through system redesign.</strong>&lt;br&gt;<strong>Strong financial governance in place between NHS Lothian and Councils over application of the Scottish Government funding enables ADPs to plan effective.</strong></td>
</tr>
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</table>

4.2.9 TARGET: Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) from March 2013; reducing to 18 weeks by December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014

<table>
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<tr>
<td>There is a need to recognise and continue to plan for greater levels of</td>
<td><strong>In line with Early Intervention, continue to provide funding to Place2Be in order to provide early counselling interventions in primary schools, to</strong></td>
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6
case complexity in children and young people with high levels of need. | reduce the potential for onward referral to CAMHS.
- Continued working with staff in the four local authorities and voluntary organisations to provide support to vulnerable groups as early as possible.
- Undertake an equality audit under the auspices of LIPKAP
- Monitor uptake by condition, socio-economic group, area and equality group

Increased demand for psychological therapies. | Continued approach of using the evidence base of “what works for whom”.
- Providing a range of social prescribing alternatives available to GPs.
- Review threshold for referrals to secondary mental health and learning disabilities services.

4.2.10 TARGET: Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15

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<tr>
<td>The system wide Reshaping Care for Older People work streams need to deliver the required changes to support the inpatient bed day rate.</td>
<td>Change Fund allocations to March 2015 will provide a catalyst for sustainable change and review of progress against the target needs to be a key metric for all partnerships.</td>
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4.2.11 TARGET: No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015

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<tr>
<td>The delivery of the existing national target of 42 days is currently proving challenging to some of the Councils in the Lothian Partnership, therefore the move to 28 days will create additional pressures.</td>
<td>This will be addressed through an increased focus on providing preventative care interventions to reduce unnecessary admissions to hospital along with community-based support to facilitate earlier discharge in order to achieve the planned reductions in the length of stay. This will be supported through the move towards integration between health and social care which will support the development of integrated budgets, with the focus on the patient rather than the service. There will also be actions to continually review all delays but also to focus on those patients waiting for packages of care of less than 14 hours; care at home as well as those on the rehabilitation list who could be supported at home. In addition we will continue to focus on the reduction in the length of time to process complex cases, including guardianship cases.</td>
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4.2.12 **TARGET:** To improve stroke care, 90% of all patient admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013

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| The key risk with this target is ensuring patients are diagnosed quickly (at the front door) and there are no subsequent delays to them receiving appropriate interventions (as per NHS HIS clinical standards for acute stroke) and stroke unit care | • Development and implementation of electronic patient records will enable front door teams to diagnose and treat patients without delay and improve their quality of care and outcomes, and appropriately admit to a stroke unit.  
• Undertake a review of current and projected bed requirements and model accordingly, to enable patient flow.  
• Change Fund monies will establish an early supported discharge service in collaboration with existing community services, to enable patient flow. |

4.2.13 **TARGET:** Further reduce healthcare associated infections so that by 2012/13 NHS Boards’ *staphylococcus aureus* bacteriamia (SAB) (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days

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| Ownership of the target at clinical level within acute and community services is key to success and needs to be universal. | • Data is fed back on a regular basis to clinical teams; weekly and monthly reports are published on the Infection Prevention and Control Team (IPCT) Intranet page and displayed at local and clinical level. Directorates are given their local trajectories and plans should be made accordingly.  
• Rapid impact assessment of all SABs to be undertaken by IPCT within two working days and feedback given to clinical teams. Outcomes from the rapid assessment should be utilised by relevant community or acute clinical teams to carry out further investigations to assist improvement in local practice and outcomes.  
• Clinical Teams to continue to engage with Scottish Patient Safety Programme in the use of care bundles and improvement methodology for practice. |
4.2.14 **TARGET:** To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14

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<tr>
<td>The key risk associate with this target is that demand will continue to increase from those members of the general public that self-present to A&amp;E services, with non-emergency conditions/injuries.</td>
<td>As this cohort does not always go through NHS24, unscheduled care services or even visit their GP, they are difficult to influence or redirect. This may mean that any increased A&amp;E capacity created by redirection and alternative treatment options offered by MIU, SAS, LUCS, NHS24 may be utilised by patients without a clinical need for emergency medicine expertise. The mitigations against this come from the continuing national and local T10 work to publicise alternatives to A&amp;E, to apply social marketing and other approaches to influence where patients choose to present. The T10 milestones for 2012-13 continue to emphasise the need to engage with the non-acute users of A&amp;E to reduce demand.</td>
</tr>
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</table>

5 **Risk Register**

5.1 As above, all risks are currently being assessed. Responsible Directors will ensure that any risks associated with their targets have been clearly identified within the risk register and escalated to the corporate risk register as appropriate.

6 **Impact on Health Inequalities**

6.1 Impact Assessments have been undertaken on targets relating to 2011/12 and recommendations have been implemented as appropriate. These will be reviewed as part of the development process for the Local Delivery Plan to ensure that any further actions are identified. The three new targets will have impact assessments carried out by the end of March 2012, once they have been agreed.

7 **Impact on Inequalities**

7.1 As above.

8 **Involving People**

8.1 The NHS Lothian Local Delivery Plan 2012-13 has been developed with Executive Directors, Lead Officers and a range of other stakeholders with responsibility for the delivery of the targets.
9 Resource Implications

9.1 In some instances, some sections included within the Local Delivery Plan may have financial implications. For HEAT targets, details of these aspects are explicitly requested as part of the Risk Management template.

David Farquharson  
Medical Director  
13 March 2012  
david.farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: LDP HEAT Risk Management Plans
Appendix 2: LDP HEAT Delivery Trajectories
Appendix 3: Summary of main workforce issues facing NHS Lothian
Appendix 4: Single Outcome Agreements (x4)
Appendix 5: Outcomes Approach
Use of Risk Management Plan

Boards should, as in previous years, use the LDP Risk Management Plan to provide contextual information on key risks to delivery of each target and how risks are being managed. Within the template, the description of the key risk should be provided in the first column and detail on how the risk is being managed should be provided in the second column. Cross-reference to local plans should be made where necessary.

- **Delivery and Improvement**: briefly highlight local issues and risks that may impact on the achievement of targets and/or the planned performance trajectories towards targets and how these risks will be managed.

- **Workforce**: brief narrative on the workforce implications of each of the HEAT targets where appropriate and relevant. This should include an assessment of staff availability to deliver the target, the need for any training and development to ensure staff have the competency levels required, and consideration of affordability cross referenced to the Financial Plan.

- **Finance**: where applicable boards should identify and explain any specific issues, e.g. cost pressures or financial dependencies specifically related to achieving the target. There is no need to repeat generic financial risks that apply to all targets.

- **Equalities**: where applicable, boards should outline any risks that the delivery of the target could create unequal health outcomes for the six equalities groups, and/or for people living in socio-economic disadvantage; and how these risks are being managed.
HEAT TARGETS FOR 2012/13

- To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

- At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours

- Reduce suicide rate between 2002 and 2013 by 20%

- To achieve 14,910 completed child health weight interventions over the three years ending March 2014

- NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014

- At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014

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- By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

- Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) from March 2013; reducing to 18 weeks by December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014

- Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15

- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015

- To improve stroke care, 90% of all patient admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013

- Further reduce healthcare associated infections so that by 2012/13 NHS Boards’ *staphylococcus aureus* bacteriamia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days

- To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14
To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

NHS BOARD LEAD: Dr Alison McCallum
Director of Public Health and Health Policy

Delivery and Improvement

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<th>Risk</th>
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<tr>
<td>Data underpinning the trajectory is provisional and subject to potential revision.</td>
<td>• The current target has been derived from Cancer Registry data – this is a different source to audit data which is proposed for ongoing monitoring. We are working with ISD and clinical audit to resolve these issues.</td>
</tr>
<tr>
<td>Analysis of patient flows may mean that we need to shift the emphasis of our Detecting Cancer Early programme action plan.</td>
<td>• Ensure an analysis of emergency admissions as part of the acute oncology improvement work includes a look at the number of new cancers detected, location of emergency presentation, deprivation of profile of presenters, and stage of disease at presentation. Finding to feed into pathway improvement work.</td>
</tr>
<tr>
<td>Oversight of pathway improvement opportunities across primary and secondary case systems, to ensure pathway redesign best supports more early detection of cancer.</td>
<td>• Engagement of Community Health and Care Partnership Clinical Directors, the GP lead for Cancer &amp; Palliative Care, Primary Care Nurse Consultant in Cancer &amp; Palliative Care, as well as GP management groups. Resource requirements have been scoped and are considerable.</td>
</tr>
<tr>
<td>Ability to increase uptake of the Breast, Bowel and Cervical screening programmes may be challenging in hard-to-reach groups.</td>
<td>• Continue to deliver and develop plans to improve uptake and to target specific groups. Use the Detecting Cancer Early programme and resources to further support this work.</td>
</tr>
<tr>
<td>Detecting Cancer Early causes requires increased use of some diagnostic modalities. The projected impact is being considered and sensitivity analyses are being conducted.</td>
<td>• Scope the access requirement for diagnostic services to better understand what access changes will deliver improved earlier detection of lung, breast and colorectal cancers. Link to service capacity funding, as below.</td>
</tr>
<tr>
<td>Cancer modernisation initiatives in radiotherapy, acute oncology, and cancer surgery are progressing. Changes in demand need to be considered as part of these strands of work.</td>
<td>• Link the evidence and approach to the Detecting Cancer Early programme in Lothian to the development of service capacity funded and taken forward under cancer modernisation.</td>
</tr>
<tr>
<td>Data quality at NHS Board level may be sub-optimal without intervention to improve the data for monitoring programme progress.</td>
<td>• Action will be taken to improve data quality at Board level and will specifically include a review of cancer audit data processes, MDT working and data collection, and linkage as necessary to cancer tracking. An outline of which variables are collected, and how these data are managed, is included below.</td>
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are stored/extracted, will be considered as part of improving quality and developing greater efficiency.

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<tr>
<td>Referral guidance to Lothian General Practitioners is being revised as a national initiative. There needs to be careful consideration of this once it is finalised.</td>
<td>• Work with the GP Lead for Cancer &amp; Palliative Care and Lothian referral advisors to ensure the national work in this area, and local work and referral resources, are taken forward in an integrated way; undertake referral audit and develop referral feedback and benchmarking mechanisms to support general practice.</td>
</tr>
<tr>
<td>Capacity for GP Leadership / Nurse Consultant support in Cancer &amp; Palliative Care needs to be increased to support work across all Lothian areas.</td>
<td>• Discuss with CH(C)P leads and consider options in Detecting Cancer Early programme funding.</td>
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<tr>
<td>Resources to improve data systems and to support performance management and redesign need to be fully utilised.</td>
<td>• Build a focus and analytical capacity within existing data and health intelligence teams; consider the need for an Information Manager to support the Detecting Cancer Early programme, building on the University of Southern California model.</td>
</tr>
<tr>
<td>Funding for additional diagnostic services activity needs to be considered as part of the programme to ensure demand associated with new access arrangements aligns with capacity available.</td>
<td>• In tandem with determining changes to diagnostic access pathways, scope the funding requirement for diagnostic services; fit into service demand and capacity planning; make the case for Detecting Cancer Early programme investment.</td>
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</tr>
<tr>
<td>As above, ability to increase uptake of the Breast, Bowel and Cervical screening programmes may be challenging in hard-to-reach groups.</td>
<td>• Develop further plans to improve uptake, using the Detecting Cancer Early national network to support further targeting.</td>
</tr>
<tr>
<td>Co-morbidities interact with decisions on cancer treatment planning in ways which affect (reduce) relative survival, often for the most deprived patients more so than the least deprived.</td>
<td>• Explore the evidence and treatment planning issues locally, and link findings into action planning under the survivorship strand of the cancer modernisation programme.</td>
</tr>
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</table>
At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours

NHS BOARD LEAD: Prof. Alex McMahon
Acting Director of Strategic Planning

Delivery and Improvement

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| Women from quintiles 4 & 5 and the hard to reach groups (e.g. vulnerable women, families, teenage pregnancy, substance using parents, women from areas of high deprivation who may not present to GP/ Midwife) who self pregnancy test may not always know or appreciate the importance of early booking within the 10-12 week window. | • Increased publicity in NHS Lothian and the four Local Authority Areas, e.g. leaflets/posters re centralised bookings in all shops, environments, etc. who stock pregnancy tests. Liaison with Children and Family Centres.  
• Continue to work with GPs to improve referral before 12 weeks.  
• Education of all groups of staff and other agencies statutory and voluntary on the target and importance of early booking before 12 weeks.  
• Incorporate into Children and Young Peoples Integrated Children’s Services Priorities – “Best Possible Start” within local SOAs.  
• Education of young women within family planning services, schools and colleges / universities in the importance of early booking and antenatal assessment and care.  
• Explore the use of drop in clinics in hard to reach areas/access points. |
| Women with Long Term Conditions, i.e. diabetes, obesity related, asthma, etc. may not present within 10-12 weeks and therefore also need to be identified within the at risk group. | • Active engagement and full implementation of the findings of the equality and diversity impact assessment and close working with primary care and third sector teams.  
• As above, increased publicity in NHS Lothian and the four Local Authority Areas, e.g. leaflets/posters re centralised bookings in all shops, environments, etc. who stock pregnancy tests. Liaison with Children and Family Centres. |

Workforce

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| There is a need to ensure the capacity is available within the Centralised Booking Office to achieve a 70% response within 24 hours to telephone booking requests. | • In conjunction with eHealth & Medical Records ensure a robust system and process and appropriate establishment within the Centralised Booking Office to ensure all telephone contacts to arrange booking appointments are responded to timeously.  
• This could be achieved as per described |
within using some of the Refreshed Maternity Framework allocation to increase administrative support.

There is also a need to ensure the capacity is available within the current Community Midwifery workforce to respond to antenatal bookings within 12 weeks.

- A Staffing Review of Community Midwifery Services has started and there will be a workforce plan that will include investment in Maternity Care Assistants who will support the midwives with the antenatal and postnatal care pathway this creating increased community midwifery capacity to target early booking, risk assessment and early intervention with our vulnerable pregnant women. We are also working with community groups in an effort to find solutions that might improve access with hard to reach groups.

plans to improve or strengthen workforce capability in relation to health and social care assessment at the booking appointment

- We are investing through framework funding in an additional member of the administrative staff team at central booking office to enable efficient throughput of the women to ensure assessment and screening by the named midwife at the earliest opportunity and by 12 weeks gestation. As part of this process we also have electronic ski gateway communication with woman’s named GPs requesting a referral from GP with woman’s history and known risk factors communicated back to central booking office.
- All our midwives are undergoing/have undergone GIRFEC training in conjunction with Public Health Nursing and others in the four CH(C)P/Local Authority Partnerships.
- Our Maternity TRAK electronic assessment is very comprehensive and we will be including the GIRFEC Practice Model within it as a future development and this will further assist all clinical staff identify needs of mother and unborn child.

### Finance

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<td>Costs of the publicity campaign – these will be set against the refreshed Maternity Framework Scottish Government financial allocation for implementation.</td>
<td>- A Financial Plan for the delivery of the target has been produced and a bid for funding has been submitted to Scottish Government.</td>
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### Equalities

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<th>Risk</th>
<th>Management of Risk</th>
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<tr>
<td>As above, women from the hard to</td>
<td>- A Rapid Impact Assessment has already</td>
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reach groups (e.g. vulnerable women, families, teenage pregnancy, substance using parents, women from areas of high deprivation who may not present to GP/ Midwife) who self pregnancy test may not always know or appreciate the importance of early booking within the 10-12 week window.

<table>
<thead>
<tr>
<th>been completed on the Centralised Booking Service and actions highlighted from that are included below.</th>
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<tbody>
<tr>
<td>• Increased publicity in NHS Lothian and the four Local Authority Areas. Leaflets/posters re centralised bookings in all shops, environments etc who stock pregnancy tests. Liaison with Children and Family Centres.</td>
</tr>
<tr>
<td>• Work to be progressed on identifying the needs of women during early pregnancy through epidemiological and qualitative work (interviews and questionnaires) in order to maximise the take up of early booking.</td>
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<tr>
<th>Women from minority ethnic groups need to be able to easily access the centralised booking service.</th>
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<tr>
<td>• A telephone interpreter service is available to women who phone in to the central number.</td>
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<tr>
<td>• Women can book an interpreter through the system for the midwife appointment and ultrasound scan.</td>
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<tr>
<td>• Review of additional communication needs.</td>
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<tr>
<th>There needs to be equitability in offer and uptake of appointments.</th>
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<td>• Active monitoring of appointments offered and subsequent uptake by disadvantaged groups.</td>
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Reduce suicide rate between 2002 and 2013 by 20%

NHS BOARD LEAD:  Prof. Alex McMahon
Acting Director of Strategic Planning

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| Not all people who attempt or complete suicide are known to health services. | • The Lothian Joint Mental Health and wellbeing team draws together work to reduce suicide and to increase the range of individuals and communities with a greater understanding of risks to mental health.  
  • The lack of contact with services for some who attempt or complete suicide has been built into our revised policy and review process as agreed by our Healthcare Governance and Risk Management Committee.  
  • Implemented a suicide review for every suicide in Lothian regardless of contact with health services. This is an opportunity to learn from and improve practice.  
  • Ensure appropriate capacity for Alcohol and Drug Liaison services. |
| There may be frequent attendees at A&E due to self harm.           | • Flag patients on IM & T system to ensure that they are referred on to the Mental Health Assessment Service.  
  • Support and develop joint work with Penumbra’s Edinburgh Self-Harm Project. |
| Services need to put in measures to ensure they pick up on clues and warning signals that may be expressed by patients. | • Continue education and training programme for both front line staff and for wider agencies, through Choose Life local training programmes with Choose Life Co-ordinators, and with key NHS Lothian trainers. |
| People feel a stigma around discussing suicide.                   | • Continue to increase awareness through delivery of Suicide Talk course and through working with local Choose Life Alliances, “see me” campaign; support local anti-stigma projects, e.g. Oor Mad History, Much More Than a Label, focusing on personality disorder. |
| There is a need to ensure adequate provision of training.         | • Continue to deliver NHS Lothian’s suicide prevention training programmes as widely as possible to NHS Lothian, local authority and third sector staff. |
| Capacity needs to continue to be assessed and built within key areas as appropriate. | • Continue to provide a suicide training programme with the recognised core courses.  
  • A two part e-learning induction package is in place for all new NHS Lothian employees to |
raise awareness of mental health, wellbeing, stigma and suicide.
- Established an Early Onset Psychosis service to enable people to be assisted earlier.
- We will continue to work with the local Choose Life Co-ordinators to build training capacity across NHS, local authorities and third sector locally.
- As part of structure of Lothian Joint Mental Health and Wellbeing Strategy, an inequalities group will look specifically at taking forward actions around reducing suicide and self-harm.
- Established QIT- Quality Improvement Team to look at the newly developed suicide review process.

Learning needs to continue to be embedded from critical incidents or completed suicide within practice and delivery of front-line services.
- A reflective practice module on critical incidents and completed suicides has been developed, in line with the national learning framework. This module is aimed specifically at senior clinical staff.
- Inclusion of suicide in NHS Lothian critical incident review policy.
- Established QIT- Quality Improvement Team to support the implementation of the revised suicide review process.

### Workforce

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| Management support is required for NHS staff to attend the courses provided through the suicide prevention training programme. | - Awareness of the importance of training will continue to be raised through articles in NHS Lothian publications including Connections, the Team Brief, and Briefing - the Lothian Mental Health and Wellbeing Team newsletter.  
- The newly developed suicide review process will allow learning and understanding to develop within teams, including managers. |

### Finance

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<tr>
<td>There needs to continue to be funding made available for the delivery of the training programme.</td>
<td>- The funding for the Co-ordinator post has been secured as part of the Mental Health and Wellbeing Strategy.</td>
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### Equalities

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<tr>
<td>Both Choose Life nationally, and the Lothian Joint Mental Health and</td>
<td>- Target services and projects for young men, older men and those released from prison.</td>
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<tr>
<td>Wellbeing Strategy has identified young men, older men and people who have been incarcerated as being at increased risk of suicide.</td>
<td>• Work with prison healthcare staff to ensure delivery of suicide prevention training.</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td>Staff need to continue to be trained to ensure patients from disadvantaged groups receive an equitable service.</td>
<td>• Ensure that staff working in specialist services which have been established to address the needs of people from disadvantaged communities receive training. Examples include the Access Point (working with people who are homeless and the vulnerable population); the Willow Project (working with women offenders); the Minority Ethnic Health Inclusion Service.</td>
</tr>
<tr>
<td>There is a need to ensure increased awareness in local services on the impact of equality strands on risk to suicide and self-harm.</td>
<td>• Learning from Equally Connected - the national exemplar project on Black and Minority Ethnic communities’ contact with mental health services will inform mainstream provision. • Lothian Joint Mental Health and Wellbeing Strategy will be focusing on older people’s services as a first year priority. • Move towards all mental health services being trauma informed, building on local Gender Based Violence work. • Continue to support and promote work with the LGBT Healthy Living Centre and national demonstration project. • Ensure that patients at increased risk of suicide, e.g. chronic physical and mental health problems have access to appropriate support and services in line with the international evidence.</td>
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To achieve 14,910 completed child health weight interventions over the three years ending March 2014

NHS BOARD LEAD: Dr Alison McCallum
Director of Public Health and Health Policy

The HEAT target is being addressed through a balanced approach of treatment and prevention (the numbering below is used by Scottish Government in data returns)

- **Get Going** treatment programme (Lothian 1): An 8-session small-group community-based intervention for overweight and obese 5-15 year olds (above the 91st centile for body mass index) and their families.

- **Healthy Families, Healthy Children** health improvement programme (Lothian 2): An 8-session school-based programme delivered to whole classes, regardless of body mass index, for 4-15 year olds.

The trajectory for 31 March 2012 for HEAT H3 for NHS Lothian is n=680, to include all overweight and obese children and young people with completed interventions between April 2011 and 31 March 2012.

**Delivery and Improvement**

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<tr>
<td><strong>Treatment:</strong> during 2011 the number of complex referrals to the Get Going programme has increased substantially. This includes children, young people and parents / carers with psychosocial problems and other comorbidities. Physical activity coaches are unable to address the complex clinical issues that arise during the assessment and care of these families. This is a consequence of having open access referral and extending and promoting the programme in new areas. These complex cases were not witnessed in the initial piloting of the Get Going programme in two areas of Lothian during 2009 and 2010.</td>
<td>• The dietician and clinical psychologist supporting the ‘Get Going’ programme have had their hours increased to provide more support to families and coaches, including debriefing sessions. This clinical support is essential for the safe delivery of the Get Going programme. • The referral and care pathways and supporting documentation for the Get Going programme are being revised to allow for screening and triage of referrals. Once the new pathways have been completed they will be made available on the RefHelp web page (a source of information about evidence-based practice and referrals for primary care staff) and disseminated to other potential referrers (e.g. allied health professionals, paediatricians and school nurses). • Enhanced child protection training is being provided for Get Going coaches through the clinical psychology team. The training will be tailored to the specific experience of the coaches. This will help coaches address needs of children and families should the need arise.</td>
</tr>
<tr>
<td><strong>Health improvement:</strong> Sixteen primary schools and four nurseries with a combined roll of 3,384 children have been recruited to take part in the Healthy Families, Healthy</td>
<td>• Parents cannot be forced into allowing their children to take part in the measurements for the programme. The “opt out” rather than “opt in” approach has been used in other parts of Scotland and is likely to maximise uptake.</td>
</tr>
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</table>
Children programme, mainly in multiply deprived areas of Lothian. It is anticipated that around 25% of these children will be overweight or obese (n=840, thereby meeting or exceeding the HEAT target for this year). Inclusion towards the HEAT target requires participation in six out of eight of the sessions, and height and weights recorded at the start and completion of the programme. Parents can opt their children out of the height and weight measurements. If substantial numbers of overweight and obese children are opted out or do not take part in the required number of sessions, then that could impact on the ability to meet the HEAT target.

- Preparatory work with schools, through the involvement of Public Health, Health Promotion, School Nursing, and local authority leads, has ensured a good relationship with schools, a relationship that has developed further through the delivery of CPD sessions by Health Promotion staff.
- An “opt out” letter was agreed with local authority leads and has been sent out by each of the participating schools two weeks before the measurements are due to be taken. Early evidence suggests that uptake of measurements is high.
- The school-based programme has been developed to meet Curriculum for Excellence Health and Wellbeing Experiences and Outcomes and sent to each class teacher on a CD ROM. The resources have been developed in close collaboration between Health Promotion and teaching staff. Many schools have reacted very positively to the materials provided, and the resources have been further strengthened by the inclusion of extended lesson plans developed over the past two years in Midlothian to meet the requirements of the previous HEAT target. Other schools have been confident to deliver classes that meet the requirements of the curriculum and they have been given the freedom to use their own approaches as long as they meet the overall requirements of the eight session programme. This has ensured a high level of trust between schools, local authorities and NHS Lothian and has led to an excellent level of uptake.

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<tr>
<th>Health improvement: The evidence for an improvement in body mass index with a short school-based programme is very limited as has been summarised in a letter from Graham Mackenzie and Alison McCallum to Cathy Higginson at Scottish Government (28 April 2011).</th>
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<tr>
<td>• We would expect that if the experience of published trials and systematic reviews is borne out in the evaluation of the HEAT target that Scottish Government will change approach and start to look for evidence of improvement in knowledge, attitudes, skills and awareness rather than body mass index. Schools in Edinburgh are piloting approaches for assessing knowledge and attitudes around healthy eating and physical activity and also considering approaches for assessing physical fitness.</td>
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"NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012"
## Workforce

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<td><strong>Treatment:</strong> A vacancy in the Edinburgh Leisure Get Going co-ordinator post between December 2010 and May 2011 has led to a sizeable waiting list (n=100 children and young people) in Edinburgh. Trained sessional staff have moved to other posts, resulting in a shortage of trained staff in some areas.</td>
<td>• Get Going co-ordinators and coaches have been working across local authority boundaries to help balance workload. • Edinburgh Leisure is appointing contracted coaches rather than sessional workers to ensure access to trained staff.</td>
</tr>
<tr>
<td><strong>Treatment (adolescent programme):</strong> there has been a delay in the delivery of Get Going programme to young people.</td>
<td>• The ‘Going Going’ co-ordinators and clinical psychology are working to deliver training and opportunities for shadowing for physical activity coaches.</td>
</tr>
<tr>
<td><strong>Health improvement:</strong> The requirement by Scottish Government to return named individual data to the Child Health Surveillance Programme-School system means that school nurses are required to take the heights and weights for the programme. However, school nurse teams have many other demands over the busiest period for the school-based programme (December 2011 to March 2012) including P1 heights and weights in all local authority funded schools in Lothian and participation in the catch up MMR campaign. This places huge demands on the time of a relatively small number of staff.</td>
<td>• School nurses have been able to work flexibly to meet the demands. They have been able to involve other trained members of staff to help them (e.g. community staff nurses and Get Going co-ordinators). A small number of schools in Midlothian may not complete the interventions until late March 2012, but these will still be eligible for inclusion towards the HEAT target for this year.</td>
</tr>
<tr>
<td><strong>Health improvement (continued):</strong> NHS staff do not have the capacity to deliver Healthy Families, Healthy Children programme.</td>
<td>• Health Promotion staff have developed and delivered a CPD programme to school staff participating in the Health Families, Healthy Children programme. Schools are reimbursed for their participation in the programme, covering staffing, training, printing, equipment and other costs.</td>
</tr>
<tr>
<td>School staff are not clinically trained and often lack confidence to raise the issue of overweight/obesity.</td>
<td>• We have undertaken preparatory work with schools through the school nurse teams who have received the NHS Health Scotland ‘Raising the Issue’ training (August 2010).</td>
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## Finance

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<tr>
<td>Scottish Government has signalled that funding will be available for</td>
<td>• Partner organisations have been informed of</td>
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2012/13 and 2013/14, but final confirmation will not be available until February 2012.

the funding arrangements, and Get Going co-ordinator and coach costs to March 2013 will largely be covered through existing agreements. Agreements with schools participating from April 2012 onwards will be signed once future funding arrangements have been confirmed. NHS salaries (e.g. senior health policy officer) are dependent on funding being confirmed by Scottish Government.

Current weighing scales need to meet national standards.

- Scales and Leicester height rules will be replaced during 2011/12, including specialist equipment for special schools.

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<th>Equalities</th>
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<tr>
<td><strong>Risk</strong></td>
<td><strong>Health Improvement and Weight Management:</strong> There has been concern expressed with regards to height and weight measurement of children with physical disability (equality and diversity rapid impact assessment, December 2008).</td>
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</table>
| | There could be low level of uptake of Get Going programme of children from ethnic minority backgrounds who have language needs (equality and diversity rapid impact assessment, December 2008). | **The revised Get Going self referral form includes information on ethnicity and language.**  
**There has been some discussion with leisure trusts and NHS Lothian to consider meeting the language needs as required, with a pilot programme planned during 2012/13.** |
NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014

| NHS BOARD LEAD: | Dr Alison McCallum  
| Director of Public Health and Health Policy |

### Delivery and Improvement

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| Meeting the target requires 7,011 successful outcomes in 40% most-deprived areas in Lothian over the 3 year target period. Activity needs to engage smokers from these hard to reach areas and we will focus on:  
- pregnant women  
- people with mental health issues  
- people with chronic disease.  
These groups historically are both difficult to attract to services and keep in services.  
By focusing on these groups there is a risk that we may not be able to attract the required numbers into services. Additionally there is also a significant challenge in providing the amount of support necessary to obtain complete abstinence in those who do engage with services. |
| - We continue to review cessation services for pregnant women and mental health services and make adjustments as required. This will ensure we can deliver the required number of successful outcomes.  
- Those clients with chronic disease continue to be targeted by focusing on hospital based cessation for both out and inpatients. Cessation interventions will focus on their specific chronic disease management which should enhance successful outcomes. |

Successful outcomes have increased significantly in previous years and while our aim is to sustain this level of activity it is anticipated that as prevalence reduces those remaining smoking will be more heavily addicted and have more complex lives. Subsequently smokers may become both harder to reach and resulting success rates may be lower over the three year time scale of the target meaning that more smokers will need to be attracted into the service to achieve the same number of successful outcomes.

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<tr>
<td>As the target groups become more challenging staff will require both to</td>
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<tr>
<td>- We have adjusted the skill mix of our cessation team to increase the numbers of</td>
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*NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012*
retain existing and acquire new skills to meet the additional challenges of providing an effective service.

staff providing face to face support to smokers to ensure the required number of outcomes is achieved.
- In addition to encouraging staff to undertake nationally accredited training, we will continue to provide a robust in-house education programme. This will continue to improve expertise and lead to ability to manage the expected challenging caseloads.
- We also provide a smoking cessation service to staff and will enhance this. This will aid role modelling.

### Finance

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<tr>
<td>There is a need to ensure the budget allocated will be able to deliver the requisite number of increasingly complex interventions with fewer or less highly skilled staff at a time when pay and prices are increasing.</td>
<td>• We have reviewed the skill mix of staff to ensure staff costs do not increase.</td>
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### Equalities

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| Services may not attract the numbers of clients required to achieve the target. As prevalence reduces it becomes increasingly challenging attracting smokers into services. Additionally, the impact of the economic downturn on tobacco misuse may be significant. In a recession, aspects of people’s lifestyle can change in unpredictable ways and have a direct impact on self-esteem, mental health and general well-being all of which can affect tobacco use and lead to less motivation to change. | • NHS Lothian plans to continue with its strategy of increasing accessibility to its stop smoking services and in particular targeting services to those most in need, e.g. pregnant women, those with mental health issues and chronic disease.
• NHS Lothian continues with an advertising strategy that includes leaflets and posters, press and bus advertising. We also carry out recruiting activity in local shopping centres and supermarkets, targeting those used most frequently by those form disadvantaged groups with high smoking rates.
• We continue to provide raising the issue of smoking training to all healthcare professionals and local authorities to encourage referrals to the service. |
At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014

**NHS BOARD LEAD:** Dr Alison McCallum  
Director of Public Health and Health Policy

### Delivery and Improvement

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| Delivery of the target will be dependent upon general dental practitioners delivering FV applications every six months. | • Active promotion of Childsmile Practice through Dental Division Executive, Area Dental Committee and GDP Subcommittee.  
• One to one promotion by Childsmile Co-ordinators with general dental practices.  
• Dissemination of good practice in coordination with the National Childsmile group. |
| There needs to be a sufficiently uniform spread of general dental practices across SIMD areas. | • All salaried dental practices to be offering Childsmile. |
| Parents need to be encouraged to take children to the dental practice at least twice per year. | • Use of Childsmile co-ordinator/dental health support worker along with public health nursing colleagues to directly encourage and facilitate attendance. Use of eight week surveillance programme in development. |

### Workforce

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<tr>
<td>Delivery is dependant upon dental nurses employed by independent general dental practices for delivery of fluoride varnish applications and have no direct control over training/quality.</td>
<td>• Regular visits by Childsmile Co-ordinators to dental practices.</td>
</tr>
<tr>
<td>Demand for training through NES needs to be able to be delivered.</td>
<td>• Work with NES in advance to estimate demand.</td>
</tr>
<tr>
<td>Support is required in recruiting Childsmile Practice staff to avoid delays.</td>
<td>• Work with finance, Employee Relations and recruitment colleagues to fast-track recruitment and revise trajectory to reflect delays in recruitment.</td>
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### Finance

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| Budget allocation from Scottish Government to NHS Lothian for the Childsmile Programme. | • Work with Scottish Government and monitoring Consultant to agree early release of budget.  
• Trajectory revised to reflect the release of < 90% of budget. |

### Equalities

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<tr>
<td>A child living in an area of</td>
<td>• Continue to provide fluoride varnish</td>
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*NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012*
| deprivation may be less likely to attend a dental practice, missing out on fluoride varnish application. | application in nurseries in most deprived 20% SIMD areas.  
• NHS Lothian Childsmile team works with the 20% of nurseries in most deprived SIMD quintile as per SG programme. However successful varnish application depends on consent, the child being in nursery on the application day, and a co-operative child on the day. Lothian is doing better than other Boards, and our application rate averages 70% of children in targeted nurseries.  
• Use feedback from local groups to redesign and refine the programme as has already been undertaken as part of Support from the Start, the Equally Well pilot programme. |
NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009

NHS BOARD LEAD: Jackie Sansbury
Chief Operating Officer

Delivery and Improvement

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<tr>
<td>• Time to deliver.</td>
<td>• Identify measures to save energy and develop an investment programme.</td>
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<tr>
<td>• Capital finance needs to be sufficient to support achievement of that target.</td>
<td>• Availability of Capital – recommend Scottish Government ring fenced funding be used to support this.</td>
</tr>
<tr>
<td>• Severe weather, e.g. extreme, continues making savings difficult.</td>
<td>• Availability of revenue to support 'invest to save' proposal. Reinvest a proportion of savings in energy efficiency projects instead of tagging as LRP efficiency savings.</td>
</tr>
<tr>
<td>• Grant support for renewable / low carbon technologies is unreliable.</td>
<td>• Capital developments adhere to low carbon / BREEAM Healthcare requirement.</td>
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<tr>
<td>• Old buildings cannot be upgraded within normal financial constraints to achieve long term target.</td>
<td>• Dispose of old and functionally unsuitable buildings.</td>
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Workforce

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<tr>
<td>• Conflicting pressures for estates staff needs to continue to be managed.</td>
<td>• Staff training to identify and manage low carbon projects.</td>
</tr>
<tr>
<td>• General staff - their engagement and ownership.</td>
<td>• Support from Carbon Trust in revised Carbon Management Plan.</td>
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<td>• Corporate Communications staff to develop their awareness programme and investment in staff initiatives.</td>
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Finance

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<td>• Management of budgets to take account of any overspend of existing budgets due to increased exposure to high energy tariffs.</td>
<td>• Clarity of accountability of Managers.</td>
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<tr>
<td>• Increased exposure to taxation of carbon emissions – EUETS, CRC, CCL and others in pipeline</td>
<td>• BMS and other automated systems response to correct failure of equipment.</td>
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<td>• Procurement – review procurement of goods and services with a view to reducing carbon costs.</td>
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Equalities

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<td>None</td>
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By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

| NHS BOARD LEAD: | Prof. Alex McMahon  
Acting Director of Strategic Planning |
|----------------|------------------------------------------------|

**Delivery and Improvement**

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| There is need to ensure that the level of service being provided meet the level of throughput. | • The new referral pathways implemented in Edinburgh and West Lothian receive continued supported by services and Alcohol and Drug Partnerships (ADPs).  
• MELDAP members implement the new pathway in Mid and East Lothian developed through the Lean in Lothian process.  
• The Edinburgh South-East Recovery Hub model is rolled out by EADP members across other areas of Edinburgh.  
• The National Enhanced Service for Substance Misuse continues to be supported by NHS Lothian. The recommendations from the 2011 review of the contract are implemented to support GPs to provide a more recovery-focused service.  
• The additional funding from ADPs in 2011 to increase the support for people to recover is sustained (this is used to fund 25 new SMART recovery groups and to establish the Serenity Café in Edinburgh).  
• ADPs invest additional funding in 2012 to support people to move on from treatment services.  
• System improvements are sustainable because statutory and 3rd sector agencies are involved in service redesign work.  
• Treatment services are performance managed by their local ADP team and NHS Lothian Strategic Planning.  
• The established regular meetings 3rd sector agencies are maintained; regular meetings with NHS Substance Misuse Directorate staff and ADP officers are established in 2012.  
• The Substance Misuse Directorate, 3rd sector providers and Primary Care have improved the discharge planning of clients.  
• DNA is not seen as an acceptable outcome to a referral and the international evidence for reducing DNA is highlighted.  
• 3rd sector capacity increased through Service Level Agreement process (capacity building |
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<th>Details</th>
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<td>Through service redesign and increase in additional support worker</td>
<td>• ADP commissioning groups monitor problems in services which require additional funding to address and increase capacity using the Scottish Government allocation for interim and long-term solutions.</td>
</tr>
<tr>
<td>Address any issues regarding temporary increases in service capacity required to remove backlog</td>
<td>• Statutory and 3rd sector services were engaged in redesign process through local ADPs and will be involved in planned service developments to ensure that model is owned by services and is sustainable.</td>
</tr>
<tr>
<td></td>
<td>• Clinical leadership capacity was increased in 2010 to drive redesign and ADPs are sustaining this capacity.</td>
</tr>
<tr>
<td></td>
<td>• Additional CPN capacity funded to support current workforce to redesign service to improve efficiency.</td>
</tr>
<tr>
<td></td>
<td>• Additional capacity in 3rd sector services to match increases in demand. This funding will be sustained in 2012.</td>
</tr>
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<td></td>
<td>• Inefficiencies in existing services have been identified using a LEAN approach. These have been removed through system redesign.</td>
</tr>
<tr>
<td></td>
<td>• Strong financial governance in place between NHS Lothian and Councils over application of the Scottish Government funding. This enables ADPs to plan effective.</td>
</tr>
<tr>
<td>Sustained increase in service capacity.</td>
<td>• ADPs have developed a process to receive and review information from 3rd sector and council services in advance of ISD deadlines.</td>
</tr>
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<td></td>
<td>• ADPs have a designated lead to monitor performance who work closely with NHS Lothian Strategic Planning.</td>
</tr>
<tr>
<td></td>
<td>• Agencies experiencing difficulties to maintain data quality or compliance receive additional support from NHS Lothian, Scottish Government and the local ADP team.</td>
</tr>
<tr>
<td></td>
<td>• Submissions to be checked before final submission.</td>
</tr>
<tr>
<td></td>
<td>• Oversight from the Data Sharing Partnership.</td>
</tr>
<tr>
<td>Risk associated with the submission of data, quality and compliance is appropriately managed</td>
<td>• PIMS support team prioritises data upload.</td>
</tr>
<tr>
<td></td>
<td>• Data will be uploaded monthly by 10th of each month.</td>
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<tr>
<td></td>
<td>• ADP officers and service managers receive monthly copy of ISD generated reports and local data to review quality; provide a local data report for NHS Lothian services by 15th of each month.</td>
</tr>
<tr>
<td>The interface between the NHS Lothian PIMS system and the ISD Waiting Times Database needs to be appropriately managed</td>
<td></td>
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</table>

*Note* : This table outlines the processes and measures in place for the NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012.
Monthly meetings established between ISD Scotland, NHS Lothian and ADP officers to monitor situation and resolve issues.

Funding the increased capacity required in clinical leadership, NHS Substance Misuse Service, 3<sup>rd</sup> Sector agencies and Primary Care.

Ensure staff engaged and participate in redesigning services; service redesign led by service providers.

All services are performance managed using local data and national waiting times data.

### Workforce

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<th>Risk</th>
<th>Management of Risk</th>
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| Commitment of Statutory and 3<sup>rd</sup> sector services to service redesign. | • Staff engaged in redesign process and services leading on redevelopment of patient pathway.  
• Staff supported by increase in additional CPN and 3<sup>rd</sup> sector capacity to implement redesign. |
| Leadership capacity to drive redesign process. | • Additional capacity for clinical lead (three extra sessions).  
• Managers in 3<sup>rd</sup> sector orgs supported to increase efficiency of service by NHS and Scottish Government through workshops and the LEAN process. |

### Finance

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<tr>
<th>Risk</th>
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</table>
| Funding the increased capacity required in clinical leadership, NHS Substance Misuse Service and 3<sup>rd</sup> Sector agencies. | • Funding identified from additional allocation received from NHS Lothian for alcohol and drug misuse. Allocation of funding reflects the impact of drug and alcohol on the burden of disease and premature death in Lothian.  
• ADP Chairs, Finance and Strategic Planning have agreed to fund posts in 2011. The Lothian substance misuse strategic finance group have confirmed funding available for ADPs in 2012. This supports ADP commissioning groups to make funding decisions.  
• Ongoing funding of primary care services in line with patient needs. |

### Equalities

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<tr>
<th>Risk</th>
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</table>
| Ensure that services are targeted at groups in society most at risk from substance misuse. | • Good partnership working between 3<sup>rd</sup> sector, statutory services and ADPs to ensure that services are focused appropriately.  
• Planning decisions are informed by ADP needs assessments.  
• An EQIA will be undertaken in all ADP areas on the impact of the action to improve access |
and achieve the HEAT target.
- Primary care teams servicing deprived areas are fully engaged.
- Monitoring of access, engagement and adherence on an ongoing basis.
Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) from March 2013; reducing to 18 weeks by December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014

<table>
<thead>
<tr>
<th>Risk</th>
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<tbody>
<tr>
<td>There is a need to ensure sufficient capacity is available within the service.</td>
<td>• Continue to use the Choice and Partnership approach to enable the booking of appointments within the target.</td>
</tr>
<tr>
<td></td>
<td>• Ongoing monitoring by the of referral rates, activity, DNA rates, CNA rates and clinic cancellations with analysis to forecast potential capacity issues – against which pre-emptive action can be taken.</td>
</tr>
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<td></td>
<td>• Completion of the Quarterly CAMHS HEAT Target report to confirm that delivery is in line with the LDP trajectory.</td>
</tr>
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<td></td>
<td>• Maximise the opportunities for joint working with other agencies for less complex patients.</td>
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<tr>
<td></td>
<td>• Ensure full compliance with GIRFEC.</td>
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<td></td>
<td>• Provide consultation and advice services in addition to face to face contacts.</td>
</tr>
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<td></td>
<td>• Adhere to redesigned pathways for children and young people in treatment.</td>
</tr>
<tr>
<td></td>
<td>• Ensure timeous recruitment of vacancies.</td>
</tr>
<tr>
<td>There is a need to recognise and continue to plan for greater levels of case complexity in children and young people with high levels of need.</td>
<td>• In line with Early Intervention, continue to provide funding to Place2Be in order to provide early counselling interventions in primary schools, to reduce the potential for onward referral to CAMHs.</td>
</tr>
<tr>
<td></td>
<td>• Continued working with staff in the four local authorities and voluntary organisations to provide support to vulnerable groups as early as possible.</td>
</tr>
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<td></td>
<td>• Undertake an equality audit under the auspices of LIPKAP.</td>
</tr>
<tr>
<td></td>
<td>• Monitor uptake by condition, socio-economic group, area and equality group.</td>
</tr>
<tr>
<td>Plans need to be in place for an increasing numbers of referrals.</td>
<td>• Continue to offer referral sources the opportunity to discuss patients and provide advice on interventions that can be provided without the need for a formal referral requiring to be made.</td>
</tr>
<tr>
<td>Ensuring that patients are matched to the appropriate psychological therapy to meet their needs.</td>
<td>• Using matched care models and integrated care pathways to ensure patients are matched to appropriate therapy.</td>
</tr>
</tbody>
</table>

NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012
Increased demand for psychological therapies.

- Continued approach of using the evidence base of "what works for whom".
- Providing a range of social prescribing alternatives available to GPs.
- Review threshold for referrals to secondary mental health and learning disabilities services.

Meeting the requirement for higher standards of practice.

- Maintaining a close working relationship with National Standard setting bodies and regular training and updating of staff.

Meeting rising public requirements and expectations of Child and Adolescent Mental Health Services, including improved access to psychological therapies in line with the HEAT target.

- Continuing to raise awareness that the mental health and well being of children and young people is everybody’s business.

Ensuring compliance against the NHS Quality Improvement Scotland Standards for Integrated Care Pathways for Child and Adolescent Mental Health Services and the Scottish Government's Psychological Therapies Matrix on evidence based psychological therapies.

- Regular monitoring of compliance against the standards and implementing the necessary actions to make agreed improvements.
- Regular reporting and monitoring on agreed data points and standards. Ensure action taken to address variances.
- Ongoing monitoring of the delivery NHS Lothian’s Psychological Therapies Delivery Plan.

Workforce

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<tr>
<td>Providing time for professional development and ensuring staff have the necessary competencies and supervision to deliver psychological therapies.</td>
<td>• Continued monitoring of staff PDPs to ensure that their identified training needs are being met.</td>
</tr>
<tr>
<td>Avoid the focus on service improvement being seen as only about delivering the access targets.</td>
<td>• Continued involvement of the staff in improvement workshops, to identify actions that will lead to improved service delivery against the range of Quality standards, of which one is access.</td>
</tr>
</tbody>
</table>
| Appropriate support needs to be provided to ensure that staff do not feel pressurised due to increased demand with no increase in capacity. | • Ensure staff are engaged with service improvement methodologies and that clinical time is maximised.  
• Ensure health care staff are aware of the role that other agencies play in delivering alternatives which may then impact on referral rates and demand. |

Finance

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<tr>
<th>Risk</th>
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<tbody>
<tr>
<td>Availability of funding to sustain additional capacity.</td>
<td>• Continuing to identify and implement service improvements can be made that enable more</td>
</tr>
</tbody>
</table>

NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012
activity to be provided within available funding baselines.

| Any potential reduction in funding by partner agencies involved in providing services to children and young people. | • Working with partner organisations to risk assess any proposed reductions in funding to quantify any potential impact these may have on delivery of the HEAT targets. |

**Equalities**

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<thead>
<tr>
<th>Risk</th>
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</table>
| There is a need to ensure equal access for all equitable access to care in line with need and that appropriate services are available for patients with protected characteristics. | • Monitoring of service delivery across the four local authority areas within Lothian to ensure that access times are equitable.  
• A Rapid Impact Assessment always carried out where service change is being considered. |
| Equitability in offer and uptake of psychological therapies across equality groups. | • Active monitoring of therapies offered and subsequent uptake by disadvantaged groups. |
| Support needs to be in place to encourage vulnerable people to attend appointments. | • Use different means to engage with groups rather than standard appointment letters.  
• Introduce greater flexibility around appointment times and clinical hours. |
Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15

**NHS BOARD LEAD:**  
Prof. Alex McMahon  
Acting Director of Strategic Planning

### Delivery and Improvement

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<tr>
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<tr>
<td>NHS Lothian has indicated a stretched target of 20% reduction from the 2009/10 baseline of 5,847 to 4,629 by March 2015.</td>
<td>Robust mechanisms of joint planning and performance management in each of the four partnerships.</td>
</tr>
<tr>
<td>The system wide Reshaping Care for Older People work streams need to deliver the required changes to support the inpatient bed day rate.</td>
<td>Change Fund allocations to March 2015 will provide a catalyst for sustainable change and review of progress against the target needs to be a key metric for all partnerships.</td>
</tr>
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### Workforce

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| Requirement to make savings across both health and social care may see reduction in workforce to deliver alternatives to hospital bed days in the wider community; the impact of this requires ongoing management across both systems. | Work with Workforce colleagues in both NHSL and Councils to ensure systems do not impede progress.  
Through the Reshaping care & Change Fund work streams test and explore new ways of working with the voluntary and private sectors to ensure value for money and effective delivery of services. |

### Finance

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<tr>
<td>Ability to release funds from services for reinvestment needs to support productivity and efficiency requirements.</td>
<td>Ensure an integrated approach is taken with resource utilisation being more transparent through the Integrated Resource Framework utilisation and the planning for future services being integrated through the joint commissioning strategy development over 2012/13 across the four Lothian partnerships.</td>
</tr>
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### Equalities

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<tr>
<td>Access to all groups and communities should not be adversely impacted with the implementation of the change fund and reshaping older people work streams, with more opportunities to live as independent lives as possible at home, or in a homely setting being the key aim in line with the national philosophy.</td>
<td>Continue to develop community services to ensure older people are supported at home or in a homely setting for as long as possible.</td>
</tr>
</tbody>
</table>
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015

NHS BOARD LEAD:  
Prof. Alex McMahon  
Acting Director of Strategic Planning

Delivery and Improvement

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<tr>
<td>Whilst the move to the 28 days target is welcomed, the delivery of the existing national target of 42 days is currently proving challenging to some of the Councils in the Lothian Partnership. With an ageing population, we need to ensure that we continue to work in partnership across health and social care to reduce pressure on the system.</td>
<td></td>
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</table>
• The reduction in the number of patients delayed, supported through more timely discharge is a key aim for the Local Transformation Plans, which are resourced by the Change Fund and have been signed off by Community Planning Partnerships.  
• An increased focus on providing preventative care interventions to reduce unnecessary admissions to hospital along with community-based support to facilitate earlier discharge will be necessary in order to achieve the planned reductions in the length of stay.  
• The range of actions through the NHS Lothian Clinical Strategy will address the wider issue of patient flow across the health and social care system, which will positively impact on reducing the number of delays.  
• The commitment to move towards integration between health and social care will support the development of integrated budgets, with the focus on the patient rather than the service.  
• The need to continually review all delays but also to focus on those patients waiting for packages of care of less than 14 hours; care at home as well as those on the rehabilitation list who could be supported at home. In addition we will continue to focus on the reduction in the length of time to process complex cases, including guardianship cases. |

Workforce

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<tr>
<td>The workforce issues reach across both health and social care staff, with health staff needing to begin discharge planning at the earliest opportunity and for social work staff to ensure timely assessment of patient’s needs.</td>
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</table>
• The implementation of the new discharge planning checklist will enable early identification of estimated discharge dates by health staff.  
• The continued close working between health and social work staff will ensure appropriate assessment and discharge planning can be
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<th>Risk</th>
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<tr>
<td>Early engagement and involvement of the family in the discharge arrangements will also contribute to a reduction in delays.</td>
<td>• Engagement with clinical staff on the range of services available locally to support patients being cared for at home or in a community setting.</td>
</tr>
<tr>
<td>Whilst there is good knowledge of community-based services by clinical staff, there is a need to ensure this is consistent across all hospital sites.</td>
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**Finance**

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<tr>
<td>The Change Fund will support a wide range of initiatives to deliver the necessary shift in the balance of care. We need to ensure that these are embedded by 2013.</td>
<td>• The performance metrics in place through the Change Fund plans will be used to determine the impact and effectiveness of the interventions through the Local Transformation Plans. • The Delayed Discharge team within NHS Lothian will closely monitor delays over 2012/13 to ensure they remain on trajectory and provide analysis to support any proposed changes required to address performance.</td>
</tr>
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We need to manage the integrations of costs for patients between health and social care. | • The development of the Integrated Resource Framework will provide clarity on the total spend across health and social care, which will support more effective service planning, with the patient at the centre. |

**Equalities**

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<tr>
<td>The right level of care and treatment needs to be provided in the most appropriate environment.</td>
<td>• Delivery of the new national standard will ensure timely discharge from hospital to ensure appropriate care and treatment can be delivered both in hospital and the community.</td>
</tr>
</tbody>
</table>

The impact of delays needs to be managed to ensure all patients will be able to access a hospital bed for treatment. | • Delivery of the new national standard will ensure timely discharge from hospital to ensure appropriate care and treatment can be delivered both in hospital and the community. |
To improve stroke care, 90% of all patient admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013

| NHS BOARD LEAD: | Jackie Sansbury  
Chief Operating Officer |

## Delivery and Improvement

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| The number of patients with stroke is expected to increase substantially over the next decade alongside the predicted increases in the elderly population. | • Undertake a review of current and projected bed requirements and model accordingly.  
• Ensure appropriate prevention in place.  
• Apply the evidence of the epidemiology of stroke to service redesign. |
| Appropriate beds need to be available for patients to be admitted to stroke unit. | • A bed on each acute site (RIE, WGH and SJH) is ring-fenced for thrombolysis admission and a further bed is nominated when this bed is used, to enable patient flow. |
| The required input of AHP staff needs to be available within stroke units to avoid increased length of stay, or delay discharge to prevent new admissions. | • AHP review to ensure that AHP levels are more consistent across units which allows discharges to be made appropriately. |
| Clinical eHealth information systems need to be sufficiently developed to provide live alerts and information to support electronic monitoring of the pathway. | • Ensure current IT systems functionality is maintained and integrated into existing and future systems.  
• Develop and implement electronic patient records. |
| The flow of patients through the stroke units needs to be managed appropriately; patients ready for discharge need to have the care they require available at the required time. This impacts on the admission of new patients to the units. | • Change Fund monies will establish an early supported discharge service in collaboration with existing community services. |
| RIE brain scanning capacity needs to be able to cope with increased stroke patient throughput once the stroke research group relocates from the Western General Hospital to the Royal Infirmary of Edinburgh (January 2013). | • Review capacity to scan patients on RIE CT / MRI scanners, and match reporting capacity. |
| Brain scanning cannot be delayed. Brain scanning helps triage stroke patients; it can reduce the numbers admitted to a stroke unit by identifying those with conditions mimicking stroke who need care outwith a stroke unit. | • Educate and raise awareness amongst medical and radiology staff about the need for, and timeliness of, brain scanning.  
• Establish greater flexibility in CT / MRI scheduling and capacity to allow rapid access to scanners by stroke patients, especially at the RIE site once the stroke research group... |
There needs to be sufficient stroke and radiologist PAs – many PAs are contributed by consultants who do not have permanent contracts (clinical academics on short-term funding).

- Review and co-ordinate job plans across Lothian and identify needs of service on all sites.

There is a need to ensure sufficient medical and radiological cover as part of the plans for the relocation of stroke research group (including clinical and radiological staff) from the Western General Hospital to the Royal Infirmary of Edinburgh by January 2013.

- Redesign the medical and radiology cover required and move staff according to service need to ensure equity of cover.

Audit/outreach nurse at St John’s Hospital also covers nursing shifts; there is a need to prioritise audit / outreach duties and ensure adequate funding is in place.

- Redesign required in 2012.
- Workforce involvement needed to ensure cover of current staff members across sites – to ensure data are available for reporting.

There needs to be timely availability of community services and staff to facilitate appropriate early discharge from acute units.

- Edinburgh Partnership Change Fund programme will set up these services.

The unusually high turnover of experienced nursing staff at the Western General Hospital needs to be appropriately managed.

- Recruitment plan with training and development for staff to be agreed and taken forward.

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<tr>
<td>Risk</td>
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<tr>
<td>Availability of funding for additional staff capacity.</td>
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<th>Equalities</th>
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<tr>
<td>Risk</td>
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<tr>
<td>All patients need to be able to gain access to a stroke unit as required.</td>
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</table>
Further reduce healthcare associated infections so that by 2012/13 NHS Boards’ *staphylococcus aureus* bacteriemia (SAB), including MRSA, cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.

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<th>NHS BOARD LEAD:</th>
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<tr>
<td>Dr Alison McCallum</td>
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<tr>
<td>Director of Public Health and Health Policy</td>
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### Delivery and Improvement

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<tr>
<td>Ownership of the target at clinical level within acute and community services is key to success and needs to be universal.</td>
<td>• Data is fed back on a regular basis to clinical teams; weekly and monthly reports are published on the Infection Prevention and Control Team (IPCT) Intranet page and displayed at local and clinical level. Directorates are given their local trajectories and plans should be made accordingly.</td>
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<td></td>
<td>• The IPCT will provide advice and support. Monitoring of data by the Infection Prevention and Control Committee and relevant clinical/management team meetings.</td>
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<td>• Rapid impact assessment of all SABs to be undertaken by IPCT within two working days and feedback given to clinical teams. Outcomes from the rapid assessment should be utilised by relevant community or acute clinical teams to carry out further investigations to assist improvement in local practice and outcomes.</td>
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<td></td>
<td>• Utilise Pareto and statistical process charts to focus work on areas of greater risk. Areas with highest infection risks will be visited by the infection prevention and control nurse when the data is available and results explained to local teams.</td>
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<td>• Clinical Teams to continue to engage with Scottish Patient Safety Programme in the use of care bundles and improvement methodology for practice.</td>
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<tr>
<td>The target is based on a “best in class” Scotland figure. There is a risk that as the level is based on a non comparable health board that the 2013 will not be met.</td>
<td>• Reduction in false positives through the introduction and application of a standard operating procedure for obtaining blood culture.</td>
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<td>• Clinical teams to take necessary action where SPSP data not achieving target.</td>
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<td>• Chairs of infection prevention and control committees and divisional nurse director work with Head of Service to provide intensive support.</td>
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</tbody>
</table>
| There needs to be consistency of focus across all healthcare settings. | • Involve tissue viability due to link between soft tissue infection and SABs.  
• Clinical teams to utilise Infection Prevention and Control data to inform improvement plans and practices to reduce incidence of Healthcare Associated Infection.  
• Collaborative working with Health Protection Scotland to continue to improve Infection Prevention and Control practice. |
| --- | --- |
| There is a need to sustain the Scottish MRSA Screening Programme. | • Investigation of patients testing positive within 48hrs of admission should include a retrospective review of previous healthcare contact. Where a link is found action should be taken by the relevant healthcare dept to investigate and address practice issues which may have contributed to acquisition.  
• Work with primary care and third sector partners, to continue to optimise early intervention in the community to reduce the risk of sepsis developing. |
| There is published evidence indicating certain antimicrobials are contributing to the risk of CDI. | • MRSA screening continues in required sites throughout NHS Lothian. Compliance with screening is stable at 95% with 3.6% incidence as positive.  
• There has been no indication from SGHD as to the future of this project beyond current funding period up to March 2012.  
• Exit Strategy developed to hand over surveillance to core infection prevention and control surveillance team from the MRSA Surveillance Nurses. Laboratory to submit finance bid to support ongoing testing processes within Laboratory. |
| There is a need to sustain the Hand Hygiene programme. | • Antimicrobial pharmacists and Microbiologists will provide guidance and advice on alternative antimicrobial prescribing in high-risk patients. Implementation of the revised UHD Antibiotic Prescribing Guidelines, which advocate minimal use of antimicrobials associated with high risk of contributing to CDI, will also facilitate a reduction in CDI rates.  
• Monitor low levels of prescribing in primary care and review to ensure continued improvement. |

*NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012*
An escalation process to be developed and implemented for failure to comply with hand hygiene practice.

Continue monitoring of audits to highlight areas at risk so necessary educational activities to influence practice can be put in place.

There is a risk of harm to patients through essential clinical interventions.

The introduction of care bundles related to Healthcare Associated Infection, for example for insertion of central venous lines, peripheral cannula and urinary tract catheters will assist in reducing the risk of bacteraemia.

There is a need to ensure that staff at clinical level take ownership.

The work required under the Scottish Patient Safety Programme will assist in reducing the risk of lack of ownership at clinical level.

For both SAB and CDI there is a need to ensure a focus on both high incidence areas and other areas with a lower incidence but larger patient population.

The work required under the Scottish Patient Safety Programme will assist in reducing the risk of lack of ownership at clinical level and encourage full coverage of the patient population.

Investigations of incidences should include review of clinical interventions in both acute and community healthcare.

IPCT can promote the use of and raise awareness of Patient Safety care bundles.

### Workforce

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<tr>
<td>Healthcare practice can contribute to the acquisition of SAB and CDI.</td>
<td>There is a need for clinical staff to recognise the importance of prompt analysis and implementation of recommendations. The impacts of interventions recommended are key to reduction in incidence. Staff will require time to investigate contributory factors and implement change.</td>
</tr>
<tr>
<td>Cross working between all involved groups and individuals is required.</td>
<td>Collaborative working and monitoring of progress through quality improvement and infection prevention and control committees.</td>
</tr>
<tr>
<td>Implementation of root cause analysis for all SAB and CDI requires support of the multidisciplinary team.</td>
<td>This can be a complex exercise and will require dedicated time, first to gather the information and secondly to progress changes in practice. As well as infection prevention and control this requires commitment from Nursing, Clinicians, Microbiologists and Pharmacists. Clinical staff have a responsibility to assess each incidence individually. Based on areas currently supporting this activity, it is</td>
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</table>
There is a need to spread key initiatives which contribute to the prevention of infections such as PVC bundles and antimicrobial prescribing guidelines.

- There is an active roll out plan utilising the Patient Safety Programme for activities to reduce the risk of infection such as PVC & CVC bundles, Hand Hygiene and Antimicrobial Prophylaxis.
- Clinical teams should be accountable for the implementation of the recommended interventions and changes in practice supported by IPCT, NHS Lothian Scottish Patient Safety Programme leaders and the NHS Lothian Antimicrobial Management Team (AMT).

There is a need to manage any loss of MRSA Screening programme staff as a result of end of dedicated project funding.

- Staff on secondment are returning to substantive posts by 31 March 2012.
- There is an impact on workforce for core surveillance team who will be required to take on this workload. It is anticipated this additional work can be supported through the movement of Surgical Site Infection for Surveillance to Lighted Data Load requirements by Health Protection Scotland.

There is a need to manage any impact of the loss of Hand Hygiene Co-ordinator posts.

- SGHD have advised that continued support for this post will be available until March 2013.

Staff need to continue to be educated sufficiently in HAI matters.

- There is an active education programme for Cleanliness Champions. HAI is a component of induction and mandatory update programme. Work is ongoing to link actions required following incidence of infection to staff development through exiting e-learning packages.
- To work collaboratively with workforce development to incorporate HAI education within the core staff workforce development policies and establish learning matrix for clinical groups.
- Provide education and awareness sessions for educators and public.

**Finance**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Management of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a need to manage any potential discontinuation funding of the Hand Hygiene Programme beyond March 2013.</td>
<td>SGHD have confirmed funding until March 2013. As part of service redesign consider how the hand hygiene co-ordinator post can be continued beyond 2013 should funding be discontinued.</td>
</tr>
<tr>
<td>Antimicrobial prescribing cost of alternatives to high risk</td>
<td>Substitution of high risk antimicrobial agents for CDI infection (i.e. broad spectrum)</td>
</tr>
</tbody>
</table>
medications. (with lower risk antimicrobials) is anticipated to be cost neutral. In addition, implementation of the CDI Reduction Programme and adherence to the revised Antibiotic Prescribing Guidelines will result in a reduction in use of antibiotics as both of these measures promote prudent antibiotic prescribing.

- As part of the surveillance of antibiotic use in NHS Lothian, the AMT plans to closely monitoring antibiotic usage and expenditure to minimise any possible risk.

There is a need to manage any potential loss of allocated time within the workplan for the Antimicrobial Lead Clinician due to funding challenges.

- Business case for continued funding of this aspect of AMT to be submitted by the Chair of the Antimicrobial Team for inclusion in the financial plan.

### Equalities

<table>
<thead>
<tr>
<th>Risk</th>
<th>Management of Risk</th>
</tr>
</thead>
</table>
| Service design, resources and delivery need to fully address the needs. | • Implementation of Infection Prevention and Control Service Redesign to ensure equity across acute and community service HAI agenda.  
  • Through monitoring and reporting priority areas can be identified to target resources to maximise impact and reduce the risk. |
| There is a need to manage patient and public anxiety over the risk of acquiring Healthcare Associated Infection. | • Enhance public confidence through patient public representatives being actively involved during the Healthcare Environment Inspectorate inspections, with one member sitting on the Healthcare Environment Inspectorate Steering Group. Other patient public representatives sit on the Infection Control Committees (Lothian Infection Control Advisory Committee, Acute and Community). |
To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14

**NHS BOARD LEAD:** Prof. Alex McMahon  
**Acting Director of Strategic Planning**

### Delivery and Improvement

<table>
<thead>
<tr>
<th>Risk</th>
<th>Management of Risk</th>
</tr>
</thead>
</table>
| There is a continuing demand for emergency access services from, growth in demand for unscheduled care, from actions of partners directing patients towards emergency access services and self presenters at A&E.  
(Impact of international evidence regarding the reduction in need for A&E attendance through preventative action, including shift from unplanned to planned care.) | • The work of the T10 Steering Group will be included in that of the Lothian Unscheduled Care Board to provide further energy to support work to address T10-related activity and to ensure actions support the re-invigorated 4-hour emergency access standard.  
• Lothian T10 actions during 2012-13 will again be aligned to the specific milestones, with identified leads for each milestone. These colleagues will be responsible for achievement of their respective milestone requirements and will report locally on progress to the service and to management and oversight groups as indicated. They will also contribute to regular informal and formal returns to the Scottish Government Emergency Access Delivery Team and others as appropriate.  
• Work will continue to explore the use of social marketing and signposting for self-presenting patients to direct them to self-care, GP care or minor injuries in line with their needs.  
• Partnership work with NHS24 and SAS will continue. This will once more focus on prevention of presentations by redirection of patients from A&E to alternative, appropriate settings in-hours and out-of-hours. As with 2011/12, this will aim to deliver a 2% reduction in all emergency activity by 2013/14. |
| There is a need to achieve data consistency across the various sites and demonstrate attributable change. | • T10 funding provided dedicated data analyst input from the Lothian Health Intelligence Unit (HIU) throughout the year to local services to service delivery partners and to the monitoring processes.  
• In 2012/13, data improvement work will be concluded and mechanisms will be developed to maintain achievements in data quality improvements in the emergency activity data. |
<table>
<thead>
<tr>
<th>Workforce</th>
<th>Management of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Management of Risk</td>
</tr>
</tbody>
</table>
| Changes to delivery of pilot arrangements over time need to be managed to secure the support of staff to make and maintain the changes over time and under pressure. | • Efforts will be made to mainstream initiatives which evaluate well and which deliver good outcomes, value for money and/or cost savings.  
• Working with colleagues in NHS 24, SAS and Lothian Unscheduled Care Service as well as colleagues in mental health and substance misuse directorates will be a focus this year. |

<table>
<thead>
<tr>
<th>Finance</th>
<th>Management of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Management of Risk</td>
</tr>
</tbody>
</table>
| Assessments need to be made on the sustainability of initiatives. | • It remains the case that when initiatives are evaluated, they will be assessed on the basis of efficiency / productivity / value for money / concordance with local and national policy.  
• Efforts will be made to mainstream those initiatives which deliver desirable clinical outcomes, while improving services in other ways.  
• Embedding of T10 work within the wider unscheduled care agenda and consideration of impacts on and relationship to the 4-hour Emergency Access Standard which also focus as part of the wider work around the clinical strategy. |

<table>
<thead>
<tr>
<th>Equalities</th>
<th>Management of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Management of Risk</td>
</tr>
</tbody>
</table>
| Service redesign and delivery needs to ensure there is no negative effect on equity of access for minority and hard to reach groups. | • Initiatives will be developed in such a way as to ensure barriers for minority and hard-to reach groups are not ‘designed in’ to the service.  
• Data will be analysed through the year to ensure services do not inadvertently exclude specific groups. |
This document is to be used by NHS Boards to

**Colour Coding Key:**

<table>
<thead>
<tr>
<th></th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance required to achieve target</td>
<td></td>
</tr>
<tr>
<td>Baseline position</td>
<td></td>
</tr>
<tr>
<td>Requested trajectories from April 2012 to achieve target delivery (Boards to complete)</td>
<td></td>
</tr>
</tbody>
</table>
2012/13 HEAT Targets

Detect Cancer Early

Early Access to Antenatal Care (SIMD)

Child Healthy Weight Interventions

Smoking Cessation (SIMD)

Child Fluoride Varnish Applications (SIMD)

Reduce Carbon Emissions

Reduce Energy Consumption

Drug and Alcohol Treatment: Referral to Treatment

Faster Access to CAMHS

Psychological Therapies

Reduction in Emergency Bed Days for Patients Aged 75+

28 Days Delayed Discharge

Stroke Unit

MRSA/MSSA Bacterium

Clostridium difficile infections

Rate of Attendance at Accident & Emergency
### Detect Cancer Early

#### Proportion of Colorectal, Lung and Breast Cancer Patients Diagnosed at First Stage of Disease

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>17.3%</td>
<td>17.5%</td>
<td>18.8%</td>
<td>20.0%</td>
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<tr>
<td>Borders</td>
<td>18.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>20.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fife</td>
<td>17.6%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>16.3%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Grampian</td>
<td>12.6%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>12.2%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Highland</td>
<td>16.8%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Lanarkshire</td>
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<td>20.0%</td>
<td>20.0%</td>
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<tr>
<td>Lothian</td>
<td>16.1%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Orkney</td>
<td>11.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shetland</td>
<td>11.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tayside</td>
<td>16.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Isles</td>
<td>15.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
1. Data based on calendar years.
2. 2005/2009 baseline data covers the average of the 5 calendar years from 2005 to 2009
3. Performance in 2014/2015 should be at least 20%
4. Performance Management Information for Target is currently under development
## Early Access to Antenatal Care (SIMD)

| Percentage of Pregnant Women Booked for Antenatal Care by 12th Week of Gestation in the worst performing quintile |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Ayrshire & Arran | Borders | Dumfries & Galloway | Fife | Forth Valley | Grampian | Greater Glasgow & Clyde | Highland | Lanarkshire | Lothian | Orkney | Shetland | Tayside | Western Isles |
| 2010 | 64.5% | 82.4% | 83.5% | 60.0% | 86.1% | 79.4% | 62.8% | 80.9% | 75.9% | 69.0% | 69.0% | 63.2% | 61.7% | 67.4% |
| Apr-Jun 12 | 70% | | | | | | | | | | | | |
| Jul-Sep 12 | 71% | | | | | | | | | | | | |
| Oct-Dec 12 | 72% | | | | | | | | | | | | |
| Jan-Mar 13 | 73% | | | | | | | | | | | | |
| Apr-Jun 13 | 74% | | | | | | | | | | | | |
| Jul-Sep 13 | 75% | | | | | | | | | | | | |
| Oct-Dec 13 | 76% | | | | | | | | | | | | |
| Jan-Mar 14 | 77% | | | | | | | | | | | | |
| Apr-Jun 14 | 78% | | | | | | | | | | | | |
| Jul-Sep 14 | 79% | | | | | | | | | | | | |
| Oct-Dec 14 | 79.50% | | | | | | | | | | | | |
| Jan-Mar 15 | 80% | | | | | | | | | | | | |

**Notes:**
1. Baseline data covers the calendar year of 2010.
2. Performance in Jan-Mar 2015 should be at least 80%.
Child Healthy Weight Interventions

<table>
<thead>
<tr>
<th>Cumulative Total</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 11 - Jun 12</td>
<td>440</td>
<td>130</td>
<td>182</td>
<td>435</td>
<td>283</td>
<td>583</td>
<td>1,403</td>
<td>364</td>
<td>1,175</td>
<td>945</td>
<td>21</td>
<td>27</td>
<td>456</td>
<td>31</td>
</tr>
<tr>
<td>Apr 11 - Sep 12</td>
<td>528</td>
<td>145</td>
<td>215</td>
<td>525</td>
<td>283</td>
<td>623</td>
<td>1,484</td>
<td>396</td>
<td>1,175</td>
<td>945</td>
<td>24</td>
<td>31</td>
<td>476</td>
<td>38</td>
</tr>
<tr>
<td>Apr 11 - Dec 12</td>
<td>616</td>
<td>180</td>
<td>248</td>
<td>615</td>
<td>433</td>
<td>803</td>
<td>1,985</td>
<td>461</td>
<td>1,375</td>
<td>1,210</td>
<td>27</td>
<td>38</td>
<td>596</td>
<td>44</td>
</tr>
<tr>
<td>Apr 11 - Mar 13</td>
<td>704</td>
<td>215</td>
<td>281</td>
<td>720</td>
<td>583</td>
<td>983</td>
<td>2,261</td>
<td>563</td>
<td>1,525</td>
<td>1,475</td>
<td>40</td>
<td>45</td>
<td>716</td>
<td>50</td>
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<tr>
<td>Apr 11 - Jun 13</td>
<td>792</td>
<td>245</td>
<td>314</td>
<td>825</td>
<td>583</td>
<td>1,156</td>
<td>2,533</td>
<td>671</td>
<td>1,650</td>
<td>1,740</td>
<td>43</td>
<td>52</td>
<td>843</td>
<td>56</td>
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<tr>
<td>Apr 11 - Sep 13</td>
<td>880</td>
<td>260</td>
<td>347</td>
<td>930</td>
<td>583</td>
<td>1,196</td>
<td>2,616</td>
<td>707</td>
<td>1,650</td>
<td>1,740</td>
<td>46</td>
<td>57</td>
<td>868</td>
<td>63</td>
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<tr>
<td>Apr 11 - Dec 13</td>
<td>968</td>
<td>296</td>
<td>380</td>
<td>1,050</td>
<td>733</td>
<td>1,376</td>
<td>3,115</td>
<td>779</td>
<td>1,745</td>
<td>2,005</td>
<td>49</td>
<td>63</td>
<td>993</td>
<td>69</td>
</tr>
<tr>
<td>Apr 11 - Mar 14</td>
<td>1,057</td>
<td>331</td>
<td>413</td>
<td>1,060</td>
<td>883</td>
<td>1,556</td>
<td>3,389</td>
<td>887</td>
<td>1,745</td>
<td>2,268</td>
<td>58</td>
<td>70</td>
<td>1,118</td>
<td>75</td>
</tr>
</tbody>
</table>

Notes:
1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above.
Smoking Cessation (SIMD)

<table>
<thead>
<tr>
<th>Cumulative Total</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 11 - Jun 12</td>
<td>1,500</td>
<td>350</td>
<td>525</td>
<td>1,480</td>
<td>1,251</td>
<td>1,940</td>
<td>4,864</td>
<td>990</td>
<td>2,471</td>
<td>3,063</td>
<td>30</td>
<td>48</td>
<td>1,526</td>
<td>73</td>
</tr>
<tr>
<td>Apr 11 - Sep 12</td>
<td>1,800</td>
<td>420</td>
<td>650</td>
<td>1,776</td>
<td>1,501</td>
<td>2,382</td>
<td>5,674</td>
<td>1,188</td>
<td>2,965</td>
<td>3,540</td>
<td>38</td>
<td>56</td>
<td>1,806</td>
<td>88</td>
</tr>
<tr>
<td>Apr 11 - Dec 12</td>
<td>2,100</td>
<td>490</td>
<td>775</td>
<td>2,072</td>
<td>1,751</td>
<td>2,770</td>
<td>6,484</td>
<td>1,386</td>
<td>3,459</td>
<td>4,005</td>
<td>50</td>
<td>64</td>
<td>2,041</td>
<td>102</td>
</tr>
<tr>
<td>Apr 11 - Mar 13</td>
<td>2,400</td>
<td>560</td>
<td>900</td>
<td>2,368</td>
<td>2,001</td>
<td>3,158</td>
<td>8,108</td>
<td>1,581</td>
<td>3,953</td>
<td>4,836</td>
<td>60</td>
<td>72</td>
<td>2,422</td>
<td>117</td>
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<tr>
<td>Apr 11 - Jun 13</td>
<td>2,700</td>
<td>630</td>
<td>1,025</td>
<td>2,664</td>
<td>2,252</td>
<td>3,546</td>
<td>8,918</td>
<td>1,776</td>
<td>4,447</td>
<td>5,361</td>
<td>70</td>
<td>80</td>
<td>2,737</td>
<td>131</td>
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<tr>
<td>Apr 11 - Sep 13</td>
<td>3,000</td>
<td>700</td>
<td>1,150</td>
<td>2,960</td>
<td>2,502</td>
<td>3,934</td>
<td>9,728</td>
<td>1,971</td>
<td>4,941</td>
<td>5,796</td>
<td>80</td>
<td>88</td>
<td>3,017</td>
<td>146</td>
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<tr>
<td>Apr 11 - Dec 13</td>
<td>3,300</td>
<td>770</td>
<td>1,275</td>
<td>3,256</td>
<td>2,752</td>
<td>4,322</td>
<td>10,538</td>
<td>2,166</td>
<td>5,435</td>
<td>6,219</td>
<td>95</td>
<td>96</td>
<td>3,251</td>
<td>160</td>
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<tr>
<td>Apr 11 - Mar 14</td>
<td>3,544</td>
<td>838</td>
<td>1,373</td>
<td>3,550</td>
<td>3,002</td>
<td>4,648</td>
<td>12,182</td>
<td>2,358</td>
<td>5,929</td>
<td>7,011</td>
<td>105</td>
<td>104</td>
<td>3,628</td>
<td>175</td>
</tr>
</tbody>
</table>

Notes:
1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above.
2. Number of successful quits at one month after the quit in 40% most-deprived areas within each NHS Board (i.e. the bottom two local SIMD quintiles).
# Child Fluoride Varnish Applications (SIMD)

<table>
<thead>
<tr>
<th>Period Ending</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-12</td>
<td>12.0%</td>
<td>44.0%</td>
<td>22.5%</td>
<td>20.0%</td>
<td>25.0%</td>
<td>40.0%</td>
<td>10.0%</td>
<td>30.0%</td>
<td>40.0%</td>
<td>14.0%</td>
<td>40.0%</td>
<td>30.0%</td>
<td>25.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Sep-12</td>
<td>19.0%</td>
<td>47.0%</td>
<td>27.5%</td>
<td>20.0%</td>
<td>30.0%</td>
<td>45.0%</td>
<td>15.0%</td>
<td>35.0%</td>
<td>50.0%</td>
<td>14.0%</td>
<td>40.0%</td>
<td>35.0%</td>
<td>30.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Dec-12</td>
<td>26.0%</td>
<td>50.0%</td>
<td>32.5%</td>
<td>30.0%</td>
<td>35.0%</td>
<td>48.0%</td>
<td>15.0%</td>
<td>40.0%</td>
<td>50.0%</td>
<td>15.0%</td>
<td>40.0%</td>
<td>40.0%</td>
<td>35.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>Mar-13</td>
<td>33.0%</td>
<td>53.0%</td>
<td>37.5%</td>
<td>30.0%</td>
<td>40.0%</td>
<td>50.0%</td>
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<td>50.0%</td>
<td>45.0%</td>
<td>40.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Jun-13</td>
<td>40.0%</td>
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Notes:
1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above.
## Reduce Carbon Emissions

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<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
<th>NationalWaiting-TimesCentre</th>
<th>State Hospital</th>
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<tbody>
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<td>2009/10</td>
<td>10,556</td>
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<td>5,875</td>
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Notes:
1. Values are in tonnes of CO2
2. Information for 2009/10 (baseline) is included in table
### Reduce Energy Consumption

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<th>Fife</th>
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<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
<th>National Waiting-Times Centre</th>
<th>State Hospital</th>
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<td>2009/10</td>
<td>289,793</td>
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**Notes:**
1. Values are in GJ.
2. Information for 2009/10 (baseline) is included in table.
## Drug and Alcohol Treatment: Referral to Treatment

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<th>Quarter of Treatment</th>
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<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
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<tr>
<td>Apr-Jun 11</td>
<td>90.4%</td>
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<td>76.3%</td>
<td>72.3%</td>
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<td>97.9%</td>
<td>49.3%</td>
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<tr>
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<td>82.0%</td>
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<tr>
<td>Jul-Sep 12</td>
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<td>92.0%</td>
<td>85.0%</td>
<td>83.0%</td>
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<tr>
<td>Jan-Mar 13</td>
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</table>

Notes:
1. Boards submitted trajectories during October 2011. These are provided in the table above.
2. Percentage of clients referred for drug or alcohol combined treatment are to be treated within 3 weeks from date referral received.
3. Published information for Apr-Jun 2011 is included in the table.
### Faster Access to CAMHS

| Patients who waited over 26 weeks for CAMHS treatment: Month of Treatment | Ayrshire & Arran | Borders | Dumfries & Galloway | Fife | Forth Valley | Grampian | Greater Glasgow & Clyde | Highland | Lanarkshire | Lothian | Orkney | Shetland | Tayside | Western Isles |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| May-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jun-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jul-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Aug-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sep-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Oct-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Nov-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dec-12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jan-13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Feb-13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mar-13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Notes:**
1. Trajectories submitted in October 2011 should be amended as appropriate with more recent performance management information.
2. Number of patients who waited over 26 weeks from referral to treatment.
3. Scottish Government are considering a tolerance for this target and this will be discussed with Boards during the LDP process.
### Faster Access to Psychological Therapies

**DO NOT COMPLETE - TO BE UPDATED DURING 2012/13 LDP YEAR**

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**Notes:**
1. Trajectories to be agreed by October 2012.
2. Number of patients who waited over 18 weeks from referral to treatment for Psychological Therapies
3. Scottish Government are considering a tolerance for this target and this will be discussed with Boards during the LDP process
Reduction in Emergency Bed Days for Patients Aged 75+

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<th>Year Ending</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
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Notes:
1. The data are the number of emergency bed days in a year per 1,000 population.
2. Boards have been provided separately with more recent performance management information (up to year ending June 2011).
The trajectories are still draft as work is planned with Scottish Government and JIT to undertake capacity and demand analysis to determine how the 4 week target will be reached in Edinb

Notes:
1. Number of NHS Delayed Discharges above 28 Days (4 Weeks)
2. Census night in October 2011 is included in the table
## Stroke Unit Access

<table>
<thead>
<tr>
<th>Quarter of Admission</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
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<th>Orkney</th>
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Notes:
1. Boards submitted 2-year trajectories for Stroke Access in the 2011/12 LDPs. These are provided in the table above.
2. Percentage of stroke patients admitted to stroke unit on day of or day following, admission to hospital.
3. Patients are assigned to the board of original hospital admission.
4. Monthly management information is available to NHS Boards.
5. All hospitals admitting acute stroke patients are included in the target.
6. Baseline information for calendar year of 2010 is included in the table.
### MRSA/MSSA Bacterium

<table>
<thead>
<tr>
<th>Year Ending</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
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Notes:
1. Boards submitted 2-year trajectories for number for MRSA/MSSA in the 2011/12 LDPs. These are provided in the table above.
2. Boards are expected to achieve a rate of 0.26 cases per 1,000 acute occupied bed days or lower by year ending March 2013. Boards currently with a rate of less than 0.26 are expected to at least maintain this, as reflected in their trajectories.
3. Boards will be held to account against the 0.26 rate.
4. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
5. Information for year ending June 2011 is included in the table.
### Clostridium difficile infections

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</tbody>
</table>

Notes:
1. Boards submitted 2-year trajectories for number for C Difficile in the 2011/12 LDPs. These are provided in the table above.
2. Boards are expected to achieve a rate of 0.39 cases per 1,000 acute occupied bed days or lower by year ending March 2013. Boards currently with a rate of less than 0.39 are expected to at least maintain this, as reflected in their trajectories.
3. Boards will be held to account against the 0.39 rate.
4. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
5. Information for year ending June 2011 is included in the table.
## Rate of Attendance at Accident & Emergency

<table>
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<tr>
<th>Year Ending</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
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Notes:
1. Trajectories show anticipated monthly average attendance rates per 100,000 population at specified departments for year ending in the months shown. The target will be monitored using the 12 month moving average - based on attendances at these sites as reported by ISD, and relevant NRS mid-year population estimates.
2. Baseline information for financial year of 2009/10 is included in the table.
As required by Scottish Government guidelines we will have developed a comprehensive Workforce Plan by the end of June.

1. PLANNED CHANGES IN SKILL MIX

In 2010/11 NHS Lothian set out a workforce plan which outlined the need to reduce its workforce by 734 whole time equivalents (wtes), approximately 1,000 headcount as part of a two year agreement with local Partnership representatives to reduce the workforce by 2,000 posts. This reflected the need to address unprecedented financial pressures faced by NHS Lothian and other NHS Boards.

NHS Lothian remains on course to achieve this targeted reduction through a wide range of measures as set out in the 2011/12 workforce plan. It is however clear that continuing to reduce the workforce to this extent each year would be unsustainable and therefore the 2012/13 efficiency and productivity plans need to focus on other means of achieving savings within workforce expenditure.

1.1. Nursing / Midwifery

Whilst nursing workforce reductions are being achieved in both 2010/11 and 2011/12 the skill mix between registered and non-registered nursing/midwifery workforce has changed only slightly. In 2012/13 there will be a considerably stronger focus on reviewing skill mix and the identification of a broader more balanced skill mix to ensure we continue to deliver safe and effective services.

NHS Lothian is however currently reviewing skill mix as part of its approach to workforce modernisation. There are currently significant differences across services and a number of service areas are now working to identify a broader more balanced skill mix to ensure we continue to deliver safe and effective services. Based on an analysis of the competences required in some areas we are setting individual skill-mix targets. For example within Out–Patient Departments, we are iteratively moving towards a 20/80 split (registered/ non-registered) within the nursing workforce, which better reflects the resource potential of the non-registered element of the workforce. We are also developing skill-mix within primary care, particularly across individual Community Health Partnerships (CHPs), where a more consistent skill mix will more effectively support the delivery of a range of community based services.

Piloting and testing of a new Healthcare Technician role has started, which has been designed to more closely align with the needs of patients. This pilot will help inform the extent to which a wider skill mix can be deployed whilst improving services and developing savings in workforce costs.
This work is being led by a working group under the direction of the Board Nurse Director and the Employee Director. The emerging outputs and recommendations will support further strategic decision making at NHS Lothian Board level.

1.2. Allied Health Professions

As part of an ongoing review of Allied Health Professions across NHS Lothian there is a commitment to review the workforce skill-mix to ensure that it will more accurately reflect the needs of the services both currently and in the future. As a result services are working towards a skill mix across the AHP workforce as whole of 75:25 (registered/ non-registered). Between March 2010 and December 2011 the proportion of the band 1 to 4 workforce has doubled from 8% to 16%. Whilst this represents significant progress further work remains to achieve the target for the AHP Review.

The review has set a target reduction of 15% in band 7 and 8 posts over the period between 2010 and 2013 through restructuring. There will also be an enhancement of single system management of AHPs across clinical pathways.

Clinical models are being reviewed and revised to improve quality and efficiency and designing novel interventions through self referral, use of tele-healthcare, utilising skill sets of other professionals such as fitness instructors and also working on more group work to maximise the efficiency available from our workforce. There are areas such as radiographer plain film reporting that are being looked at on a regional basis to see whether they offer the opportunity to generate saving and free up time for Radiologists to focus on more complex areas.

In 2012/13 there will also be a focus on introducing skill mix within all job families and all areas as through the evolving models of work and information technology there are opportunities modernise the workforce.

2. EXISTING AND PLANNED NEW SERVICE AREAS WHICH WILL REQUIRE WORKFORCE REDESIGN

NHS Lothian has a detailed 5 year capital plan aimed at modernising Healthcare premises in order to meet current and future service demand both within acute hospitals and community settings. The following section sets out some of the key projects underway. These projects will require us to redesign our workforce in order to meet the service modernisation plans.

2.1. Reprovision of services for older people in North Edinburgh

This includes a new Royal Victoria Hospital facility at the Western General Hospital, which is currently under construction. This project is underpinned by a revised model of care which will see both enhanced hospital and health and social community care capacity and is being progressively implemented. The implementation of the model of care, ensuring appropriate flow through the whole system will see the development of new ways of working within hospital medical, nursing and allied health professional teams. The subsequent change in relationship with community health and social care teams is the key focus in ensuring
increased productivity and improved outcomes for older people, as we move forward to deal with growing older population. The Royal Victoria Building is due to be operational in June 2012.

2.2. Building a new department of clinical neurosciences and a children and young people’s hospital at Little France

NHS Lothian plans to relocate the Department of Clinical Neurosciences from the Western General Hospital, and the Royal Hospital for Sick Children at Sciennes, to a new building alongside the Royal Infirmary of Edinburgh (RIE) at Little France. This is a key project aimed at:

- Providing a modern purpose-built hospital with improved facilities for patients and staff
- Providing age appropriate facilities for all patient groups
- Co-locating a range of specialist adult, maternity and neonatal services in the RIE to provide improved clinical care and patient journeys
- Service delivery that supports sustainable local, regional and national services

This project will require us to consider the integration of services within Clinical Neurosciences and Children, with the main site which will have significant implications for our staff but will provide a more efficient and effective workforce model for acute services.

The Outline Business Case to deliver the new build as a Non Profit Distributing (NPD) project was submitted to Scottish Government in December 2011. Agreement to proceed to procurement of an NPD partner is expected by the end of March 2012.

2.3. Musselburgh Primary Care Centre

NHS Lothian’s long term strategy echoes the principles of local accessibility by emphasising the need to provide a wider range of services to people in their local communities and to develop greater local integration. The re-provision of integrated health services in Musselburgh is one of the priorities within Lothian’s Improving Care Investing in Change (ICIC) strategy and the Board’s Capital Plan.

Bringing together the NHS services that are currently dispersed across the Edenhall Hospital site, the three Musselburgh GP Practices and other areas of Musselburgh into a purpose built Musselburgh Primary Care Centre (MPCC) will allow every opportunity for maximum integration to take place.

Developments such as this will be key in facilitating the shift in the balance of care through proving access to the full range of primary care services in a modern ‘state of the art’ facility. To complement this we will have to redesign and reorganise staff groups which will be affected by this change.
3. WORKFORCE PRESSURES

The requirement for substantial workforce reductions in 2010/11 and 2011/12 has been met by the achievement of a large number of detailed local reinvestment plan efficiency and productivity schemes. These plans have been developed and implemented with a high degree of involvement of partnership from services and trade unions working side by side.

However there have remained a significant number of workforce pressures both in terms of the supply and demand for both financial resources and workforce. Whilst the financial climate has undoubtedly provided substantial challenges in the short to medium term the challenges associated with the long term remain.

Providing world class services to a population that is projected to grow significantly across all age ranges whilst the level of financial resources remain significantly behind the nationally identified NRAC allocation. Whilst it is recognised that removing resources from other areas with contracting populations is difficult this does not negate the challenges in providing services for a growing population.

NHS Lothian is currently developing its Clinical Strategy to set out how these long term challenges will be addressed.

3.1 Reshaping the medical workforce

The planned reduction as part of the national reshaping project will make sustaining training grade rotas difficult unless alternative staffing models can be found. The development of alternative workforce solutions, such as advanced practitioners requires to be funded at least 2 years in advance of monies being released. It is also difficult to determine where vacancies/gaps will occur and therefore where funding may return to the service.

Clinical Management Teams have been tasked with developing local action plans, which set out sustainable workforce models. Planning for the reductions can also be difficult where there is uncertainty around projected numbers and glide paths.

Whilst there is a commitment to return funding to Boards following the removal of a training post it is not yet clear where the funding for new training programmes set out in the annual SG consultation on training numbers will come from.

3.2 Addressing workforce supply issues

Whilst reshaping the medical workforce provides one of the main challenges as outlined above there are substantial workforce pressures already in existence within Lothian and the South-east region.

Within the South-east region there are pressing challenges in sustaining Higher Specialty Trainee rotas within Paediatrics Services. There have been substantial pressures for the last three years as a result of the unprecedented level trainees on either maternity leave, out of programme research or achieving placements on UK level sub specialty training programmes.
In previous years the South-east region has worked collaboratively to deploy trainees to help support out of hours cover where gaps arise. However the magnitude of gap anticipated in the first half of 2012 (up to 14.5 slots) will make this unsustainable with a consequent requirement for trained doctor replacements.

Whilst challenges within Paediatrics are pressing medical workforce issues there are also workforce supply challenges within other areas where we have small specialised areas within our workforce such as medical physics, oncology medical physics and orthoptists. There are also other similar areas that will be detailed in our workforce plan where there are relatively small numbers of specialist areas where there are difficulties either in either recruitment or succession planning due to the lack of training programmes within Scotland.

4. WORKFORCE EFFICIENCY SAVINGS

The following section details how the workforce is contributing to efficiency savings.

4.1 Workforce Projections

- The workforce reduction target for 2011/12 was 734 wte
- Trajectory for December 2011 was 550 wte
- Actual reduction of 653.4wte at December 2011
- 103.4 wte ahead of trajectory
- With 3 months to go we have achieved 89% of our target, 14% ahead

4.2 Sickness Absence

- Sickness absence latest average of 3.74% for the current year (November 2011)
- It was 4.23% for same period in 2010/11
- This equates to 85wte or £3.3m

4.3 25% Management Reduction

- Scottish Government target to reduce management by 25% over 2010 to 2014
- Target of 43.6wte
- March 2012 trajectory of 21.8wte, (50%)
- Actual reduction of 27.7wte i.e. 65.3% of target, 5.9wte and 15.3% ahead of trajectory
- Planning for additional 'spend to save'

4.4 Workforce Productivity

The following chart illustrates the increasing workforce productivity since 2010, with the population increasing by 2.3% whilst the workforce has reduced by 4.2%.
The following chart illustrates the increasing workforce productivity in relation to activity since 2010, with overall activity increasing by 1% whilst the workforce has reduced by 4.2%.

4.5 Staff Turnover

Staff turnover remains at a level sufficient to achieve the workforce change in overall numbers. However the staff turnover rate is not at the same level throughout services and job families and therefore there is a requirement to place individuals on the local redeployment register.

Achieving the Management and Managerial reductions is especially challenging, with Senior/Executive Managers and Band 8 and above as turnover is low.
### 4.6 Workforce Projections for 2012-13

Workforce savings will be dependant upon:
- Achieving skill mix change
- Continuing to reduce sickness absence and consolidate reductions
- Reducing the wider cohort of managerial posts

Achieving these changes will focus on:
- Less use of staff bank
- Review of off ward nurses
- Alignment to service/clinical change

### 5. HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT STRATEGY

The Human Resources & Organisational Development Strategy will shape how we move forward through our fundamental principles highlighted below.

- **Living Values**
  - Employability and Social Responsibility
  - Promoting Organisational Values and an Aspirational Culture

- **Engaging leadership**
  - Best Practice in Leadership, Staff Governance Standard, Performance Management and Compliance
  - Managing Change – Organisational Design, Development, Implementation and Sustainability

- **Delivering Quality**
  - Workforce Planning and Redesign, Modernisation and Productivity
  - Provision of Care and Expert Human Resources and Organisational Development Services and Systems

Some specific challenges from the Strategy will include:
- Making a step change in performance in relation to Socially Responsible Recruitment as part of a public health approach to minimising the links between poverty and ill health
- Improving our performance management arrangements
- Getting sickness absence down to 3.5% then sustaining it
- Making sure staff are motivated to do the best for patients everyday all of the time
# NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements

Please refer to the Guidance Notes prior to completing the template.

<table>
<thead>
<tr>
<th></th>
<th>NHS Board:</th>
<th>Community Planning Partnership:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lothian</td>
<td>East Lothian</td>
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</table>

| 3. | Summary of critical issue: | Early Years |
|    |                           | Getting it right for children and young people, families and carers, from the start, ensures that young children are healthy, happy and ready to succeed in life. Children’s life chances depend significantly on the quality of experience they have in their first years; the secure and reliable attachments they have with parents and other adults important to them; the relationships they build with other children and within their families and communities; the quality of care they are given by parents and other carers; the richness of the learning opportunities they have; and the support and services which children, parents, families and carers can rely on.  

East Lothian Council and its partners in health, the voluntary, third and private sectors have done much in recent years in this area. A key development has been the Support from the Start test site which has been running in some areas of the country.  

Support from the Start was established in East Lothian as a test site for the National Equally Well strategy in October 2008. It built on existing planning arrangements but sought to more effectively address inequalities in health and well being by doing some new things and doing some things differently. The development of a network of service and community champions, active community engagement and shared learning were integral to the successful development of the test site. |
An evaluation undertaken by Queen Margaret University found that:

Changes identified by parents and families include:
- Parents identifying greater confidence and resilience in their children
- Improved routines and patterns in family life
- Improved transitions between services for children and their families.

For parents their involvement in ‘Support from the Start’ groups led to:
- Improved family relationships
- Improvements in mental health and wellbeing
- Reported increase in confidence.

Early years practitioners have developed:
- New ways of working and
- Increased ability to manage devolved budgets.

Learning from ‘Support from the Start’, as documented in the evaluation report, includes:
- Strategic leads need to endorse and be visible in the health inequalities agenda
- Community engagement and involvement in service design has been fundamental
- Support structures need to be in place to facilitate shared learning
- Giving permission and support to front line staff to progress action in a way that they believe will make a difference has resulted in improved early outcomes.

| 4. Community Planning Partnership Outputs: | The approach envisaged in the second phase of Support from the Start and the broader early years review process fits well with the findings and recommendations the report by Susan Deacon as national early years champion – ‘Joining the Dots’. It also accords well with principles set out by the Christie Commission on the future management of public services, with a particular focus on prevention and early intervention. |
It will contribute significantly to the single outcome agreement (SOA) – ‘East Lothian’s children have best start in life and are ready to succeed’ by investing in and developing community resources for early child development.

Tackling inequality as envisaged by the ministerial task force for Equally Well remains at the heart of the proposed second phase of Support from the Start by giving priority to the best possible start for all East Lothian’s children. As such this work will also contribute to SOA outcome no 4 – ‘The life chances for children, young people and families at risk or with a disability in East Lothian are improved’.

5. **Local Outcome(s):**
   - East Lothian’s children have best start in life and are ready to succeed
   - The life chances for children, young people and families at risk or with a disability in East Lothian are improved

6. **National Outcome(s):**
   - Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
   - Our children have the best start in life and are ready to succeed.
   - We have improved the life chances for children, young people and families at risk.

7. **Please detail the specific contribution of the NHS Board in tackling this critical issue?**

There are a range of contributions currently made in the area of early years support, from midwifery, health visiting, primary care and other services. However specifically in relation to Support from the Start Mid & East Lothian Community Health Partnerships have agreed that the Public Health Practitioner post holders will provide co-ordination to the local cluster/link up groups as part of their roles.

Current Support from the Start Champions will also be expected to help lead on area of development across the area, ensuring that any barriers to service change are addressed at the earliest opportunity.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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</thead>
<tbody>
<tr>
<td>8. Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?</td>
<td>This work is fully integrated into the community planning process and feeds back directly through the Getting it Right for Children and Young people Community Planning Theme group. The achievement of the outcomes within Support from the Start can’t be achieved without the strong partnership working across other community planning partners such as education, voluntary organisations, private sector agencies and perhaps most crucially, local communities.</td>
</tr>
</tbody>
</table>
| 9. Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP? | Performance management is undertaken by the Early Years review group and fed into the Support from the Start Project Board which links into the Getting it Right for Children and Young people Community Planning Theme group. This theme group is part of the wider Community Planning structures within East Lothian and reports on progress to the CP Board of which NHS Lothian are represented. The overall performance management is linked to the local outcomes and indicators within the Single Outcome Agreement, which include:  
  • % of children exclusively breast-fed at 6-8 weeks  
  • % of all East Lothian children aged 3-5 registered with a dentist (by postcode)  
  • % of children in P1 who are above the 95th centile of BMI (Body Mass Index)  
  • % of children assessed as 'vulnerable' in East Lothian communities in the five domains of early development (Physical Health and Wellbeing; Social Competence; Emotional Maturity; Language and Cognitive Skills; Communication Skills) as assessed by the Early Development Index |
<p>| 10. Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue? | There is already good evidence of continuous improvement associated with Support from the Start as demonstrated through the research into the first phase of the programme. The work has now been extended to include Midlothian and additional Public Health Practitioner time has been allocated to support the work in Midlothian as part of phase 2. There has also been a series of information sessions to key stakeholders across Lothian on the approach adopted within Support from the Start and this will continue as the programme develops further. |</p>
<table>
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<th><strong>NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements</strong></th>
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<tr>
<td>2.</td>
<td><strong>Community Planning Partnership:</strong> Edinburgh</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Summary of critical issue:</strong> Female offending is less frequent, less serious and more transient than offending by men and women represent a relatively small proportion of those imprisoned by the courts (McIvor, 2007). However, in last 10 years the number of women in custody in Scotland has doubled. Over the same period there is no evidence of increased incidence or seriousness of crime committed by women (McIvor &amp; Burman, 2011). In July 2011 HMP Edinburgh opened a women’s wing as additional capacity was required in the prison estate to respond to sustained increases in sentencing women to custody. Many women involved in offending behaviour are vulnerable people whose offending is a result of chaotic lifestyles, mental health difficulties and severe addiction problems. Women in HMP Corton Vale were found to have exceptionally high levels of health needs with 98% having an addiction problem, 80% having a mental health problem, 70% having been abused and 50% engaging in self-harm (Scottish Government, 2008). Women who have offended are frequently serially victimised in childhood and into adulthood. While male offenders often share many of these characteristics, problems among women are generally more acute, intense and complex and women present less of a threat to public safety (Loucks, 1998). The Equally Well task force recommended that improving the health of women offenders should be a priority area for action addressed through partnership working (Scottish Government, 2008).</td>
</tr>
</tbody>
</table>

The Equally Well task force recommended that improving the health of women offenders should be a priority area for action addressed through partnership working (Scottish Government, 2008).
The complexity in the lives of women who offend requires a multi-agency community based response. Imprisonment often weakens or destroys women’s ties to the community, including ties with their children (Sheehan & Flynn, 2007). Women have different pathways into and out of crime than men and require flexible, responsive and intensive community support delivered in a safe and accessible environment (McIvor, 2007). Evidence suggests the provision of a holistic ‘one-stop-shop’ underpinned by effective multi-agency co-operation enabling access to services and supports has the potential to support women out of crime and address their unmet health, welfare and social needs.

4. Community Planning Partnership Outputs:

NHS Lothian, SACRO and City of Edinburgh Council work in partnership to pilot a holistic, women centred, integrated service for women who have offended that is less stigmatising, more cost effective than custodial sentences and more importantly engages women and addresses their multiple needs. Staff from the partner agencies work together in a co-located multi-disciplinary team. The pilot service is based around a groupwork model, although each woman is assigned a key worker to focus on their individual needs.

From September 2010 to December 2011, 15 women completed the programme. Outcome measures and external evaluation show women completing Willow to have:

- Improved well being, self-confidence and self identity
- Improved physical health and access to healthcare services
- Improved social connections and positive relationships
- Improved ability to cope with past traumas and abuse
- Reduced use of drugs and alcohol
- Reduced offending

5. Local Outcome(s):

- Edinburgh’s citizens experience improved health and wellbeing, with reduced inequalities in health
- Edinburgh’s communities are safer and have improved physical and social fabric
6. **National Outcome(s):**
   - We have tackled the significant inequalities in Scottish society
   - We have improved the life chances for children, young people and families at risk
   - We live our lives safe from crime, disorder and danger
   - We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others

7. **Please detail the specific contribution of the NHS Board in tackling this critical issue?**

   **NHS Lothian:**
   - is the lead partner and chairs the strategic project board
   - commits £60k per year to the pilot service including the following staff time: 0.2 wte Clinical Associate Applied Psychology and 0.1wte Keep Well Nurse Case Manager
   - provides accommodation for the programme delivery and hosts the multi-agency team
   - works closely with partners to develop integrated policies to support quick and easy access to NHS services

8. **Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**

   **NHS, CEC Criminal Justice Social Work and SACRO staff work as a co-located multi-disciplinary team bridging traditional organisational boundaries to provide a service to this excluded and vulnerable group of women. A range of additional partners, including Venture Trust, Edinburgh Community Food Initiative, Festival Theatre and Access to Industry, contribute to the overall programme.**

   Women attend Willow two days a week and participate in a group work programme. Each woman is also assigned a key worker for individual support and person centred goal planning. The programme includes:
   - Connections – supporting desistence by promoting self-esteem, self identity and addressing offending behaviour
   - Survive and Thrive – support to cope with the effects of trauma and abuse
   - Reaching In – Reaching Out – building social capital and developing links with the local community
• Health Promotion including smoking cessation, physical activity, nutrition and sexual health
• Health Check and support to access primary and secondary health care services
• Support to access further education and employability services

The partnership has overcome financial, structural, cultural and process challenges to deliver the service through one access point. Through pooled resources and working together women completing the programme have experienced transformational change that could not be achieved by any single agency input.

9. Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?

NHS Lothian co-ordinate and convene a multi-agency project board to oversee the development and delivery of Willow.

The following 5 outcome areas are measured pre and post programme and reported to the project board.

<table>
<thead>
<tr>
<th>Outcome Area</th>
<th>Outcome Measure</th>
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<tbody>
<tr>
<td>Mental Health &amp; Wellbeing</td>
<td>CORE and PTSD Checklist</td>
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<tr>
<td>Offending</td>
<td>Self report</td>
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<tr>
<td></td>
<td>Staff observation/report</td>
</tr>
<tr>
<td>Physical Health</td>
<td>Self report</td>
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<td></td>
<td>Staff observation/report</td>
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<td>Health improvement</td>
<td>Self report</td>
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<td></td>
<td>Staff observation/report</td>
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<tr>
<td>Substance use</td>
<td>Self report</td>
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<td></td>
<td>Staff observation/report</td>
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Longer-term follow up to assess if outcomes are sustained 6-2 months after completion of the programme is planned.
The work within Willow will also contribute to the local indicator within the Edinburgh SOA to reduce reoffending rate for adults subject to public protection arrangements p.a. / 1000 population compared to peer authorities.

The outcomes from Willow are reported through the Edinburgh Community Health Partnership, which has a strategic lead within the Edinburgh Partnership for overseeing the health outcomes. There is also emerging work through the Community Safety Partnership to ensure the contribution of the Willow Service is reflected in the wider reoffending agenda.

| 10. | **Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?** | Willow is continuously reviewed and improved through a process of internal audit of outcome measures on completion of each group work programme. The service is continuously evolving based on the evidence of what works gained both from the academic literature and through the delivery of the service itself. NHS Lothian is also working closely with Lothian and Borders Community Justice Authority to explore how the ethos and approach of Willow could be rolled out across other parts of Lothian. |
**NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements**

Please refer to the Guidance Notes prior to completing the template.

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<tr>
<th></th>
<th>NHS Board:</th>
<th>Community Planning Partnership:</th>
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<tr>
<td>1</td>
<td>Lothian</td>
<td>Midlothian</td>
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<td>2</td>
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</table>
| 3 | Summary of critical issue: | In Midlothian, the Community Planning Partnership has analysed socio economic and demographic information as a means of influencing the development of this SOA. Taking into account planned new housing developments, Midlothian’s Community Planning Partnership estimates the area’s population will increase to 89,750 by 2020. This contradicts recent estimates produced by the General Registers of Scotland predicting a slight population decrease of approximately 79 people by 2020. The 60+ age groups are growing in comparison with the rest of the population. Midlothian will soon have more people of pensionable age than children. This is likely to have major implications for public services and for the local labour market. The recent report by GROS are projecting an increase of over 100% in the 75+ population between 2010-2035.

In terms of the wider policy agenda on shifting the balance of care, the Midlothian partnership has successfully achieved its target for delayed discharges but continues to maintain it as a priority area. Resources have been transferred from care home settings into community based alternatives and this process will continue. The role of unpaid/family Carers is a Local and National priory and Social Work works with partner agencies in the voluntary sector to ensure that their needs are identified and appropriate support and short breaks are available. |
The Midlothian partnership has been able to utilise the initial Change Fund resources to build on the successes of its transformation programme. This is perhaps best-evidenced through the workstreams that support capacity-building in the voluntary/independent sector, such as the extension of the reablement model. This continues the direction of travel and supports sustainability in future years. Such transformation has only been possible through strong partnerships and the Change Fund has accelerated the process by which the existing partnerships can jointly develop and manage commissioning strategies to ensure more effective and efficient services.

However, it is clear to all partners that if we are to realise our ambitions of providing seamless integrated care across primary, secondary, community and social care, then further work is required, support by the Change Fund.

4. Community Planning Partnership Outputs:

The Change Fund in Midlothian is a partnership approach with Midlothian Council, NHS Lothian and Midlothian CHP, Midlothian Voluntary Sector Providers, Midlothian Independent Sector Care Providers and VOCAL. A range of activities and interventions (detailed below) are being supported during 2012/13 to support the delivery of local and national outcomes.

- Preventative & Anticipatory care
  - Day treatment in local community hospital
  - 24-hour falls response service inc. SAS referral
  - Specialist input on respiratory conditions
  - Implementation of extra care housing mode. This will include the new development in Penicuik as part of the Phase 2 new build housing programme agreed by Council on 22/02/11
  - Day support – social isolation
  - Carers education
  - Short Breaks

- Proactive Care and Support at home
  - Increased skills to support people to die at home/ in care homes (linked to Complex...
<table>
<thead>
<tr>
<th>Local Outcome(s):</th>
<th>National Outcome(s):</th>
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<tr>
<td>- Enhance the Quality and Capacity of Services to Support People Safely in Their Own Homes&lt;br&gt;- Enhance Support Systems for Carers</td>
<td>- We live longer, healthier lives&lt;br&gt;- We have tackled the significant inequalities in Scottish society&lt;br&gt;- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others&lt;br&gt;- Our public services are high quality, continually improving, efficient and responsive to local people’s needs.</td>
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Development of more capacity in care homes to manage ill health/end of life care. Telecare/telehealth

- Effective care at times of transition
  - Assessment and step-down beds in Highbank
  - AHP time to enhance Community Rehab. capacity in relation to Intermediate Care
  - Working with social care sector on medication management
  - Local authority and independent CAH providers Reablement and Rehabilitation

- Hospital & Care Homes
  - Assessment and step-down beds in Highbank
  - Hospital in reach and needs assessment (L.T. replace SW service provided by City of Edinburgh)
  - Working with social care sector on medication management
  - Development of more capacity in care homes to manage ill health/end of life care.

- Enablers
  - Increased skills to support people to die at home/in care homes (linked to Complex Care Review)
  - Development of more capacity in care homes to manage ill health/end of life care.
  - Quality assurance of independent sector

5. Local Outcome(s):

6. National Outcome(s):
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<th>7.</th>
<th>Please detail the specific contribution of the NHS Board in tackling this critical issue?</th>
<th>As noted above in section 4, there are a range of activities and workstreams to support the delivery of the outcomes, of which NHS Lothian are specifically contributing to, including provision of AHP and nursing input as well as input from acute and community health services. The role of Midlothian CHP is crucial in co-ordinating this contribution. Strategic Planning direction and leadership – service redesign with local authority colleagues associated with the development of joint plans/strategies for older people and catalysed by the NHS top sliced change fund contribution. Health Intelligence Unit support to confirm projected capacity against future demand – feed this into the joint commissioning strategies development.</th>
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<td>8.</td>
<td>Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?</td>
<td>The governance for the partnership is firmly rooted within community planning partnership structures, acknowledging that the Change Fund ethos of equal partnership between sectors aligns with community planning’s vision of agencies and communities working together to plan and deliver better services. This approach is strengthened by the capacity to utilise lower-level partnerships within the community planning structure to allow more meaningful involvement from a greater number of voluntary and independent sector representatives.</td>
</tr>
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</table>
| 9. | Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP? | The key indicators used to monitor performance, and reported through the appropriate governance structures within NHS Lothian are:  
- reduce emergency admissions  
- reduction in acute bed days rate  
- reduction in delayed discharges  
- improve quality of healthcare experience  
- improve end of life care, improve mental well being |
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<tr>
<th>10. Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?</th>
</tr>
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</table>

- improve support to meet care needs
- improve perceptions of care needs
- increase levels of support in intensity and numbers

There is also performance monitoring on local indicators undertaken via the joint performance framework locally in Midlothian, which in turn will report on progress through the SOA into the Midlothian Community Planning Steering Committee.

Performance management information will be used to determine trends and evaluate projections against population increases to determine demand on services, which will be enhanced, and reshaped to meet future needs.

The Change Fund allocation has a specific innovation element to it, allowing new ways of working and service delivery to be tried to achieve best results in the future.

The joint plan will be implemented using the Change Fund as a catalyst to achieve a shift in the balance of care to home or homely setting, whilst redesigning health and social care delivery and supports in order to meet future demands, across the whole system.
**Summary of critical issue:**

Scots across all ages and socio-economic groups are drinking to harmful levels. The resultant health and social harms from problematic alcohol are evident in West Lothian and place a heavy burden on us all, including costs to health and social work services, crime, loss of productive capacity and wider social costs such as mortality and family breakdown. There were 1,146 hospital discharges for alcohol-related causes in West Lothian in 2010, and levels of hospitalisation for alcohol-related medical causes in West Lothian are the highest of the Lothians and similar to Scotland’s high average. Drinking is also a major contributory factor to crime rates in Scotland, with 50% of prisoners reporting being drunk at the time of their offence (77% for young offenders) and 70% of assaults requiring treatment in A&E are thought to involve alcohol.

Within Lothian, alcohol consumption within the male population is extremely high and 31.7% of men who drink are hazardous drinkers (i.e., they drink over 21 units/week, levels which may cause long-term health harm). Likewise the female population of Lothian has among the highest levels of alcohol consumption in Scotland; 23% of women drink at hazardous levels (over 14 units per week). More than a quarter of the adult population in Lothian are drinking at harmful levels and they are the main target of prevention and early intervention measures.
The West Lothian Tobacco Alcohol and Drug Partnership (TADP) is a multi-agency strategic and operational partnership that reports to the CHCP and is tasked with identifying and co-ordinating local action and prioritising on tobacco, alcohol and drug use. Reducing the alcohol consumption of heavy but non-dependant drinkers is a key part of TADP’s whole population strategy to reduce alcohol related harm.

Among the raft of interventions and policies directed at achieving this outcome is the delivery of **Alcohol Brief Interventions (ABI’s)** – structured conversations between a professional and an individual about their drinking, which aim to motivate and empower them to change their behaviour. ABI’s have a significant impact on people who are drinking enough for it to be causing health, personal or social problems but are not (presently) so severely affected to need treatment. They are a highly effective and inexpensive way to encourage heavy (but non-dependent) drinkers to reduce their consumption. Opportunistically intervening with those who would never present to specialist services can have a dramatic and enduring effect on individuals, and the effect of a programme of these is potentially significant in reducing the total amount of alcohol consumed in the community.

### 4. Community Planning Partnership Outputs:

There are two interconnected programmes operating within the CHCP relating to ABI’s:

One is the national initiative to deliver ABI’s through primary care, which is funded through partnership money under an NHS run contract.

The second is the training of non-clinical workers, whose work brings them into contact with problematic drinkers, to implement ABI’s. This training is jointly delivered by an agency contracted by TADP (the West Lothian Drug and Alcohol Service) and by the NHS training team. This programme is led by the ADP officers, who are located in the council, and is provided to professionals from Housing, Social Work, Health Workers, Youth Workers, the voluntary sector, the Police and Fire and Rescue services. ABI’s are also delivered to
members of the community at local events, through various communities projects such as Community Action Blackburn. There is good evidence of the effectiveness of brief interventions in non-clinical settings.

5. **Local Outcome(s):**
   - Parents / carers are responsive to their children’s developmental needs. Children are ready to start school
   - Everyone’s life chances are maximised
   - Our young people are successful learners, confident individuals, responsible citizens and effective contributors and have a positive destination
   - Every adult has the skills and ability to secure and sustain employment

ABI’s also cut across a range of the CHCP’s outcomes around alcohol, but most directly relate to the following outcome from the joint strategic plan:
   - People at risk in all life stages are informed about the low-risk use of alcohol and about the risks of tobacco and drugs and have opportunities and support to reflect on and change their problematic substance use

6. **National Outcome(s):**
   - We live longer, healthier lives
   - We have tackled the significant inequalities in Scottish society
   - We live our lives free from crime, disorder and danger
   - We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others

7. **Please detail the specific contribution of the NHS Board in tackling this critical issue?**

NHS Lothian contributes to the delivery of ABI’s at multiple levels: Strategically, they are involved in allocation of resources for and in the development and management of the training team, which has been a pivotal resource in all the local developments.

Operationally, they are central to the delivery of clinical ABI’s through provision of funding, promotion of the programme and monitoring activity and impact. In the non-clinical programme, they provide much of the training resource and significant efforts in raising the profile of ABI’s across a wide range of partnership agencies.
8. **Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**

See above – NHS Lothian’s contribution is extensive and cuts across both the clinical and non-clinical strands of the programme.

NHS Lothian jointly develops and delivers the training to the Council and its partners and raises the profile of ABI’s across partnership agencies.

9. **Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**

Clinical ABI’s are delivered under a HEAT target (HEAT a4) and the local work on non-clinical ABI’s is part of the CHCP workplan and is reported on in narrative reports to the CHCP sub-committee, which reports into the CPP.

10. **Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**

As noted above there are ongoing reviews of both the clinical and non-clinical strands of this work. The training programme for non-clinical work is evaluated regularly (and consistently very positively) while the clinical element is regularly reviewed for both effectiveness and strategic relevance.
Over the last four years NHSScotland has developed its outcome approach. The Quality Strategy sets out NHSScotland's vision to be a world leader in healthcare quality, described through three quality ambitions: effective, person centred and safe. These ambitions are articulated through the six Quality Outcomes that NHSScotland is striving towards:

1. Everyone gets the best start in life, and is able to live a longer, healthier life
2. People are able to live at home or in the community
3. Healthcare is safe for every person, every time
4. Everyone has a positive experience of healthcare
5. Staff feel supported and engaged
6. The best use is made of available resources

Twelve ‘direction of travel’ Quality Indicators help demonstrate progress towards the six outcomes (these are not targets). Every year a small number of HEAT targets are agreed with NHSScotland and partners. These set out the accelerated improvements that will be delivered across Scotland in support of progress towards the Healthcare Quality Ambitions and Outcomes. The latest statistics can be accessed through Scotland Performs.

The Scottish Government and NHSScotland are supporting frontline clinicians to adopt international best practice through improvement programmes including the Joint Improvement Team, the Quality Efficiency Support Team, and Scottish Patient Safety Programme. These programmes support delivery of system-wide improvement.
NHSScotland is a publicly funded and publicly delivered service. The services are planned in partnership on a national, regional and local basis. The principles underpinning the approach to performance management are set out in the Local Delivery Planning guidance.

Local outcomes and the approach for their delivery are agreed through Single Outcome Agreements. The Scottish Government’s three social frameworks (Equally Well, Early Years Framework and Achieving Our Potential) provide the strategic direction for action to contribution towards delivery on national outcomes.

NHS Boards are committed to Community Planning and tackling the identified Local Outcomes within the Single Outcome Agreement. They demonstrate this through their Local Delivery Plans which describe their contribution to a specific critical issue, derived from an identified Local Outcome, and which relates to the three interconnected social frameworks, or to economic recovery.

**Embedding the NHS Scotland Quality Strategy 2010**

NHS Lothian’s continued response to the NHS Scotland Quality Strategy is summarised below:

**Quality Measurement Framework**

Quality Report is a standing item on the Board Agenda which provides a suite of measures at system level to allow monitoring of quality of care in NHS Lothian.

The ‘core’ measures such as Healthcare Associated Infection (HAI), adverse events, and Hospital Standardised Mortality Rate (HSMR) are presented in the NHS Lothian Quality Report to reflect the Quality Outcome indicators.

In addition to the core measures, we have agreed with clinical and management colleagues a small number of system-level clinical effectiveness measures to be reported to the Board as a rolling programme across a care pathway, which includes Coronary Heart Disease, Stroke, Cancer, Mental Health and Early Years.

**NHS Lothian Quality Improvement Strategy (2011-2014)**

In response to the NHS Scotland Quality Strategy, NHS Lothian has developed its own Quality Improvement Strategy, which was approved by the Board in November 2010 and includes improvement aims, including HEAT requirements. The NHS Lothian Quality Improvement Strategy acknowledges the developmental nature of the National Quality Strategy and the importance of weaving the quality ambitions through all NHS Lothian’s activities from strategy development through to service-based improvements. Within this strategy is the need to build capacity for improvement and the development of a data infrastructure to inform improvement from service to Board level.

NHS Lothian has continued to actively align its strategic priorities and objectives to reflect the quality strategy set within the context of HEAT targets. The table below sets out some of these activities to illustrate the relationship between NHS Lothian’s actions and realisation of HEAT targets.
<table>
<thead>
<tr>
<th>NHS Lothian Activities/Strategic Intent (alignment with HEAT and Quality activities)</th>
<th>NHS Scotland Priority Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Report to the Board which sets out a range of indicators that examine NHS Lothian’s provision of Healthcare against the three quality ambitions. It also seeks national and international comparators in order to identify variation where possible and include HEAT targets where applicable such as HAI, Smoking Cessation, Screening, etc.</td>
<td>1,2,3,4,5,6 Report available in NHS Lothian Board papers.</td>
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<tr>
<td>The Quality Improvement Strategy aims to demonstrate improvements in patient experience and outcome of care which is supported by a robust measurement framework (service to Board) and the acknowledgement of the alignment of the Quality Outcome Measures, HEAT and local improvement programmes. It includes patient experience, staff wellbeing, safe care and a focus on variations at programme level. In addition the older people’s pathway work under the Lean programme supports effective and efficient discharge and partnership working. A progress report on the strategy was submitted to Healthcare Governance &amp; Risk Management Committee in December 2011.</td>
<td>1,2,3,6 Available on NHS Lothian Internet website. Strategy Progress Report available.</td>
</tr>
<tr>
<td>Current NHS Lothian strategies and those undergoing revision have to be examined in light of the Quality Strategy. For example, the fundamental principles that will shape development of NHS Lothian’s Human Resources &amp; Organisational Development strategy are Living Values, Engaging Leadership and Delivering Quality.</td>
<td>1,2,3,4,5,6 where applicable</td>
</tr>
<tr>
<td>Capacity building and application of improvement methodology is a key element of the Quality Strategy. NHS Lothian has a range of opportunities for staff to understand and apply improvement methodologies at ward level and strategic level through application of 5x5x5 programme, patient safety programme, Lean programme and Delivering Better Care programme. The 5x5x5 on stroke care has contributed to enhanced compliance with the HEAT stroke target. The patient safety programme continues to improve compliance with HAI targets, and LEAN methodology improves compliance with waiting times targets. There has been further work on making data readily available to frontline teams through the development of a ward scorecard to inform continuous improvement.</td>
<td>1,2,3,4,6 (see NHS Lothian Quality Improvement Strategy)</td>
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</table>

Through our Local Delivery Plan, we set out how we will be judged in terms of performance on our operational targets, which have been agreed with Government and across NHSScotland to support delivery of the outcomes and Quality Ambitions.

In addition, through Community Planning Partnerships, we have worked with Local Authorities and other public bodies to agree the priority local outcomes and related indicators. With our partners, we are also developing our outcomes-based approach,
individually and together. This will require each organisation to be clear about their relative contributions. Each organisation will be responsible for ensuring that they have appropriate local performance management systems in place to ensure the delivery of their particular responsibilities; this local delivery plan is an important aspect of our performance management system.

Progress has been made in reviewing the HEAT targets so that they reflect the NHS contribution to the National Outcomes, and this process continues each year. In addition, we can demonstrate how the HEAT targets positively support the three Quality Ambitions.

The HEAT core set contains a number of nationally set targets. The national pursuit of these across NHS Scotland, backed up with dedicated and focussed improvement support from the Government, has been demonstrated to support real progress, e.g. significant reductions in inpatient waiting times and reduced healthcare associated infections. Also, in line with the outcomes-based approach of agreeing shared outcomes with other public sector delivery partners, HEAT has introduced a number of priorities where we set out, in this Local Delivery Plan, our local planned levels of performance, e.g. reductions in A&E attendances.

Achievement of HEAT targets will demonstrate progress and contribute towards delivery of the Scottish Government’s national outcomes and the Quality Ambitions (see mapping of the 2012/13 targets on to the national outcomes and targets).

We have also made a range of contributions towards the delivery of the local single outcome agreement over and above the HEAT targets and these are set out in our Local Delivery Plan. This focuses on our Board’s contributions to the four national priority areas:

- Health inequalities
- Early years
- Tackling poverty
- Economic recovery

These areas have been identified as requiring major contributions from a range of partners, but are also areas where there is the potential for significant collaborative gain.
### HEAT TARGETS CONTRIBUTING TOWARD SCOTTISH GOVERNMENT’S NATIONAL OUTCOMES

<table>
<thead>
<tr>
<th></th>
<th>We have tackled the significant inequalities in Scottish society</th>
<th>Our children have the best start in life and are ready to succeed AND We have improved the life chances for children, young people and families at risk</th>
<th>We live longer, healthier lives</th>
<th>Our public services are high quality, continually improving, efficient and responsive to local people’s needs</th>
<th>We reduce the local and global environmental impact of our consumption and production</th>
<th>We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others</th>
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<tr>
<td>Detecting Cancer Early</td>
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<td>Access to Antenatal Care</td>
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<td>Suicide reduction</td>
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<td>Child healthy weight interventions</td>
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<td>SIMD Smoking cessation</td>
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<td>SIMD Child Fluoride Varnishing</td>
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<td>Carbon Emissions &amp; Energy Consumption</td>
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<td>Drug &amp; Alcohol misuse treatment</td>
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<td>Faster access to mental health services</td>
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<td>Emergency bed days for over 75s</td>
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<td>Discharge from Hospital</td>
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<td>Stroke services</td>
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<tr>
<td>Healthcare associated Infection</td>
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<td>Reduce A&amp;E attendances</td>
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**clear line of sight in supporting short term**

**indirect or longer term contribution**

NHS Lothian Local Delivery Plan 2012/13 – submission date 31 March 2012
**Healthcare Quality Ambitions:**

- **Person-centred** - mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
- **Safe** - there will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times
- **Clinically Effective** - the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated

**HEAT TARGETS CONTRIBUTING TOWARD SCOTTISH GOVERNMENT’S NHS QUALITY AMBITIONS**

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<th>HEAT TARGETS CONTRIBUTING TOWARD SCOTTISH GOVERNMENT’S NHS QUALITY AMBITIONS</th>
<th>People live longer healthier lives</th>
<th>People supported to live at home / community with access to treatment</th>
<th>Healthcare is safe</th>
<th>People have a positive experience of healthcare</th>
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<td>Reduce A&amp;E attendances</td>
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Participation:

NHS Lothian’s Board approved the “Framework for Mutuality: - Involving People, Improving People’s Experience of Care Strategy (2009-13)” in July 2009. This set out our commitments to involve people in shaping NHS Lothian services and our commitments to improve people’s experiences of care.

NHS Lothian was assessed by the Scottish Health Council against the new Participation Standard for 2010-11. NHS Lothian was assessed as either evaluating or moving to improve in the evaluation. Our recent self assessment gave a detailed description with evidence of how NHS Lothian involves people in service planning and redesign and receives assurance through corporate governance of the Board’s commitment to involving people. A corresponding action plan highlights some of the actions taken during the last twelve to fifteen months to achieve the outcomes. Some of the outcomes have been achieved while others due to the requirements of involving people are ongoing.

As the Strategy is due to expire in 2013, this year will see the development of a draft framework for beyond 2013. It will build on the achievements in the action plan and the self-assessment for the Participation Standard. It will seek to ensure that evidence of the difference that involvement makes is strengthened. It will also take account of developments envisaged by the Scottish Government, for example their plan to integrate adult health and social care.
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 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.
- Support the implementation of the Scottish Government Health Department Healthcare Associated Infection Information Management and Technology Bid.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 16 episodes of *Staphylococcus aureus* Bacteraemia recorded in February 2012 (1 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*), compared to 19 in January 2012 (2 Meticillin Resistant *Staphylococcus aureus*, 17 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 0.31.

3.2 *Clostridium difficile* Infection: there were 17 episodes of *Clostridium difficile* Infection in patients aged 65 or over in February 2012, compared to 31 in January
2012. 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 0.36.

3.3 The seventeenth bi-monthly national hand hygiene audit report, published 25/1/2012, indicated that NHS Lothian is achieving a hand hygiene compliance of 97%, which exceeds the national compliance of 95%. Local monthly hand hygiene audits continue throughout all patient care areas, with delivery of hand hygiene education and training targeting areas of non-compliance. A standard operational procedure for escalation of non-compliance with hand hygiene has been developed and is in the consultation phase with staff partnership and other key stakeholders.

3.4 Meticillin Resistant *Staphylococcus aureus* National Screening Programme: to date the Screening Programme has screened more than 10,000 patients. NHS Lothian is achieving 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 National Screening Programme is now entering the final stages of handover to the sustaining team following completion of the roll-out requirements for 2011-12.

3.4.1 Exceptions to Plan: Key Performance Indicators remain undefined and unclear for 2012-13 - further information from the Scottish Government Health Department is expected in April 2012. However, NHS Lothian is well placed to address any requirements the Scottish Government Health Department place on Boards through the extensive use of electronic data gathering.

3.5 Healthcare Environment Inspectorate: following an unannounced inspection by the Healthcare Environment Inspectorate at St John’s Hospital on 24/1/2012, an action plan with the four requirements and two recommendations has been completed (Appendix 2). The report was published on 5/3/12.

3.6 Incidents: from January to March 2012, the Infection Prevention and Control and Health Protection Teams have been involved in investigating number of incidents, which include:
- Invasive Group A *Streptococcus*
- Various Norovirus Outbreaks
- Colonisation of *Pseudomonas*
- *Clostridium difficile* cluster within one directorate.
- Tuberculosis
- Scabies

3.7 Antimicrobial Management Team:
3.7.1 Alert antibiotic pilot-study: the Alert Antibiotic Policy has been running at the Royal Infirmary Edinburgh site for a month. This policy supports appropriate use of selected broad-spectrum antibiotic agents (termed ‘alert antibiotics’) in order that development of antibacterial resistance is reduced. It is anticipated that the policy will be extended to the other two acute sites later this year.

3.7.2 Antibiotic Prescribing indicators: in clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is below the target level (95% compliance with Guidelines) for the Royal Infirmary Edinburgh and Western General Hospital but above the target level for documentation of indication for antibiotic treatment at all acute sites. For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy has increased in the last month but is still currently below target level. However,
administration of single dose antibiotic prophylaxis is above the target level (95% compliance with Guidelines and administration of a single dose).

3.7.3 Antibiotic expenditure: the total expenditure for 2011/12 is down 18% 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.

3.8 Domestic Services: following the retirement of Mary Kelly, Head of Service for Domestic Services, Callum Gordon began as Associate Director of Operations in February 2012. The first Patient Experience Indicators Audit was carried out at the Royal Victoria Hospital on 31/1/12 and these will now be carried out monthly. The Patient Experience Indicator visit and assessment is part of NHS Lothian’s quality assurance programme and looks at a range of patient experience issues relating to the ward such as physical environment, food, infection control and Health & Safety matters etc.

3.9 Norovirus outbreaks: a point prevalence report is submitted weekly to Health Protection Scotland and published on their website. Within NHS Lothian the first norovirus case for the season 2011-2012 was recorded at the Western General Hospital during August 2011. To date there have been 78 incidents of gastro-enteritis investigated in NHS Lothian. Of these, norovirus has been confirmed in 44 (56%) of the incidents by the Virology laboratory. In the remaining 34 (44%) the cause was not identified. This was due to norovirus not being detected, no samples having been received from affected patients or samples not yet tested by the laboratory.

3.10 NHS Lothian was successful in their bid for the Scottish Government Health Department Healthcare Associated Infection Information Management and Technology Fund and was awarded £309,556 for the development of improved surveillance and early response systems. A Short Life Working Group is being implemented to ensure the action plan is completed and monies appropriately spent by the deadline of June 2012.

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 is necessary for 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.
- If the funding and building bocks to deliver improvements in surveillance and early response associated with improvements in Information Management and Technology infrastructure are not in place by June 2012 there is the possibility that the allocated sum may be reclaimed.
5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register is currently graded high. The risk register covers norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Health Inequalities

6.1 There have been no specific issues with the Equality Diversity Impact Assessment as Healthcare Associated Infection is an ongoing issue. However, infection with the organisms used as markers for Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. As these are socio-economically patterned, reducing the burden of Healthcare Associated Infection will reduce the excess burden of avoidable disease in patients from these groups.

7 Impact on Inequalities

7.1 Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. Accordingly, changes made are reducing the burden of Healthcare Associated Infection.

8 Involving People


9 Resource Implications

9.1 The excess cost of each episode of Staphylococcus aureus Bacteraemia and Clostridium difficile Infection is variable depending on increased length of stay and additional treatment requirements.

Alison McCallum
Director of Public Health
14 March 2012
alison.mccallum@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
Appendix 2: Healthcare Environment Inspectorate Requirement and Recommendations following Unannounced Inspection at St Johns Hospital
Key Healthcare Associated Infection Headlines for March 2012

- During February 2012 there were 16 episodes of SAB recorded in NHS Lothian (1 MRSA, 15 MSSA)
- There were 17 episodes of CDI in patients aged 65 or over in February 2012

**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:


*Staphylococcus aureus* Bacteraemia: there were 16 episodes of *Staphylococcus aureus* Bacteraemia recorded in February 2012 (1 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*), compared to 19 in January 2012 (2 Meticillin Resistant *Staphylococcus aureus*, 17 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 0.31.
**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

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:


**Clostridium difficile** Infection: there were 17 episodes of *Clostridium difficile* Infection in patients aged 65 or over in February 2012, compared to 31 in January 2012. 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 0.36.

**Hand Hygiene**

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be found at:

http://www.washyourhandsofthem.com/

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:


The 17th bi-monthly national hand hygiene audit report was published on 25th January 2012. This indicated that NHS Lothian is achieving a hand hygiene compliance of 97%, which exceeds the national compliance of 95%. Local monthly hand hygiene audits continue throughout all patient care areas, with delivery of hand hygiene education and training targeting areas of non compliance. A standard operational procedure for escalation of non compliance with hand hygiene has been developed and currently continues 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/

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

**Domestic Services**

Following the retirement of Mary Kelly, Head of Service for Domestic Services, Callum Gordon began as Associate Director of Operations in February 2012. The first Patient Experience Indicators Audit was carried out at the Royal Victoria Hospital on 31/1/12 and
these will now be carried out monthly. The Patient Experience Indicator visit and assessment is part of NHS Lothian’s quality assurance programme and looks at a range of patient experience issues relating to the ward such as physical environment, food, infection control and Health & Safety matters etc.

Healthcare Environment Inspectorate

Healthcare Environment Inspectorate: Following an unannounced inspection by the Healthcare Environment Inspectorate at St Johns Hospital on Tuesday 24th January 2012 an action plan with the 4 requirement and 2 recommendations has been completed. The report was published on Monday 5th March 2012.

Outbreaks

Norovirus

A point prevalence report is submitted weekly to Health Protection Scotland and published on their website. Within NHS Lothian the first norovirus case for the season 2011-2012 was recorded at the Western General Hospital during August 2011. To date there have been 78 incidents of gastro-enteritis investigated in NHS Lothian. Of these, norovirus has been confirmed in 44 (56%) of the incidents by the Virology laboratory. In the remaining 34 (44%) the cause was not identified. This was due to norovirus not being detected, no samples having been received from affected patients or samples not yet tested by the laboratory.

Incidents

During the period January – March 2012, the Infection Prevention and Control Team have been involved in investigating number of incidents which include:

- Invasive Group A *Streptococcus*
- Various Norovirus Outbreaks
- Colonisation of *Pseudomonas*
- *Clostridium difficile* cluster within one directorate.
- Tuberculosis
- Scabies

Other HAI Related Activity

Antimicrobial Management Team update

Alert antibiotic pilot-study:

The Alert Antibiotic Policy has been running at the Royal Infirmary Edinburgh site for a month. This policy supports appropriate use of selected broad-spectrum antibiotic agents (termed ‘alert antibiotics’) in order that development of antibacterial resistance is reduced. It is anticipated that the policy will be extended to the other two acute sites later this year.

Antibiotic Prescribing indicators:

In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is below the target level (95% compliance with Guidelines) for the Royal Infirmary Edinburgh and Western General Hospital but above the target level for documentation of indication for antibiotic treatment at all acute sites. For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy has increased in the last month but is still currently below target level. However, administration of
single dose antibiotic prophylaxis is above the target level (95% compliance with Guidelines and administration of a single dose).

Antibiotic expenditure:

The total expenditure for 2011/12 is down 18% 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**

Meticillin Resistant *Staphylococcus aureus* National Screening Programme: to date the Screening Programme has screened more than 10,000 patients. NHS Lothian is achieving 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 National Screening Programme is now entering the final stages of handover to the sustaining team following completion of the roll-out requirements for 2011-12.

Exceptions to Plan:

Key Performance Indicators remain undefined and unclear for 2012-13 - further information from the Scottish Government Health Department is expected in April 2012. However, NHS Lothian is well placed to address any requirements the Scottish Government Health Department place on Boards through the extensive use of electronic data gathering.

**Funding Bids Achieved**

NHS Lothian was successful in their bid for the Scottish Government Health Department Healthcare Associated Infection Information Management and Technology Fund and was awarded £309,556 for the development of improved surveillance and early response systems. A Short Life Working Group is being implemented to ensure the action plan is completed and monies appropriately spent by the deadline of June 2012.
There were 16 SAB recorded during February 2012 (1 MRSA & 15 MSSA). The lowest number recorded in the last 12 month period is 14 (June 2011).

CDI There were 20 CDI recorded in February 2012, 17 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

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Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of ‘Report Cards’ that provide information, for each acute hospital [and key community hospitals – delete if appropriate] in the Board, on the number of cases of *Staphylococcus aureus* bloodstream 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)
- [Staphylococcus aureus](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)

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the “out of hospital” report card.

Understanding the Report Cards – Hand Hygiene Compliance

Good hand hygiene is crucial for infection prevention and control. More information can be found from the Health Protection Scotland’s national hand hygiene campaign website:


Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The first page of each hospital report card presents the percentage of hand hygiene compliance for all staff in both graph and table form.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:


The first page of each hospital Report Card gives the hospitals cleaning compliance percentage in both graph and table form.

Understanding the Report Cards – ‘Out of Hospital Infections’

*Clostridium difficile infections* and *Staphylococcus aureus* (including MRSA) bacteraemia cases are all associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes and. The final Report Card report in this section covers ‘Out of Hospital Infections’ and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital. Given the complex variety of sources for these infections it is not possible to break this data down in any more detail.
**Royal Infirmary of Edinburgh**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 3 SAB recorded during February 2012.

**Clostridium difficile Infection (CDI)**
There were 4 CDI recorded during February 2012.

This is the new Report Card Format introduced by Scottish Government July 2011

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### Total Staphylococcus aureus Bacteraemia (SAB) Cases

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### Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

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### MSSA Bacteraemia Cases

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Western General Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during February 2012.

**Clostridium difficile Infection (CDI)**
There were 7 CDI recorded during February 2012.

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 John’s Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during February 2012.

**Clostridium difficile Infection (CDI)**
There were 4 CDI recorded during February 2012.

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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### MSSA Bacteraemia Cases

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### MRSA Bacteraemia Cases

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**Liberton Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during February 2012.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during February 2012.

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This is the new Report Card Format introduced by Scottish Government July 2011

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Royal Hospital for Sick Children

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during February 2012.

**Clostridium difficile Infection (CDI)**
There were no CDI recorded during February 2012.

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

### MSSA Bacteraemia Cases
**Royal Victoria Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during February 2012.

**Clostridium difficile Infection (CDI)**
There were 2 CDI recorded during February 2012.

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**

**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 was 1 CDI recorded during February 2012.

This is the new Report Card Format introduced by Scottish Government July 2011

---

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MSSA Bacteraemia Cases**
Out of Hospital Infections

*Staphylococcus aureus Bacteraemia (SAB)*
There were 9 SAB recorded during February 2012 that were identified as Out of Hospital Infections.

*Clostridium difficile Infection (CDI)*
There was 1 CDI recorded during February 2012 that were identified as Out of Hospital Infections.

This is the new Report Card Format introduced by Scottish Government July 2011.
Healthcare Environment Inspectorate Requirement and Recommendations following Unannounced Inspection at St Johns Hospital 24/1/12

Requirements:
1. **NHS Lothian must ensure that staff left in charge of a ward in the absence of the senior charge nurse, understand their roles and responsibilities and implement measures for the prevention and control of infection.**

   **Action:**
   Procedure for the Temporary Opening/Closure/ Decommissioning of Wards and Departments Policy to be reviewed. Revision will incorporate updated Infection Prevention and Control guidance as a component of governance issues.
   Chief Nurses will reinforce importance of compliance with Infection Prevention and Control policies to staff via Clinical Nurse Managers (CNMs).

2. **NHS Lothian must ensure that all staff groups adhere to the local policy for use of personal protective aprons to reduce the risk of infection.**

   **Action:**
   Chief Nurses to reinforce importance of compliance with use of personal protective aprons to clinical staff.
   AHP’s awareness of the issue to be raised via the AHP Manager for UHD.
   Acting Director of Facilities to ensure importance of compliance in the use of personal protective aprons is cascaded to domestic staff through inclusion in Tool Box Talks.
   IPCT to reissue “PPE Apron Colours for Clinical Staff” Poster to all clinical areas to remind staff of appropriate use of aprons.

3. **NHS Lothian must ensure that patients are receiving appropriate and up to date information regarding the prevention and control of hospital acquired infections.**

   **Action:**
   Patient information leaflets to be made available for clinical areas.
   Charge nurses to ensure that leaflets are easily accessible for patients and their visitors.
   Infection Prevention and Control Nurses (IPCNs) when informing clinical areas of positive results will request that clinical teams provide patient with appropriate patient leaflet.

4. **NHS Lothian must assure themselves that induction training and information is provided to all staff including temporary staff.**

   **Action:**
   Ensure local induction is robust and up to date. Line Managers to ensure that all staff have completed mandatory and local induction in a timely manner.
   Ensure compliance with requirement for bank staff to complete corporate induction process.
Specific induction for temporary and bank staff to be carried out by local staff on arrival at the placement area.
Specific induction for medical staff will be undertaken by Clinical Director for career grade staff and placement supervisor for junior medical staff.
Specific induction for temporary and bank staff to be carried out by appropriate lead clinician on arrival at the placement area.
Local unit induction policy for doctors to be developed and presented to the Clinical Risk Management Group.

Recommendations

a  NHS Lothian must assure themselves that suitable and sufficient management support is given to those in charge of all wards.
   Action:  
   Chief Nurses to ensure process for obtaining managerial support and development is in place.

b  NHS Lothian must ensure that surveillance and audit information displayed is kept up to date, to ensure that staff, patients and visitors have access to the current information.
   Action:  
   On receipt of audit results staff to ensure prompt printing and display of audit and surveillance information.
   To ensure information is updated regularly this will be added to Clinical Nurse Manager (CNM) checklist.
NHS LOTHIAN BUSINESS CONTINUITY MANAGEMENT PROGRAMME

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an update of work being undertaken within NHS Lothian’s Business Continuity Management (BCM) programme, as requested and noted within the HG & RM Committee meeting of the 7 February 2012.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Review the key elements which are in place to monitor and develop NHS Lothian’s pursuance of becoming a more mature, resilient organisation linked to the Civil Contingences Act (CCA) 2004 and NHS Scotland Strategic Guidance; Business Continuity – A Framework for NHS Scotland 2009

2.2 Note the more detailed feedback of arrangements which have been set out against the two main duties placed upon NHS Lothian as a category 1 responders; that of maintaining appropriate Business Continuity plans which should be approved and signed off by senior management. Along with the requirement to regularly exercise BCM arrangements (at least once annually, with an exercise of the cascade communications system carried out on a 6 monthly basis)

2.3 Note the feedback on arrangements being put in place to ensure BCM gains a sufficiently high profile within NHS Lothian. Ensuring BCM is a business-owned, business-driven process which establishes a fit for purpose strategic and operational framework.
3 Discussion of Key Issues

3.1 Key aspects of NHS Lothian’s BCM programme have been identified encompassing, commissioning, governance, risk management and infrastructure arrangements, in order to meet the duties placed upon us through legislation and guidance.

These have been encapsulated within;

- NHS Lothian BCM Strategic Group; who are responsible for ensuring that requirements of the BCM programme are consistent with the role of a category 1 responder under the Civil Contingencies Act and NHS Scotland Strategic Guidance.

- Recommendations and performance monitoring of the NHS Lothian’s BCM programme to the Executive Management Team and Health Governance and Risk Management Committee.

- Business Continuity Strategic Level Guidance providing an escalation protocol for BCM programme issues of non compliance.

- Incident management controls andentions as defined in NHS Lothian’s Business Continuity Strategic Level Guidance; Principles, Guidelines and Control Documents for NHSL Business Continuity Plans.

With this approach and commitment to an ongoing management process to BCM an interactive cycle of review and updates when necessary has been established. For example; during recent disruptive events and subsequent debriefs (industrial action and high winds) the need to strengthen the infrastructure of NHS Lothian’s main strategic control room was identified; in order to provide a more stringent environment for command and control. This has now been taken forward with the purchase of additional equipment, being made.

3.2 Particular focus has also recently been given to the two main duties placed upon NHS Lothian; that of maintaining appropriate Business Continuity plans, along with the requirement to regularly testBCM arrangements.

An escalation protocol for BCM programme issues of non compliance has provided additional reassurance that plans are maintained, updated and controlled as necessary. Key performance indicators have been set, with the first week in November of each year being identified for signed off by appropriate Executive Directors and General Managers of each area to confirm that plans have been maintained.

A review has also been undertaken of the BCM exercising arrangements. The approach to become “smarter” in the way we conduct BCM exercises and the use of resources has led to arrangements being put in place to offer directorates and business area’s to link to a combined BCM exercise programme.
Dr Farquharson has agreed to be the overall NHS Lothian Executive Director sponsor for the 2012 combined exercise, scheduled for the 21 May 2012.

A further five local senior sponsors have been indentified representing various elements of the organisation; showing a positive commitment to the programme

An exercise planning team, along with timelines and tasks to deliver these has been established. Arrangements are in place to provide regular updates and progress reports to EMT, Members of the NHSL Strategic Business Continuity Group and BC Champions.

As with plan maintenance, key performance indicators have also been set within the escalation protocol for BCM programme issues of non compliance, requiring Executive Directors and General Managers to confirm that appropriate actions have been undertaken within post exercise action plans. This will include recommendations on changes to the plan and BCM arrangements or protocols. Annual Submissions are required in the first week of October

3.3 All staff must be reminded of the importance of BCM for the organisation and that they have an important role to play in maintaining the delivery of critical services to their patients, as such a number of initiatives to embed BCM within NHS Lothian’s culture have been undertaken including:

3.3.1 An audit to assess the inclusion of BCM in relevant staff’s job descriptions and or appraisals

NHS Lothian’s Strategic Business Continuity Group wrote to Executive Directors and General Managers to confirm that this requirement had been actioned, as recommended within various internal audit management actions.

The table below gives an overarching view of findings

<table>
<thead>
<tr>
<th>Total number of staff recorded within survey</th>
<th>Number of staff with evidence of BC in job descriptions and appraisals</th>
<th>Number of staff with evidence of BC in appraisals only</th>
<th>* Staff who may be considered as having responsibilities for staff, systems or programmes of work within NHS Lothian Staff graded 7 – 9 Executive Level</th>
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<tr>
<td>21,602</td>
<td>308</td>
<td>432</td>
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<td>740</td>
<td></td>
<td>135</td>
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<td></td>
<td>2,230</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Only 33% off staff* recorded currently have BC in job descriptions and or appraisals, against expected pool</td>
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</tbody>
</table>

These findings suggest that additional work to ascertain that BCM which has been included within the Mandatory Corporate Accountabilities for Senior Managers under Legislative Compliance linking to Performance Management Arrangements, has also been afforded the same principles and protocols for staff* linked to Agenda for Change within the NHS Knowledge and Skills.
Framework. Demonstrating that BCM continues to be embedded within our organisation and a continual improvement model of maturity is sought.

3.3.2 The development of a more structured training and awareness BCM programme within NHS Lothian

BCM training is a statutory requirement placed on NHS Scotland under the CCA and is also supported by the NHS Scotland Strategic Guidance for Business Continuity. A scoping exercise has recently been undertaken by the NHS Lothian Strategic Business Continuity Group.

The findings of which are currently being developed into a BCM training matrix identifying specific staff who, due to their role maybe required to have particular resilience competences. Specific training sessions will be detailed further (providers, aims, intended audience and frequency) before establishing where suitable funding and resources can be made available to deliver a training programme as part of the overall establishment of BCM. Requirements will be presented to the Healthcare Governance & Risk Management Committee and Executive Management Team.

3.3.3 Consideration of other key aspects within NHS Lothian’s BCM programme for 2012; moving forward.

Dr. Farquharson, has recently written to Executive Directors and General Managers, asking for continued support in delivering all key elements of NHS Lothian Business Continuity programme for 2012, including:

- Supporting staff identified to attend NHS Lothian Strategic Business Continuity Group
- Ensuring that suitable arrangements are in place for taking forward NHS Lothian Business Continuity work plans at a local level within Directorates and Business area and that BC coordinators are senior enough to have the authority to act and ensure delivery of Business Continuity work plans.
- Part of the programme devised for this years BCM combined exercise programme (21 May), will be used to consider issues around reassurance that organisational BCM and local BCM programmes have been aligned; originally planned as a separate workshop

NHS Lothian will be running a poster campaign during Business Continuity Awareness week (19 – 23 March), Business Continuity Awareness Week (BCAW) is a global educational event for people to learn more about Business Continuity Management.

NHS Lothian’s Business Continuity Management intranet site has been enhanced to link to the poster campaign, providing additional information including; reference documents, templates, resources, websites, exercising and the civil contingencies act.
4 Key Risks

4.1 Additional assurances are still required to address management actions highlighted through internal audit.

5 Risk Register

5.1 As detailed within 3.2 of the paper issues of non compliance will now be taken forward as per the Escalation Protocol for Business Continuity Management Programme.

6 Impact on Health Inequalities

6.1 As detailed within NHS Lothian’s Business Continuity Strategic Level Guidance for Generic Principles, Guidelines and Control documents for NHSL Business Continuity Plans; arrangements have been built upon and should be maintained to link into NHS Lothian’s Equality and Diversity Strategy following the principles and statement of aims of the said.

7 Impact on Inequalities

7.1 None noted.

8 Involving People

8.1 Further work to provide a more informed position is currently being undertaken, focusing on enabling all staff that may require to have appropriate BCM competences to respond effectively when faced with a significant business interruption, as described in 3.3 of this paper.

9 Resource Implications

9.1 The adequacy and effectiveness of business areas across the organisation to meet controls in order to achieve compliance Scottish Framework for NHS Scotland through the recently published Business Continuity internal audit has been rated as having significant issues on three counts and an important issue on a further one. It should be recognised that the maintenance of an effective business continuity environment will need to be resourced both in terms of money and workforce. These issues are being addressed as detailed within this paper.

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14 March 2012
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BACKLOG MAINTENANCE ISSUES IN RELATION TO THE NHS LOTHIAN ESTATE

1 Purpose of the Report

1.1 The purpose of the paper is to provide the Board information concerning the Backlog maintenance issues in relation to NHS Lothian’s estate.

2 Recommendations

2.1 The Board is requested to:

- Note that backlog maintenance issues and costs for the estate are detailed within the Property Asset Management Strategy (PAMS) 2011 – 2015 and are risk assessed.

- Note that the future investment in the estate infrastructure continues to be risked assessed and that NHSL exposure will be reduced by circa £80m 2/3 by the Board’s Capital Development Programmes.

- Agree that the development of the Property Strategy and plans to address the backlog maintenance are scrutinised through the Finance & Performance Review Committee.

3 Discussion of Key Issues

3.1 NHS Lothian has a large estate comprising of a geographically and functionally diverse property portfolio that provides around 600,000 sqm with a reported value of £644,777,000 (directly owned properties) as at 1 April 2011. This encompasses all properties currently used in the support and delivery of healthcare for NHS Lothian and includes NHS owned, leased and privately financed properties.

3.2 The Property Asset Management Strategy (PAMS) submitted annually to Scottish Government provides details of the condition of the estate in accordance with the 6 multi facet surveys (i.e. physical condition,
statutory compliance, quality, functional suitability, space utilisation and energy). It is a requirement of the Board to survey 20% of the estate on a yearly basis. This is currently being updated as part of the 2012 - 2016 Property Asset Management Strategy.

3.3 Backlog maintenance costs are based on the findings of the surveys and the cost to upgrade a property to a B rating. These surveys have been undertaken by external consultants including the consultant group Capita which was part funded by Scottish Government.

3.4 Backlog maintenance costs presented in the State of the Estate 2011 Report detailed a cost for NHS Lothian of £140m. However the Capital Investment Programme for major sites such as Royal Victoria Hospital, RHSC/DCN, Royal Edinburgh and Edenhall as well as a number of smaller sites will reduce this total to circa £80m by 2018.

3.6 Estates have assessed the key risks associated with Infrastructure and the investment required in the short to medium term to address this. The Statutory Compliance Audit Review Tool (SCART) will provide the exact criteria on a risk basis for undertaking the proposed infrastructure works.

3.7 Priorities for investment include areas such as service continuity, supporting future Service Development, Fire Precautions and HAI. This will require investment across a number of the older NHS Lothian hospital sites. In particular, the Western General Hospital, St John’s Hospital, Royal Edinburgh, Astley Ainslie, Liberton and Roodlands.

3.8 Plans are currently being developed to take this work forward but this is against a background of a reduction in the capital allocation across NHS Scotland. Recognising the challenge the Scottish Government Health Department plan to increase the Capital Programme from revenue and similarly the forward financial plan for NHS Lothian will need to reflect this requirement for investment.

3.9 In parallel, through ICIC, the Property Asset Management Strategy is being reviewed with the specific objective of achieving further asset rationalisation. This will need to be consistent with the developing Clinical Strategy. The output from this will be considered by the Finance & Performance Review Committee at its meeting in June.

4 Key Risks

4.1 The key risks associated with backlog maintenance works are noted below:

- Business Continuity – Failure of critical service such as electrical distribution, heating plant and bed & passenger lifts
• Future Service Developments which are government funded could be severely compromised by insufficient capacity in the infrastructure on the main hospital sites.
• Failure to maintain current standards and positive feedback received from HEI visits.
• The availability of capital to invest in the infrastructure of the estate and raise the standard of accommodation to the B standard.
• Failure to comply with statutory legislation, for example Control of asbestos, legionella and fire precautions.
• Reputation in risk to any of the above.

5 Risk Register

5.1 Within the PAMS, backlog maintenance items have been based on risk using the multi facet surveys and SCART criteria and investment will be prioritised.

5.2 Risk assessments for individual projects are included in the specific Business Case.

6 Impact on Health Inequalities

6.1 An Equality and Impact Assessment has not been undertaken on this paper. An Equality and Impact Assessment will be undertaken for individual projects.

7 Impact on Inequalities

7.1 No Impact Assessment has been undertaken on this paper. The recommendations and improvements should reduce inequalities. This will need to be assessed in relation to individual projects.

8 Resource Implications

8.1 In addition to the Capital Investment Programme and the annual Statutory Standard investment plans are being developed to prioritise areas of key risk. This will be required to be addressed through the financial planning process.

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21 March 2012
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1 Purpose of the Report

1.1 The purpose of this report is to recommend to the Board that the NHS Lothian pharmaceutical care services plan be approved for publication on the NHS Lothian website.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to:

- approve the document for publication on the NHS Lothian website.
- approve the proposal to update the document annually but seek NHS Board approval every 3 years.
- approve the proposal to rename the document as The Provision of Pharmaceutical Care Services in NHS Lothian rather than use of the title ‘Pharmaceutical Care Services Plan’ is appropriate.

3 Discussion of Key Issues

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 2011. The requirements of the plan are that Boards have to monitor their Pharmaceutical Care Services Plan annually to reflect changes in service provision or patient needs. This requirement refers to NHS services provided via community pharmacy.

The 2012 plan has been produced in line with guidance from the Directors of Pharmacy group which was produced in collaboration with the Scottish Government health Department. This guidance sets out the order of the plan, the type of information to be provided and the description of NHS services to include an introduction to the NHS Board area, description of current pharmaceutical...
services available in the NHS Board area, description of general medical service provision in the NHS board area (done via maps in this plan), analysis of pharmaceutical needs within the health board area and recommendations to meet identified under provision.

It has also been agreed at the Directors of Pharmacy group that the pharmaceutical care services plan title is slightly misleading with NHS Boards providing a description of available pharmaceutical care services within their NHS Board area and describing any reported gaps in that area. The document may develop further with time but this requires national agreement to ensure a standard approach to this piece of work. The use of the term plan may be misleading and this was recognised at some CHP subcommittees as an issue.

The plan is required to be considered by the pharmacy practices committee when they deliberate on applications for inclusion onto the pharmaceutical list, however it is not the only information they will consider. More detailed information is provided relating to the neighbourhood under consideration and the NHS Board plan provides a Board wide perspective on provision of pharmaceutical care services. The pharmacy practices committee membership and constitution is laid out in regulations and it is for them to decide whether or not an application to provide NHS pharmaceutical services are necessary or desirable to ensure adequate provision in a Board area.

Within the legislation for control of entry an annual description of services must be produced however, there is no power within those regulations for it to be used as the basis for commissioning services.

In 2011 the document published was the contents of the pharmaceutical list describing each service provided by each pharmacy. The updated plan provides context and description of services and in line with requirements it will be published on the internet in colour.

4 Key Risks

The pharmaceutical care services plan identifies a gap that no contractor wishes to fill or the plan identifies no gaps in need and the Pharmacy Practices Committee still award a pharmacy contract

5 Risk Register

No risks included in any risk register

6 Impact on Health Inequalities

An equality and diversity impact assessment was carried out in relation to the pharmaceutical care services plan on March 7th 2012. The document was found to have a broadly positive impact and there is a recommendation to examine ethnicity data in relation to pharmacy services once the figures for the 2011 Census become available.
7 Impact on Inequalities

As above

8 Involving People

The document has been consulted upon with the Area Pharmaceutical Committee and its Primary Care Subgroup, Primary Care Joint Management group, CHP subcommittees of East Lothian, Edinburgh, Mid Lothian, and West Lothian CHP and their respective Public Partnership Forum and by the representative patient for the Area Clinical Forum. This has been a useful exercise but in reality there is likely to be little change to the document on an annual basis. An annual update with a 3 year presentation to the Board may be a more efficient use of time.

9 Resource Implications

There will be resource implications for Pharmacy services and for the department of Public Health & Health Policy in the production of this annual update as this is an additional piece of work. There are no resource implications directly for the Board linked to successful applications to provide NHS pharmaceutical services as this budget is a fixed sum held centrally with payment agreed through a national contract.

David Farquarson
Medical Director
8 March 2012
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List of Appendices

Appendix 1: Pharmaceutical Care Services Plan 2012
NHS Lothian

Pharmaceutical Care Services Plan

Provision of Pharmaceutical Care Services
Delivered via Community Pharmacy

1st April 2012
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1 Introduction to NHS Lothian Population

1.1 Background

The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011/32) amended regulations so that NHS Boards are obliged to publish Pharmaceutical Care Services Plans and monitor their plan annually to reflect changes in service provision or service need. A pharmaceutical care services plan will give a summary of pharmaceutical services provided in the area of the Board together with an analysis by the Board of where it believes there is a lack of adequate provision. Further guidance on the content of a pharmaceutical care services plan has been produced by the NHS Scotland Directors of Pharmacy Group and this has been followed in production of this plan.

1.2 Age and Population

To put the pharmaceutical care service in context a brief description of the NHS Lothian population is a useful starting place. The spread of the population by age is important for pharmaceutical care services as patients tend to require more medication as they get older. Mothers and babies also tend to have particular needs from the pharmacy relating from advice to treatment of minor ailments.

Figure 1 gives a view of comparative populations in the CHPs in NHS Lothian. Not surprisingly Edinburgh CHP has the largest population of the 4 CHP areas. However to get a better view of the age breakdown of the NHS Lothian population Figure 2 looks at the age groups in terms of percentage of the population.
When age is considered in these terms there are not huge differences in the extremes of age that may well require additional pharmaceutical care input. Edinburgh whilst having the largest populations of those under 15 and over 65 has a smaller proportion of its population in those groups than the other CHP areas. It is therefore reasonable to expect similar pharmaceutical needs in terms of age across NHS Lothian.
The majority of people over 75 will be on at least one medication and as people get older they are more at risk from adverse effects of medicines and likely to be on multiple medicines. As more people are living longer these issues are more significant and as can be seen in Figure 3 those aged over 60 from a substantial proportion of the NHS Lothian Population.

Figure 4 – NHS Lothian Life Expectancy by CHP and CHP.

Overall life expectancy for the population in NHS Lothian is better than the Scottish average for both males and females with the average for males being 75.8 years compared with 74.5 years for the Scottish average and for females life expectancy is 80.3 years in Lothian compared with the Scottish average of 79.5 years

1.3 Disease Burden in NHS Lothian

It is very difficult to describe completely the burden of disease within the area because of the complexity of co-existing disease states and variety of diseases. Therefore while it is possible to describe individual disease states this does not necessarily tell the whole story as many patients will have more than one disease. An illustration for some of the priority health areas is given to show where NHS Lothian sits within the context of time and in Scotland as a whole where relevant. The disease areas have also been chosen because of their potential links to pharmaceutical needs.

1.3.1 Coronary heart Disease

There has been an overall reduction in incidence of coronary heart disease over time. This is due to a large investment in this area and is a combination of lifestyle changes and packages of care, including evidence based
treatment. Patients with a diagnosis of coronary heart disease will often be on multiple medicines and be managed primarily in Primary Care making these patients high users of pharmaceutical services. Figures also show a reduction in mortality for the same time period with the greatest reduction being for males aged 45-64.

Figure 5 – NHS Lothian Hospitalisations by CHP: 2007-2010

Figure 6 – NHS Lothian CHD Early Deaths (<75) by CHP: 2007-2009
Provision of NHS Lothian Community Pharmacy Services

NHS Lothian as a whole has fewer CHD related hospitalisations than the Scottish average. Figure 5 clearly shows a lower rate of coronary heart disease hospitalisations in Edinburgh CHP compared with the other 3 areas and Figure 6 illustrates the higher rates of early death in Midlothian and West Lothian.

1.3.2 Cancer

The potential role for the community pharmacy in promoting healthy lifestyle and cancer prevention has already been highlighted in the Better Cancer Care Cancer Action Plan 2008. In April 2011, the Cabinet Secretary announced that the new administration would pursue a programme to achieve earlier diagnosis of cancer. This programme will support a fundamentally new approach to the management of cancer in NHS Scotland, promoting engagement with the Scottish population that embeds mutual partnership, delivers on quality and efficiency and results in better outcomes.

Figure 7 – NHS Lothian Cancer Registrations by CHP: 2003-2007

NHS Lothian has fewer cancer registrations than the Scottish average. In terms of overall mortality figures for deaths from cancer, there would appear to be a reduction over time. In terms of pharmaceutical care needs, cancer medication is complex and there is also a trend towards oral medication rather than injections and this will not only result in a shift of where treatment may be delivered but also the contribution that pharmacists may make because of those different protocols.

1.4 Smoking

Smoking is the largest single cause of preventable serious ill-health and premature death. It is also the single biggest contributor to the differences in
life expectancy between the social classes. It kills between a half and two-thirds of long-term smokers with around 25% of smokers dying before reaching retirement age. In general, smokers endure poorer health than non-smokers.

The benefits of stopping smoking are well known and the smoking cessation service delivered via community pharmacy in NHS Lothian has made a substantial contribution to the number of successful quits reported in NHS Lothian.

Figure 8 – NHS Lothian Percentage of Smokers by CHP

The Scottish Government had aimed to reduce the percentage of smokers (>16 years old) to 22% in Scotland by 2011. The information in the above graph shows the baseline percentage of smokers across NHS Lothian at the baseline for this target. By 2011 the percentage of smokers across Scotland was 24%.

1.5 Sexual Health

Emergency hormonal contraception has been available to buy from community pharmacy since 2001. When the community pharmacy contract was renewed in 2006, emergency hormonal contraception became available free of charge from community pharmacies in 2006. In terms of describing the population of NHS Lothian One of the most widely used indicators of sexual health is unplanned pregnancy and the measure commonly used is the number of abortions. However, this is an indicator of unwanted rather than unplanned pregnancy. There are many pregnancies that, although unplanned, are continued to the birth of a baby. In most cases the baby is accepted and
cared for, although rarely he or she is put up for adoption. It is, therefore, not possible to ascertain the true level of unplanned pregnancy.

For the past two years there has been a fall in the number and rate of abortions with 12,826 in 2010 compared to 13,108 in 2009 and 13,902 in 2008 (representing rates of 12.3 per 1000 women aged 15-44 in 2010, 12.6 in 2009 and 13.3 in 2008). This fall is a change to the overall pattern of increase since the implementation of the 1967 Abortion Act, although small dips for short periods have been observed before. The rate of terminations in 2010 was highest in younger women, 16-19 (21.4 per 1000) and those aged 20-24 (22.4 per 1000). Lower rates are seen in the older age groups; women aged 25-29 (15.3 per 1000); aged 30-34 (10.8 per 1000); aged 35-39 (6.3 per 1000) and in women aged over 40 (2.1 per 1000).

As an additional measure of sexual health associated with unplanned pregnancy is teenage pregnancy. With a higher rate of teenage pregnancy than most other western European countries, reducing unintended teenage pregnancy is a national target for the Scottish Government. Teenage pregnancy is also linked to deprivation with the rates of teenage pregnancy in deprived areas more that treble those of the least deprived areas. The teenage pregnancy rate in Scotland in 2007 in the <16 year old age group was 8.1 per 1,000 women (713 pregnancies). The teenage pregnancy rate in the <18 year old age group has fluctuated since the early 1990s, peaking in 1996/97 at 45 per 1,000 women.

There is little difference between CHP areas for teenage pregnancies as shown in Figure 9 and could therefore be argued that the need for the emergency hormonal contraception service is likely to be similar across each CHP.

Figure 9 – NHS Lothian Teenage Pregnancies by CHP: 2006-2008
2. Description of Pharmaceutical Services in NHS Lothian

2.1 Background

The new community pharmacy contract replaces one where NHS pharmacy services mainly related to dispensing of medication. The new contract aims to use the skills and knowledge of pharmacists better. Pharmacists now graduate at a Masters level of degree education. The location and facilities of pharmacies could be better utilised to meet the needs of patients.

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

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

These services are described in more detail.

All of these core services are in place; the Chronic Medication service is the final service to be implemented as part of the new contract while the Minor Ailment Service (MAS), the Public Health Service (PHS) and Acute Medication Service have been in place for some time.

There are also some additional service contracts negotiated for services that are required in addition to the core services. These may not be available in all community pharmacies.

2.2 Summary of Pharmaceutical Care Services in NHS Lothian

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of community pharmacies</th>
<th>Population (GRO 2007 estimates for council areas)</th>
<th>Population per community pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian</td>
<td>183</td>
<td>809 790</td>
<td>4425</td>
</tr>
<tr>
<td>East Lothian</td>
<td>23</td>
<td>94 440</td>
<td>4106</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>108</td>
<td>468 070</td>
<td>4333</td>
</tr>
<tr>
<td>Midlothian</td>
<td>19</td>
<td>79 510</td>
<td>4184</td>
</tr>
<tr>
<td>West Lothian</td>
<td>33</td>
<td>167 770</td>
<td>5083</td>
</tr>
</tbody>
</table>

There is no standard as to the number of population that should be served by a pharmacy but Table 1 shows that there is some difference in the average population served by each pharmacy between the four CHP areas. Work done in 2007 showed there are a similar number of pharmacies per head of the population in surrounding Boards.
Maps

**Map Showing Pharmacies in NHS Lothian** in relation to population density illustrates that pharmacies are located in the areas of the most dense population and the more dense the population the higher number of pharmacies there are. Pharmacies also tend to be nearby local and main routes of access and this can be seen particularly in the more rural areas of Lothian. They are spread across the area, with major conurbations having a pharmacy. There is good co-location near GP practices (**Map Showing GP Practices for each CHP area in NHS Lothian**). Under the new community pharmacy contract where all 4 core services are required to be provided, co-location with GP practices is not necessarily required. However the nature of both these services means that they tend to be accessible and located in local communities. Several maps also illustrate the pharmacies located within each CHP and the surrounding multiple index of deprivation.

See following maps in Appendix 1

- **2009 Scottish Index of Multiple Deprivation for Edinburgh- by datazone**
- **2009 Scottish Index of Multiple Deprivation for East Lothian- by datazone**
- **2009 Scottish Index of Multiple Deprivation for Midlothian- by datazone**
- **2009 Scottish Index of Multiple Deprivation for West Lothian- by datazone**

There can be a variety of reasons for a community pharmacy location and a mix of accessible pharmacies would appear to exist within NHS Lothian.

2.2.1 Hours of Service

Normal hours of service for pharmacies are laid out in the NHS Lothian Hours of Service Scheme under Regulation 11(1) of the National Health Service (Pharmaceutical Services) (Scotland) Regulations as:

**All places of business on the Pharmaceutical List shall be open for the supply of drugs and prescribed appliances (as the case may be), on the days and at the hours following:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>On five full week days in the week (less any public holidays in the week).</td>
<td>9am to 6pm (during which time they may be closed for a maximum of one hour in the middle of the day).</td>
</tr>
<tr>
<td>On one half week day (the Early Closing Day as defined in the Shops Act 1950-65).</td>
<td>9am to 1pm.</td>
</tr>
</tbody>
</table>

Additionally at any other time when a pharmacist’s place of business is open for the purpose of supplying drugs or appliances he shall supply drugs or prescribed appliances which are ordered under the regulations.
Provision of NHS Lothian Community Pharmacy Services

This effectively means that each contracted pharmacy must open five and a half days per week and the opening hours tend to reflect local surgery times. However there are variations to these hours depending upon individual circumstances and applications for slightly shorter or longer hours have been made at various times to suit the local situation. Longer hours are at the discretion of the individual pharmacy and not enforceable through regulations.

Table 2 Community Pharmacy Opening Hours in NHS Lothian (June 2011)

<table>
<thead>
<tr>
<th>Location</th>
<th>NHS Lothian</th>
<th>East Lothian</th>
<th>Edinburgh</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of community pharmacies</td>
<td>183</td>
<td>23</td>
<td>108</td>
<td>19</td>
<td>33</td>
</tr>
<tr>
<td>Number of pharmacies open until 6pm</td>
<td>116</td>
<td>12</td>
<td>67</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>Number open between 6pm and 10pm weekdays</td>
<td>22</td>
<td>0</td>
<td>17</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Number open on Saturdays morning only</td>
<td>85</td>
<td>9</td>
<td>53</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Number open all day Saturday</td>
<td>95</td>
<td>14</td>
<td>54</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Number open Sunday</td>
<td>19</td>
<td>0</td>
<td>15</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

2.2.2 Facilities

Many community pharmacies have been developed to provide private areas which can be utilised for the provision of counselling and/or advice. These enable patients to have private conversations and to enable other private service such as emergency hormonal contraception to be provided in a confidential manner. The development of consultation or private areas in many pharmacies has been an enabling factor in the development of these services. These areas can be either fully enclosed providing complete audible and visual privacy or can provide a lesser degree of privacy.

In recent years there has been significant investment in improving pharmacy premises to ensure that they are fit for purpose. This has been supported by the Scottish Government, the Right Medicine and contractors themselves. The majority of pharmacies now have a private consulting room or a private area where more sensitive issues can be discussed.
Table 3 Premises Facilities in NHS Lothian. Numbers of pharmacies with each facility and as a percentage of total pharmacies in the area (March 2011)

<table>
<thead>
<tr>
<th>Area</th>
<th>FACILITY INDUCTION LOOP</th>
<th>FACILITY WHEELCHAIR ACCESS</th>
<th>FACILITY PRIVATE CONSULTING AREA/ROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian</td>
<td>148 (81%)</td>
<td>168 (92%)</td>
<td>168 (92%)</td>
</tr>
<tr>
<td>East Lothian</td>
<td>20 (87%)</td>
<td>22 (96%)</td>
<td>20 (87%)</td>
</tr>
<tr>
<td>Midlothian</td>
<td>16 (84%)</td>
<td>17 (89%)</td>
<td>19 (100%)</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>86 (79%)</td>
<td>98 (91%)</td>
<td>99 (92%)</td>
</tr>
<tr>
<td>West Lothian</td>
<td>26 (79%)</td>
<td>31 (94%)</td>
<td>30 (91%)</td>
</tr>
</tbody>
</table>

In NHS Lothian 92% of pharmacies currently have either a private area or room. The majority also have induction loop facility and wheelchair access.

Results from the 2005/6 community pharmacy customer satisfaction project carried out in NHS Lothian showed that less than 2% of respondents had any difficulties gaining access to the pharmacy premises, the services it provides or in obtaining information in an appropriate format.

2.2.3 Travel time

Previous national research has indicated that 86% of the population are within 20 minutes travelling time of their pharmacy and 44% are within 10 minutes. This data also showed that 47% of respondents travelled by car and 42% walked. The majority (83%) started and ended their journey at home with only 8% travelling from their place of work. Another UK wide survey showed that 56% of respondents were a short walk away from a pharmacy with an additional 22% further than a short walk but less than one mile. The respondents in this survey reported a mean distance of travel of 0.8 miles to a pharmacy.

The travelling time of 20 minutes for driving, cycling and walking has been shown on an NHS Lothian map and on each CHP to show more detail. It can be clearly seen that most city centre pharmacies are within 20 minutes walk for most of the population and more rural areas are within 20 minutes drive from their nearest pharmacy.

Results from the 2005/6 community pharmacy customer satisfaction project carried out in NHS Lothian showed that 59% of customers chose the pharmacy they were visiting because they lived close by, 28% because of the quality of service and only 4% because they worked nearby. This also illustrates a clear link to travelling from home to pharmacy.
Provision of NHS Lothian Community Pharmacy Services

See the following maps in Appendix 1

- Map showing 20 minute isochrones in East Lothian for driving, cycling and walking.
- Map showing 20 minute isochrones in Edinburgh for driving, cycling and walking.
- Map showing 20 minute isochrones in Midlothian for driving, cycling and walking.
- Map showing 20 minute isochrones in West Lothian for driving, cycling and walking.

Travel times by public transport across NHS Lothian are more complex and have not been mapped for this plan. The NHS Lothian area is serviced by a wide bus network and has some rail connections. The positioning of pharmacies on main routes as discussed previously aids accessibility.

2.3 Essential (Core) Services for Community Pharmacy

All community pharmacies will be required to provide all 4 core pharmacy services:

- Chronic Medication Service
- Minor Ailments Service
- Public Health Service
- Acute Medication Service

2.3.1 Chronic Medication Service (CMS)

The Chronic Medication Service is the continuity of pharmaceutical care of patients with long term medical conditions.

The Chronic Medication Service (CMS) provides personalised pharmaceutical care by a pharmacist to patients with long term conditions. It is underpinned by a systematic approach to pharmaceutical care in order to improve a patient’s understanding of their medicines and to work with the patient to maximise the clinical outcomes from the therapy.

There are three stages to CMS:

- Stage 1. Reviewing patients medicines
- Stage 2. CMS care plan
- Stage 3 Serial prescriptions

Work is being done to test the electronic communication between selected pharmacies and GP practices. The initial requirements for implementation of the chronic medication service encouraged registration and only now is encouraging completion of pharmacy care records. This is reflected in the figures shown in Figure 10.
2.3.2 Minor ailment service (MAS)

Minor ailments can be generally described as common, often self-limiting conditions. They normally require little or no medical intervention and are usually managed through self-care and the use of appropriate products that are available to purchase without a prescription.

This service aims to support the provision of direct pharmaceutical care within the NHS by community pharmacists. The service allows eligible people to register with the community pharmacy of their choice for the consultation and treatment of common self-limiting conditions. The pharmacists advise, treat or refer the person (or provides a combination of these actions) according to their needs. To be eligible for the minor ailment service a patient must be registered with a Scottish GP practice and in one of the following categories:

- persons who are under 16 years of age or under 19 years of age and in full-time education;
- persons who are aged 60 years or over;
- persons who have a valid maternity exemption certificate, medical exemption certificate, or war pension exemption certificate;
- persons who get Income Support, Income-based Jobseeker’s Allowance, Income-related Employment and Support Allowance, or Pension Credit Guarantee Credit; and
- persons who are named on, or are entitled to, an NHS tax credit exemption certificate or a valid HC2 certificate.
2.3.3 Public Health Service (PHS)

There are two patient service elements of the public health service.

2.3.3.1 Smoking Cessation Services

This service consists of the provision of a smoking cessation service comprising advice and supply of nicotine replacement therapy (NRT) and other smoking cessation products over a period of up to 12 weeks, in order to help smokers successfully stop smoking.

To fulfil contractual obligations, pharmacists must complete both a payment claim form and a minimum dataset form. There is a national database to record smoking quit attempts and the figures for quits through pharmacy based interventions contribute to the Boards smoking cessation HEAT target. The minimum dataset form is the means for capturing this information.

In NHS Lothian for the 12 months between 1st August 2010 and 31st July 2011 the number of quits recorded at 4 weeks via community pharmacy was 1343. This accounted for 29% of 4 week quits achieved within NHS Lothian through all stop smoking services during this time period. The quit rates for community pharmacies is 26% which is less than stop smoking specialist services and this reflects a similar finding across NHS Scotland.

2.3.3.2 Sexual Health Services

The sexual health service involves consultation on, and supply of the emergency hormonal contraception (EHC) to women 13 years and above.

Where a pharmacy contractor decides not to supply emergency hormonal contraception (EHC), they should give notice in writing to the
Provision of NHS Lothian Community Pharmacy Services

Health Board and advise the Agency of their decision and ensure prompt referral of patients to another provider who they have reason to believe provides that service.

In addition, an individual pharmacist who chooses not to supply EHC on the grounds of religious, moral or ethical reasons must treat the matter sensitively and advise the client on an alternative local source of supply (such as another pharmacy, GP or sexual health service).

Figure 12 – Emergency Hormonal Contraception

Figure 12 shows that the demand for emergency hormonal contraception, while fluctuating slightly month to month, shows no increasing trend. The need for this service would therefore appear to be stable. It is also known from pharmacy level data that there is capacity within the system to meet any increasing demand.

2.3.4 Acute Medication Service (AMS)

The Acute Medication Service is the provision of pharmaceutical services for prescriptions.

The Acute Medication Service represents the provision of pharmaceutical care services for acute episodes of care and supports the dispensing of prescriptions and any associated counselling and advice.

In Scotland in 2010/11 9 1891 010 items were dispensed by community pharmacies and 10 957 150 of these were in NHS Lothian. Figure 12 below shows the year on year increase in the number of prescriptions requiring to be dispensed in NHS Lothian.
2.3.5 Unscheduled Care

Community pharmacy is an important access route for people requiring unscheduled care particularly over weekends and public holidays. One of the tools available to pharmacists is the National Patient Group Direction for the Urgent Supply of Repeat Medicines and Appliances.

Community Pharmacies can also use Direct Referral to local Out of Hours services where the pharmacist feels that the patient does not have a medicines supply issue but requires input from another health professional.

2.4 Additional Services

There are several additional services agreed within NHS Lothian. These are locally negotiated contracts and as such not all pharmacies participate. It is the responsibility of the NHS Board to ensure that these additional services meet the needs of the population. This does not mean that the population requires these services equally across NHS Lothian or that it is necessary to provide them from every community pharmacy. The services might also be provided by other agencies and so provision must be looked at in the context of wider healthcare services.
2.4.1 Substance Misuse

2.4.1.1 Supervised Self Administration of Methadone (SSAM)

SSAM has become a key component of any methadone maintenance programme. The main reason for supervising the dose is to check that the dose is correct for the patient (i.e. neither too high nor too low). However, it also ensures that the patient takes the prescribed dose of methadone and it is not being illegally shared, swapped or sold.

The use of community pharmacists for dispensing methadone allows patients to be treated in their own communities. Community pharmacists are the best placed healthcare professionals to carry out the supervision of methadone. Supervision of methadone ensures that adequate blood and tissue levels of methadone are maintained and helps to prevent diversion onto the black market. All pharmacies are available to dispense methadone however supervised methadone service may not be available in all areas to all patients due to capacity issues.

Information on the number of pharmacies delivering supervision of methadone is not held within NHS Lothian and may fluctuate. A snapshot for the month of April 2011 has been obtained to illustrate numbers.

Table 4 – Pharmacies Dispensing methadone during the period 1st April 2011 to 30th April 2011

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of community pharmacies</th>
<th>Number of Pharmacies dispensing methadone (areas)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian</td>
<td>183</td>
<td>167</td>
</tr>
<tr>
<td>East Lothian</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>108</td>
<td>94</td>
</tr>
<tr>
<td>Midlothian</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>West Lothian</td>
<td>33</td>
<td>31</td>
</tr>
</tbody>
</table>

The Information and Statistics Division reported that from January 2010 to March 2010 169 pharmacies dispensed methadone and 156 supervised methadone treatments. Clearly there are small variations in number of pharmacies dispensing but this is likely in response to demand and not a pharmacy decision.

2.4.1.2 Supervised self-administration of buprenorphine

There are 15 community pharmacies in Lothian registered in the supervised self-administration of buprenorphine scheme. Buprenorphine supervision was introduced as a pilot for detoxification only, in July 2002, and pharmacists working in these pharmacies received training at that time.
Many more pharmacies dispense buprenorphine without any supervision of the client.

Table 5 – Pharmacies Dispensing buprenorphine during the period 1st April 2011 to 30th April 2011

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of community pharmacies</th>
<th>Number of Pharmacies dispensing methadone areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian</td>
<td>183</td>
<td>90</td>
</tr>
<tr>
<td>East Lothian</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>108</td>
<td>40</td>
</tr>
<tr>
<td>Midlothian</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>West Lothian</td>
<td>33</td>
<td>21</td>
</tr>
</tbody>
</table>

2.4.1.3 Injection Equipment Provision

Injection equipment provision is provided with the aims of reducing the transmission of blood borne viruses by sharing of injecting equipment; to protect the public from discarded equipment; to make contact with drug users who are not in contact with drug treatment services; and to improve access to health and harm reduction advice. Pharmacies providing the service will give limited advice on injecting, dealing with wounds and finding health and drug services. They all provide needles and syringes, and other injecting paraphernalia.

This is not a pharmacy specific scheme and needle exchange may be available in other community based settings. As of November 2011, there are 21 pharmacies in NHS Lothian providing this service in pharmacies but this is under review following a needs assessment carried out which aims to reduce pharmacy numbers but improve quality of service.

2.4.2 Pharmaceutical Advice to Care Homes

The aim of this scheme is to ensure that all drugs and medicines supplied to the residents of a home are handled, stored and administered correctly.

Community pharmacists are the best placed healthcare professionals to offer this type of advice to homes within their vicinity. Basically, any pharmacy on the scheme is responsible for providing pharmaceutical advice on the safe handling, storage and correct administration of any drugs and medicines that they supply to the residents of home to which they are affiliated.

Payment for this service is made for up to a maximum of five homes per contractor. Payment is made on a sliding scale depending on the number of beds in the care home.
Provision of NHS Lothian Community Pharmacy Services

This service would not be expected to be geographically spread but instead correspond to the needs of care homes within their local area. It would not be necessary for a pharmacy to be located in the same CHP as the care home.

2.4.3 Palliative Care Network

The Palliative Care network was reviewed in December 2011. The Palliative Care network was launched in November 2000, and was developed in response to concerns expressed in accessing palliative care drugs for patients being cared for at home, particularly outwith normal working hours. The scheme follows the framework described in the Scottish Circular MEL(1999)78 for a Community Pharmacy Pharmaceutical Care Model Scheme for Palliative Care, and is funded by this initiative. The review takes into account geographical spread of pharmacies across NHS Lothian and ensures a robust on call mechanism for access to palliative care drugs out of normal working hours.

The aims of the scheme are to:

- Allow timely access to palliative care drugs for patients being cared for at home.
- Provide information regarding palliative care drugs to patients, carers and other health care professionals.
- Support and maintain the formation of a network of “palliative care” community pharmacies in NHS Lothian and liaise with other health care professionals on palliative care issues.

Patients or their carers are encouraged to continue to use their usual community pharmacy to obtain prescriptions. The community pharmacies participating in the scheme should only be accessed in the following situations:

- During normal working hours, when the patient’s usual community pharmacy cannot supply the palliative care drug(s) within the timescale required.
- Outwith normal working hours when the patient requires the palliative care drug(s) urgently.

There are now 22 pharmacies taking part in the palliative care network across NHS Lothian and of an on call service from 8 pharmacies.
Chapter 3  Recommendations

Hours of Service

1  Opening hours outwith core hours are likely to remain fluid and a local process for agreement of any opening hour changes should be retained.

Essential Core Services

2  There is clear identified need for acute and chronic medication services illustrated by dispensing information and prevalence data.

3  There is no evidence of patients being unable to source a pharmacy to dispense a prescription which could be taken as evidence that there is no unmet need for the acute prescription service.

4  There is no evidence of patients being unable to register for minor ailment service which could be taken to show there is no unmet need in this area, although it would appear that registrations and usage of this service are likely to increase. NHS Lothian should support the awareness of this service for those that are eligible.

5  The supply of emergency hormonal contraception is led by patient demand and there is no increasing need for this service illustrated by the supply figures.

6  Under the provisions of the contract all four core services must be delivered. The chronic medication is the final core service to be implemented in pharmacies and as yet the demand and workload has not yet been established. It may be useful in the future to assess the capacity in existing pharmacies and any changes to staffing skill mix that may help meet increasing demands.

7  NHS Lothian should support the continued development of community pharmacy capacity and staff development to ensure capacity for new services can be developed as they are implemented.

Additional Services

Substance Misuse

8  There would appear to be no current evidence of unmet need for the supervised methadone service. And while this is the one area where work around capacity has been done, the data needs to be updated to gauge current capacity within the system. The use of buprenorphine has been increasing and some pharmacies provide supervision of this without payment. The services provided by pharmacies relating to substance misuse are part of an overall strategy led by the Drug and Alcohol Action Team and services require to be addressed within that
Provision of NHS Lothian Community Pharmacy Services

wider context and appropriate funding identified to support any increase in demand.

9 Needle exchange is not a specific pharmacy scheme and is available from other providers in NHS Lothian, determined by the Harm Reduction Team. As pharmacies can often offer longer opening hours than drop in centres pharmacy delivered needle exchange adds capacity to the harm reduction team.

Palliative Care Services

10 The Palliative Care Service has just been reviewed to ensure best coverage for the population of NHS Lothian of a small number of local experts for provision of palliative care drugs and advice both in and out of hours.
Provision of NHS Lothian Community Pharmacy Services

Pharmacy locations and associated population density
Provision of NHS Lothian Community Pharmacy Services

Pharmacies and GP Practices in Edinburgh CHP

By Mette Tranter, HIU, NHS Lothian, 23rd August 2011
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Provision of NHS Lothian Community Pharmacy Services

Pharmacies and GP Practices in Midlothian CHP
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Pharmacies and GP Practices in West Lothian CHP

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Pharmacies and GP Practices in East Lothian CHP

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Pharmacies and GP Practices in Edinburgh CHP

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Provision of NHS Lothian Community Pharmacy Services

Drive time (isochrones) from pharmacies in East Lothian CHP

By Mette Tranter, HU, NHS Lothian, 24th August 2011
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Provision of NHS Lothian Community Pharmacy Services

Drive time (isochrones) from pharmacies in Midlothian CHP

By Mette Tranter, HLIU, NHS Lothian, 24th August 2011
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Provision of NHS Lothian Community Pharmacy Services

Drive time (isochrones) from pharmacies in West Lothian CHCP

By Mikel Tranter, HIU, NHS Lothian, 24th August 2011
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COMMITTEE CHAIRS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the appointment of Paul McLennan as Chair of the Audit Committee, taking over immediately from Steve Renwick.

Any member wishing additional information should contact the Chairman in advance of the meeting.

2 Recommendations

The Board is recommended to agree the appointment of Paul McLennan as Chair of the Audit Committee from 1 April 2012.

2.1

3 Discussion of Key Issues

3.1 As Steve Renwick’s term of office was intended to end in March 2012, he came off all committees other than the Endowments Finance Advisory at that juncture. Given that he has now had a three month extension, he will be undertaking a risk based project during his extension period and not be involved in committee work. It is therefore proposed that Paul McLennan be appointed as Chair of the Audit Committee from 1 April 2012.

4 Key Risks

4.1 There is a risk of a break in the operation of an effective governance arrangement if a Chair of the Audit Committee is not in place before 5 April, the date of the next Audit Committee meeting.
5 Risk Register

5.1 There is no corresponding entry on the risk register - the appointment will address the issue.

6 Impact on Health Inequalities

6.1 This appointment reflects the application of the terms of a previously agreed Framework of Governance, and as such, no impact assessment has been performed.

7 Impact on Inequalities

7.1 This is an administrative matter and has no impact on Inequalities.

8 Involving People

8.1 This issue has been discussed with the Board members concerned.

9 Resource Implications

9.1 There are no resource implications arising from these recommendations.

Charles Winstanley
Chairman
20 March 2012
charles.winstanley@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
28 March 2012

Medical Director (Executive Lead)

SOUTH EAST SCOTLAND RESEARCH ETHICS COMMITTEES

1 Purpose of the Report

1.1 The purpose of this report is to seek the approval of the Board for a revised structure and membership of the South East Scotland Research Ethics Committees.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Agree the revised South East Scotland Research Ethics Committees structure and memberships as detailed in Appendix 1.

3 Discussion of Key Issues

3.1 Whilst the appointment of NHS Research Ethics Committees (RECs) members is the responsibility of NHS Boards in Scotland, these Committees are part of a National Research Ethics Service (NRES). A general decline in the number of applications to RECs, a redefining of the types of research studies that require REC review and a move toward proportionate review of some REC applications, has resulted in a decrease in the number of applications received by UK RECs. This has led NRES and the Chief Scientist Office recommending the closure or merger of RECs on a regional basis. There are currently three South East Scotland RECs: SESREC01, SESREC02, SESREC03, and it is proposed to close SESREC03 from April 1st 2012. The historical work from SESREC03 will be managed by the remaining two SESRECs and the members of SESREC03 will join either SESREC01 or SESREC02. Additionally, a number of the South East Scotland Research Ethics Committees members have now reached their maximum tenure as defined by the Governance Arrangements for Research Ethics Committees (GAfREC) and have stood down from their REC. As a consequence, the membership of the South East Scotland Research Ethics Committees has been revised, as detailed in Appendix 1. The revised Research Ethics Committee structure does not require the recruitment of any new members and all Committees remain fully accredited as per the NRES accreditation process.
4 Key Risks

4.1 There are no risks attached to the recommendations.

5 Risk Register

5.1 There are no risks attached to the recommendations.

6 Impact on Health Inequalities

6.1 There are no health inequalities implications arising from this report or recommendations.

7 Impact on Inequalities

7.1 There are no inequalities implications arising from this report or recommendations.

8 Involving People

8.1 N/A.

9 Resource Implications

9.1 The revised structure and membership of the Research Ethics Committees will result in a 25% reduction in face-to-face meetings and a 15% reduction in committee members. Both reductions will decrease the costs associated with running the South East Scotland Research Ethics Committees.

David Farquharson
Medical Director
13 March 2012
david.farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Proposed Membership of the South East Scotland Research Ethics Committees
<table>
<thead>
<tr>
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<td>Lindsay Murray (VC)</td>
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<td>Calum MacKellar</td>
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<td>Alanah Kirby</td>
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<td>Andy Neustein</td>
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<td>Hester Ward</td>
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<td>Sara Smith</td>
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<td>Derek Santos</td>
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UPDATE ON SEAT ACTIVITIES

1 Purpose of Report

The purpose of this paper is to update the Board on the last meeting of SEAT held on 17 February 2012.

2 Recommendations

Board members are asked to:

- accept the update
- acknowledge the benefits of SEAT work for NHS Lothian residents
- note that the SEAT work streams have proactive involvement of NHS Lothian Chief Executive and Directors, Employee Director and other NHS Lothian staff.

3 Background

Collaborating SEAT Boards include NHS Lothian, Borders, Fife, Forth Valley, Tayside and NHS Dumfries and Galloway (for cancer services). SEAT benefits from proactive input of partnership representatives and special health board and Scottish Government input. The principles of subsidiarity and proportionality underpin this collaboration which may include, for example, shared provision of services, deployment of professional staff beyond their Board of employment and financial risk share arrangements.

SEAT is currently chaired by Professor James Barbour. Its business is now conducted routinely through telepresence to minimise travel time and costs and ensure best use of participants’ time.

4 Key Issues

4.1 Regional Eating Disorders Unit

As previously reported the 12 bedded regional Eating Disorders Unit based at St John’s Hospital and managed by the West Lothian CHCP, was officially opened by the Minister for Public Health in January 2012. SEAT recognised the significant contribution to the development of the new unit by Linda Irvine,
Programme Manager in NHS Lothian and Dr Chris Freeman, Regional Consultant Psychiatrist working in conjunction with colleagues across the region.

4.2 IVF Eligibility Criteria and Service Provision across SEAT

SEAT discussed the variation across the region in terms of eligibility criteria for IVF and agreed the need to coalesce to the same criteria across SEAT Boards, preferably to those currently adopted by NHS Lothian.

4.3 SEAT Regional Tier 4 Child and Adolescent Mental Health Services (CAMHS)

SEAT received an update on the regional Tier 4 CAMH project from the lead clinician Cathy Richards, lead clinician for CAMH psychology in NHS Lothian and the regional project manager Dan Isaac. This project was set up to support a new model of intensive community treatment for young people with a range of severe mental health problems. Working collaboratively as part of a regional consortium, clinicians and managers from NHS Lothian, Borders and Fife have driven whole system changes across specialist Tier 4 CAMHS, including the adolescent in-patient unit in Lothian. These include:

- an increase in treating young people in a community setting;
- a reduction in the lengths of stay in the Lothian in-patient CAMH unit from an average of 112 days in 2008 to 37 days in 2011;
- a reduction in use of non-specialist and predominantly adult psychiatry beds for people under 18 years of age: 5.5 admissions per 100,000 under 18 population in 2010/11 compared to 18.4 admissions in 2007/8;
- improved CAMHS bed availability providing improved access for young people across the region – 18% of beds occupied by young people from Borders and Fife in 2011 compared to 6% in 2008;
- improved pathways and policies developed collaboratively;
- joint training across the region for family based therapy.

4.4 Managed Clinical Network for Neonatal Services

SEAT approved the work plan for a regional Managed Clinical Network for neonatal services presented by the clinical lead for the MCN (until very recently a consultant neonatologist in NHS Lothian) and the regional project manager. The work plan focuses on continuing to improve neonatal care by working across the region in key areas including clinical guidelines, development of audit, patient pathways, joint training and education approaches and a joined up approach to the development of Advanced Neonatal Nurse Practitioners.

SEAT also received an update on the position regarding paediatric medical trainee rotas.
4.5 Rebalancing Care – Orthopaedics

This cross SEAT work stream has regularly been part of previous reports on SEAT activities. Director level leadership within NHS Lothian and Borders supported by regional colleagues and clinical and operational teams has ensured that the rebalancing of circa 230 orthopaedic procedures from NHS Lothian to NHS Borders will proceed as of April 2012. Additionally, inappropriate non-tertiary referrals from NHS Borders are no longer seen by NHS Lothian. The methodology adopted for orthopaedics now needs to be considered for other specialities across the region to consider best use of regional capacity in the interests of patients in individual Boards.

4.6 Performance Standards and Minimising Variation

Dr Alison McCallum, Director of Public Health continues to lead this work on behalf of SEAT and assured SEAT that work continues with Medical Directors to ensure thresholds are put in place for specific interventions such as hip and knee procedures across the region to minimise variation and maximise productivity.

4.7 Technology / Radiology

As a result of regional collaboration and identification of potential savings, work is ongoing within individual Boards to develop plans to realise efficiencies in skill mix in the use of radiographers for plain film reporting.

4.8 Complex Care Packages

Work continues on a strategic commissioning approach for people with learning disabilities with complex care needs via senior manager engagement across the SEAT Boards. This is synergistic with the NHS Lothian Disability strategy and the repatriation of out of area placements.

4.9 Corporate Services

As a result of discussions arising from a recent NHS Lothian Finance and Performance Review committee, SEAT members recognised the need to learn the lessons from work to date on corporate services for any future potential in corporate services across the region.

4.10 Reprovision of RHSCE / DCN

A substantive item on the SEAT agenda is reprovision of RHSCE and DCN. This allows other SEAT Board colleagues to be abreast of developments in this complex project to support communication and discussion within their respective Boards.
5 Key Risks

Partnership working is a key element to ensuring the successful delivery of the above workstreams. The Director of Regional Planning works closely with individual Board colleagues, particularly Directors of Planning and Finance to ensure an agreed SEAT work plan, to ensure the minimisation of risk to progress and that the opportunities offered by regional collaboration and working are maximised.

6 Risk Register

Boards are expected to record any issues as appropriate within their respective Board risk registers.

7 Impact on Health Inequalities

The thrust of all of the work streams above will be to reduce inequalities or drive improvements in the delivery and access to care and treatment. This paper highlights and comments on existing workstreams therefore a separate equality impact assessment has not been undertaken.

8 Involving People

People will be involved in the shaping of any proposals within individual work streams and in any consultation that may be required in respect of any proposed changes to service delivery.

9 Resource Implications

No resource implications have been identified with respect to this update paper.

Jacqui Simpson
Director of Regional Planning (Interim)
15 March 2012
Jacqui.simpson@nhslothian.scot.nhs.uk
## Communications Received

### 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:

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<td>CNO(2012)001</td>
<td>National infection prevention and control manual for NHSScotland – chapter 1: standard infection control precautions (SICPS) policy</td>
<td>13/1/2012</td>
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<td>16/1/2012</td>
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<td>Relocation and excess travel expenses: Training grades</td>
<td>24/01/12</td>
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<td>A Policy on sustainable development for NHSScotland 2012</td>
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<td>Pharmaceutical Services Amendment to drug tariff Discount clawback rate PT 7</td>
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</table>

James Barbour  
Chief Executive  
19 March 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