NHS LOTHIAN

BOARD MEETING

DATE:       WEDNESDAY 25 JULY 2012
TIME:       9:30 A.M. - 12:30 P.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.

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* = paper attached  
# = to follow  
v = verbal report  
p = presentation

For further information please contact Peter Reith, ☏ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
5. Performance Management (9.55am – 11.15am)

5.1. Financial Position to 30th June 2012  
5.2. Performance Management  
5.3. Waiting Times Progress and Performance

6. Policy & Strategy (11.15am – 11.35am)

6.1. Mental Health Strategy Update  
6.2. Sexual Health Strategy Update

7. Governance (11.35am – 12.30pm)

7.1. Quality Report  
7.2. NHS Lothian’s Quality Improvement Strategy 2011-2014  
7.3. The Role of the Boards in Quality and Safety NHS Lothian Action Plan  
7.4. Healthcare Associated Infection Update

8. Other Items

8.1. Reference Committee Chair

9. Date, Time and Venue of Next Meeting: Wednesday 26 September 2012 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

LUNCH 12:30 p.m.

Dates of Meetings in 2012:

26 September 2012
24 October 2012
28 November 2012
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 27 June 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Executive Directors: Mr T Davison (Interim 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 Burley; Dr M Bryce; Mrs T M Douglas; Mr E Egan (Vice-Chair); Councillor R Henderson; Mr P Johnston; Professor P Murray; Ms S G Renwick; Mr G Walker; Mr I Whyte and Dr R Williams.

In Attendance: Mrs J Donnelly (Associate Director of Corporate Improvement) (For item 25); Mr J Forrest (Director, West Lothian Community Health and Care Partnership); Mr A Jackson (Associate Director of Strategic Planning) (For item 25); Ms D Milne (Specialist in Public Health) (For Item 24); Mr R Martin (Head of Corporate Reporting) (For Item 27); Dr D McCormick (Consultant in Public Health) (For Item 24); Mr D A Small (General Manager, East and Midlothian Community Health Partnership); Ms S Thorn (Lead Health Protection Nurse); (For Item 24); Councillor F Toner (West Lothian Council Representative Designate); Mr D Weir (Corporate Services Manager); Mr S R Wilson (Director of Communications).

Apologies for absence were received from Councillor D Grant, Professor J Iredale, Mrs J McDowell and Mr B Peacock.

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 Mr Renwick should signal his intention to withdraw from debate if he felt there was any potential conflict.

20. Chair’s Opening Comments – Welcome to Members of the Public and Press

20.1 The Chair welcomed members of the public and press to the meeting. He reported this would be Mr Burley, Mrs Douglas and Mr Renwick’s last meeting as Board members as their terms of office had expired and thanked them, on behalf of the Board, for their input over a number of years. He advised a Board dinner had been arranged for 28 June 2012 to mark their contribution.
20.2 The Chair advised Councillor R Henderson, City of Edinburgh Council and Councillor D Grant, East Lothian Council had both been invited by the Cabinet Secretary to become members of the Board. Councillor Toner, West Lothian Council and Councillor Johnstone, Midlothian Council nominations were still going through due process. It was agreed Councillor Toner would be In Attendance at the current meeting and would be eligible to contribute to the debate.

21. Minutes of the Previous Meeting of Lothian NHS Board held on 23 May 2012

21.1 The Minutes were approved as a correct record.

22. Matters Arising

22.1 Proposal to Reduce Paediatric Inpatient Activity at St John’s Hospital during July 2013 - Dr Farquharson advised the Board efforts to recruit to consultant posts at St John’s Hospital to cover the Paediatric rota continued with a view to the service being less reliant on trainees. He commented despite strenuous efforts to co-ordinate annual leave cover, cover in the unit was extremely tight with there being no locum staff availability.

22.1.1 Dr Farquharson commented an unplanned absence of one key staff member for one or two shifts could be managed. He commented, however, unplanned absence of two key staff members, including the on-call consultant that could not be covered by colleagues elsewhere would require a change in the service provided at St John’s. He advised inpatient paediatrics would need to move to the Royal Hospital for Sick Children. If neonates could be covered by a neonatologist or advanced neonatal nurse practitioner, maternity services would be unaffected. Dr Farquharson advised in the event of being unable to do this, most planned births would need to be redirected to the Royal Infirmary of Edinburgh and other units in surrounding Boards. Dr Farquharson commented an inability to cover shifts for a period of more than a few days would require changes as described.

22.1.2 Dr Farquharson commented there would be a clinical risk associated with a need to reconfigure the service at short notice and consequent confusion for families, Scottish Ambulance Service, primary care and NHS 24. It had, therefore, been, with heavy heart, that it had been decided to recommend to the Board a planned reduction in the service at St John’s for the high risk period of July so that in the event of a crisis there was less potential impact on patient safety. Dr Farquharson stressed there would be no change to maternity or neonatal services at St John’s over this period.

22.1.3 The Vice-Chair commented he was disappointed at the lack of Lothian Partnership Forum engagement in the proposals before the Board with colleagues in West Lothian having been unaware of the proposals. He questioned, if there was no alternative to the proposed course of action, how confident Dr Farquharson was that inpatient services would be properly restored at the end of July. He commented because of the lack of partnership engagement, the paper was light on detail about how existing staff would be deployed over the period in question.
22.1.4 Dr Farquharson stressed he had been keen to secure Board approval to the proposals in the first instance and work moving forward would include full engagement with partnership colleagues.

22.1.5 Councillor Toner thanked the Board for the opportunity to speak on this item. He advised West Lothian Council rejected the proposals in the Board paper in their current format because the Council did not support the downgrading of St John’s Hospital. The Council felt a solution should have been in place by now and whilst the additional staffing in August was to be welcomed, there remained concern about the comment in the paper that previous experience suggested the rota would remain vulnerable to sudden losses of some or all trainees. He advised the Council were concerned the proposals represented a first step towards downgrading St John’s Hospital. Councillor Toner also referred to the summary of the Royal College of Paediatric of Child Health report, attached as part of the Board paper, which stated “St John’s current staff cannot sustain 24/7 provision of training or service. Unless further trained staff are appointed, the creation of a short-stay paediatric assessment unit (SSPAU) in Livingston, fully integrated with Edinburgh, would be a beneficial option to explore and would offer suitable training opportunities.”

22.1.6 Councillor Toner advised he and the Council had concerns in the short and medium term and, for this reason, the current proposals were unacceptable. The Chair advised he was aware of the debate around the issues at West Lothian Council and that the Chief Executive of the Council had written to him explaining the Council’s position.

22.1.7 Dr Farquharson comment all rotas were vulnerable and the statement referred to by Councillor Toner equally applied to other units, hence the current focus to become less reliant on trainees in general. He advised, subject to a successful recruitment outcome, he was committed to return services to St John’s Hospital.

22.1.8 Dr McCallum advised she supported the direction of travel proposed, although she suggested in the longer term there was an opportunity in the west of West Lothian to think differently about the provision of expert care. She commented it would be important to think how best to use clinical expertise to minimise the need for children to be hospitalised in the first instance.

22.1.9 Mr Boyter reminded colleagues what was being proposed was a temporary change in service provision for a 3-week period from 9 July 2012. He reported weekly meetings had been held with Directors of Operations and Clinical Directors and, in that regard, there had been strong clinical engagement in reaching the default position and in attempting to sustain services. Mr Boyter felt the proposal was the best option and undertook to work with Dr Farquharson to address the Vice-Chair’s point about ongoing engagement with Trades Union colleagues, including in the implementation process.

22.1.10 Dr Williams advised he was disappointed about the position reached and commented West Lothian General Practitioners had also expressed concerns. It would be important, therefore, that General Practitioners received clear guidance on how to manage such children over the temporary period. Dr Farquharson
stressed there would be a period of clear communication with patients, families and health professionals.

22.1.11 Mr Johnston advised he was bitterly disappointed to be discussing on 27 June proposals for a 9 July service change, particularly given at the previous Board meeting the report had simply indicated robust plans were being worked on and additional trainees would become available during August. It was surprising, therefore, to be told there was no alternative but to change service provision for a period of 3 weeks. Mr Johnston reported this would potentially affect 60-80 children over the 3-week period, who would require to travel to Edinburgh for treatment and this was unacceptable.

22.1.12 Mr Johnston commented he did not accept the view of West Lothian Council that this was an attempt to downgrade services at St John’s Hospital, although he was concerned about the comments of the Postgraduate Dean. He was delighted to see progress being made in interviewing for permanent consultant-level posts.

22.1.13 Mr Johnston questioned what steps could be taken to sustain services during July on a 24/7 basis, as the paper suggested this was possible except for the 3-week period referred to. Dr Farquharson advised the service was absolutely covered over the whole of July but only if nobody went off work unexpectedly as had been the case in June. He stressed all available staff across Lothian had been utilised with a further difficulty being out-of-hours cover was provided by a married couple who would be on leave at the same time in July.

22.1.14 Mrs Douglas advised as Chair of the St John’s Hospital Stakeholder Group, she was disappointed by these events. She appreciated the need to err on the side of patient safety and the need to make firm decisions in order that patients and families knew where to go for treatment. She questioned, however, how this position had arisen given the potential situation had been known for a period of time. Mrs Douglas questioned whether the process would be subject to a critical incident analysis. She felt given other challenges on the medical workforce, it would be important to learn appropriate lessons as, in her opinion, the system could have responded better than it had to the current circumstances.

22.1.15 Dr Farquharson reminded the Board the paediatric position had been known about nationally since last autumn and following that a recruitment process had been undertaken in Lothian for fixed term and permanent appointments. He commented this particular national problem would also affect other 24/7 services in future and there would be a need for robust plans to be put in place to sustain services based on lessons learned around paediatrics.

22.1.16 Mr Walker commented whilst he was unhappy about the current situation, he did congratulate Dr Farquharson for taking on this problem and, given the paper put patient safety first, he would have to support its contents, albeit sadly. He felt, however, there were questions to be asked about how the position had arisen in the first place.

22.1.17 Councillor Toner reported at the St John’s Hospital Stakeholder Group, it had been suggested the 3-week period of service change might be reduced and he sought
an update on this position. Dr Farquharson advised despite all efforts the minimum period of service change would be 3 weeks. He confirmed he would be intending to work with West Lothian Council around the patient awareness campaign.

22.1.18 Mrs Allan commented the ongoing service fragility was concerning and there was a need to look at this in more detail. Mr Wilson advised in response to Mrs Allan that his team would communicate the detail of the service change through a wide network of people using existing media arrangements, as well as social networking sites to include direct contact with patients. Mr Forrest advised if the proposal was approved by the Board, he would work closely with Mr Wilson to ensure the West Lothian community and General Practitioners were aware of the position, as well as contacting regular users of the services.

22.1.19 Mr Renwick commented whilst nobody was happy about the current position, he was clear in the 8 years of his Board membership the downgrading of St John’s Hospital had never been discussed.

22.1.20 The Interim Chief Executive advised he was also disappointed at the position which had been reached, although it was important the Board was sighted on medical staffing issues, as some specialties were fragile. He advised, for instance, the spinal surgery service was exempt for 1 year from national targets because of the lack of available medical staff. The Interim Chief Executive advised similar issues had occurred in a number of specialties in other hospitals over a number of years as a consequence of issues like major changes in training.

22.1.21 The Interim Chief Executive reported the significant reduction in doctors’ hours had been anticipated and had largely been planned for. In the case of paediatrics, there had been step change in maternity leave, which had reduced the number of people available to fill training posts. He advised the ability to appoint to vacant posts, and how quickly people could start work, would be a major determinant of how quickly the service returned to a sustainable position.

22.1.22 The Board noted eight additional anaesthetics had been appointed with two of these about to go on maternity leave. The Interim Chief Executive advised the key issue was to develop a plan to sustain paediatrics by trained staff and Dr Farquharson’s action plan would address this issue. The Interim Chief Executive stressed the scenario presented by Dr Farquharson represented the absolute irreducible minimum position and any unplanned absence would leave the service without safe cover. He suggested the Board accept Dr Farquharson’s proposals but that Dr Farquharson should bring back to the Board a paper about how to deliver this service moving forward.

22.1.23 Professor Murray commented as Chair of the Healthcare Governance and Risk Management Committee, she felt it was positive risk assessments had been undertaken and commended the bold steps taken. She advised between now and the end of August, the situation would be monitored with any issues of concern reported back to the Healthcare Governance and Risk Management Committee.

22.1.24 The Chair commented the Board had displayed considerable concern at the current position and advised, given the patient safety priority, it was with reluctance he recommended the proposal was agreed. He stressed the sustainable trained
doctors model needed to be spread across all specialties. He assured Councillor Toner that this in no way suggested a lack of commitment to St John’s Hospital with there being no intention to downgrade services at the hospital. He would write to the Chief Executive of West Lothian Council stressing the short-term nature of the current position.

22.1.25 Mr Johnston stressed it was totally unacceptable for less than 24/7 services to be provided for paediatrics at St John’s Hospital and for these to be removed at less than 3-weeks notice to the detriment of 60-80 children. He recognised, however, the weight of advice and that patient safety was paramount. Mr Johnston sought a clear commitment that normal service would resume after the 3-week period and full use would be made of partnership arrangements in West Lothian to ensure wide communication including schools.

22.1.26 Mr Johnston further commented patients and relatives would incur additional expenditure and simple re-imbursement arrangements should be put in place to cover the 3-week period. He advised, subject to all these provisos being met, he would reluctantly accept the proposal in the paper. Dr Farquharson advised he anticipated three if not four trainees being placed at St John’s Hospital from the beginning of August. He advised all efforts would be made to contact families and he would look at the travel expenses position.

22.1.27 The Interim Chief Executive stressed it was not possible to provide absolute guarantees, although the proposal had been clear about recruitment requirements with current expectations being these would be achieved. He felt it was right and proper to be open and transparent about this position at Board level and it was also important to recognise there were a range of variables around recruitment that were outwith the gift of NHS Lothian. The Interim Chief Executive advised he and his colleagues were committed to returning services to St John’s Hospital and this would happen subject to the system being able to deliver the recruitment plans. The Interim Chief Executive advised the Board would be kept up-to-date on progress.

22.1.28 The Board agreed the recommendations contained within Dr Farquharson’s report.

23. Committee Minutes

23.1 Area Clinical Forum – Minutes of the Meeting held on 17 May 2012 – the Board adopted the Minutes.

23.2 Healthcare Governance and Risk Management Committee – Minutes of the Meeting held on 12 June 2012 – the Board adopted the Minutes. The Vice-Chair commented he was surprised the decision to transfer patients from the Royal Victoria Hospital to Corstophine Hospital had not been discussed by the Board. The Chair commented this had been an operational matter and the Interim Chief Executive had kept him advised.

23.2.1 The Interim Chief Executive reported he and the Chair were currently discussing the nature of routine information that needed to come to the Board and commented whilst on rare occasions there might be a need for operational issues to be
reported, this would be on an exception basis. He felt, however, the position being discussed was an operational one to accommodate 30 delayed discharge patients on a temporary basis. He cautioned if operational issues were brought to the Board on a routine basis, this would impact on the length of Board meetings.

23.3 Mutualities and Equality Governance Committee – Minutes of the Meeting held on 29 May 2012 – the Board adopted the Minutes.

23.4 Edinburgh Community Health Partnership Sub-Committee – Minutes of the Meeting held on 4 April 2012 – the Board adopted the Minutes.

24. Legionnaires Disease Outbreak

24.1 Dr McCallum commented the purpose of the report was to acknowledge the recent outbreak of Legionnaires disease in south west Edinburgh and the efforts taken by NHS Lothian and its partners to manage the outbreak. She advised an interim report was being provided to the Board as the outbreak was ongoing. A final report would be available within 3 months of the outbreak being declared over. A structured debrief would take place to inform the report and recommendations.

24.2 The Chair welcomed Dr Duncan McCormick, Ms Simone Thorn and Ms Dona Milne to the meeting advising they had been instrumental in managing the outbreak from an NHS Lothian perspective.

24.3 Dr McCormick advised NHS Lothian had established an Incident Management Team on Sunday, 3 June 2012 in response to an outbreak of Legionnaires disease. He provided details of how this type of outbreak was normally investigated, as well as further information of investigations underway to identify the source of the outbreak. Dr McCormick updated the Board on the number of people affected by the outbreak which sadly included two deaths.

24.4 Dr McCormick advised he had chaired the Incident Management Team, which had included representatives from the City of Edinburgh Council, the Health and Safety Executive, Health Protection Scotland, the Scottish Government, the National Legionella Reference Laboratory Service and NHS Lothian. A number of investigations were being undertaken by the Health and Safety Executive. He commented on 5 June 2012, the Scottish Government Health Directorates had activated the Resilience Room into which NHS Lothian had contributed.

24.5 The Chair commented NHS Lothian’s response to the Legionella outbreak had been outstanding.

24.6 Professor Murray commented this represented an excellent example of team work and congratulated all colleagues involved on the systematic approach and the extremely effective communication lines which had been put in place. Mr Renwick commented he too felt this was an exemplary way of conducting an investigation. The Board noted the team had been invited to attend Parliament the previous day to discuss their engagement in the management of the outbreak. Dr McCormick advised in response to a question from Mr Burley that the owners of the sites which had been under investigation had co-operated fully and had responded quickly to
the advice offered to them by the Health and Safety Executive and the City of Edinburgh Council.

24.7 Mrs Sansbury commented in respect of the acute team response, they had built quickly on previous experience around the business continuity planning process and the H1N1 flu arrangements whilst working to avoid the unnecessary cancellation of elective admissions.

24.8 Dr McCallum commented the role of the Director of Public Health was to ensure the Incident Management Team worked effectively. She had been on leave over the period in question and paid tribute to Ms Dona Milne who had been deputising in her absence and had managed the Team in an exemplary fashion. She also paid tribute to the General Practitioners concerned, Professor McMahon and Ms Lyn McDonald for providing a seamless response to the outbreak.

24.9 The Interim Chief Executive commented he felt given the scale and national profile of the outbreak, it had been important feedback was provided to the Board. He commented it was important to remember this outbreak had occurred over a public holiday weekend whilst the Director of Public Health was on holiday and, despite the fact that two people had tragically died as a consequence of the outbreak and people continued to be unwell, he felt NHS Lothian had performed extremely well in response to this challenge. He commented it was also important to note fewer elective admissions had been cancelled than in the previous period.

24.10 The Interim Chief Executive advised the Chief Executive of the NHS in Scotland planned to meet the Team and pass on his thanks for their efforts. The Chair commented he was very proud of NHS Lothian’s response.

24.11 The Board agreed to consider the full report on the outbreak and any lessons learned at a future Board meeting within the next 3 months.

25. Waiting Times Recovery and Capacity

25.1 Dr Farquharson advised it was intended to provide the Board with a presentation on the waiting times recovery and capacity plans covering the following three aspects:

- reasonable offer of alternative treatment
- external provider office (EPO) and the hub to support patients going to hospitals outwith Lothian
- financial implications and procurement process

25.2 Dr Farquharson advised the Interim Chief Executive chaired a weekly Waiting Times Group, which included partnership and Scottish Government Health Directorates representation. He reminded the Board on 1 October 2012 there would be a legal requirement to meet the 12-week target. He reminded the Board as at December 2011, NHS Lothian had only achieved compliance of 85-86% against the 90% target in respect of 18-weeks referral to treatment targets. He advised the approach being adopted was to focus on addressing the inpatient backlog and then swiftly move to address outpatients. Dr Farquharson commented
currently there had been a poor uptake of patients accepting referral to external providers and Mrs Donnelly would address these issues in her presentation around the EPO.

25.3 Dr Farquharson commented another strand of work was around his Waiting Times report and the PricewaterhouseCoopers (PwC) report, which had stressed the requirement for a single source of information and the need for the monitoring of “clock stops”. He advised Mr Martin Egan (Director of eHealth) and Mr Harry Purser (Health of Health Intelligence) had attended the Waiting Times meeting the previous week and had committed to ensure appropriate processes were in place.

25.4 Dr Farquharson advised the position in respect of patients waiting over 12 weeks in April had been 2,000 with this having reduced slightly to 1,948 in May. The position for 9-week waits was 2,670 in April and 2,671 in May. He commented, however, there had been a reduction in the overall size of the waiting list. In respect of outpatients, the April position had been 4,490 patients and this had risen to 4,601 in May. He commented part of the reason for this rise might be around diagnostic capacity and also increased demands through the Detect Cancer Early programme, although action plans were being put in place to address these issues.

25.5 Dr Farquharson reported on a range of actions being undertaken to mitigate the position and gave as an example of the establishment of the EPO by Mrs Joan Donnelly which, as part of its remit, worked to make the provision of hotel and transport arrangements much simpler for patients travelling outwith Lothian. He advised Medinet had been engaged to provide staff to reduce the waiting list following due diligence being undertaken on the CVs of the staff involved. He commented available capacity at neighbouring Health Boards would also be utilised and all of these arrangements would include appropriate clinical engagement to ensure clinical safety was maintained. He advised the impact of the British Medical Association’s day of industrial action had resulted in 260 outpatient cases having been cancelled and 50 theatres cases, which was less than would have been anticipated on a pro rata basis against the rest of Scotland. He commented in respect of paediatric cases that provision in England was being looked at.

25.6 The Board received a joint presentation from Mr Andrew Jackson covering the reasonable offer, Mrs Joan Donnelly covering the previous use of external providers and the establishment of the EPO in the Royal Infirmary of Edinburgh, and Mrs Goldsmith on the procurement process.

25.7 Mrs Goldsmith commented the resource implication in respect of the waiting times recovery process was estimated at £20m. She advised this was no more than a reasonable estimate at this point and was based on a balance of activity and expenditure between internal/ Golden Jubilee Hospital and the independent sector. She advised the use of Medinet would also impact on this figure as they would be less expensive as they used NHS Lothian facilities. She advised the £20m represented the worse case scenario based on an assessment of imbalance. She commented the funding source had been secured with £10m being provided internally by NHS Lothian and the remaining £10m being provided by the Scottish Government Health Directorates with this requiring to be repaid and off-set against future NRAC allocations.
25.8 The Interim Chief Executive advised there had been extensive discussion with the Scottish Government Health Directorates about what could be regarded as a reasonable offer of alternative treatment with the recommendation being that this should be based on the travel time between Lothian and the Golden Jubilee Hospital. He commented, however, it was for each NHS Board to determine what would be accepted as a reasonable alternative offer of treatment.

25.9 Dr Williams advised he felt uncomfortable with the proposals and commented whilst he appreciated there was a situation which needed to be addressed and that there might be a need to use the private sector, the plan being presented to the Board seemed to suggest long-term reliance on the private sector. He commented the preferred option must be for NHS Lothian patients to get treatment from NHS Lothian and sought an assurance the system would revert back to normal practice once the current position was resolved. He commented the amount of money being spent in the private sector could be used to increase capacity in NHS Lothian. He further advised he was concerned about the establishment of the EPO, as well as the practice of identifying patients for private sector treatment.

25.10 The Interim Chief Executive advised the overall plan was to develop core capacity to treat Lothian patients. He commented, however, it was not possible to recruit the infrastructure and core capacity to address the level of backlog currently in the system with there being a need to recognise patients were not receiving treatment. He advised the EPO was critical to bring clarity to the position and also to act as a single conduit to deal with excess demand over capacity. He advised when the need to engage with external providers had receded then the EPO would be stood down. However, he could not give assurance at this stage that the arrangements would be short-term because the system did not have sufficient core capacity in place to get the operational system into equilibrium. The Interim Chief Executive commented he hoped the current response would be on a one-off basis, although he felt there would be a need to use external capacity for possibly 2 years until NHS Lothian could recruit its own core capacity. He advised, in that regard, that eight consultant anaesthetists had been recruited at a cost of £1m with two of those already on maternity leave.

25.11 The Chair commented the system in the past had allowed capacity to reduce and there was now a need to identify, as soon as possible, what a balanced position would look like and to ensure adequate staffing was in place.

25.12 Mr Walker commented he thought the paper represented an excellent and honest plan and was a sensible pragmatic way of progressing. However, he was sympathetic to the points raised by Dr Williams. He supported the proposal to base the reasonable offer on travel time, although this required further clarity in respect of the consequences for patients turning down an offer. Mr Walker commented he felt the EPO was the correct way forward, although he had a concern about external providers contacting patients. In respect of building future capacity, there would be a need to consider how long this would take and at what cost in respect of building infrastructure.

25.13 The Interim Chief Executive advised the first port of call for reducing the waiting times list was on NHS Lothian own core capacity and thereafter utilising waiting list
initiatives. The next phase would be to use Medinet utilising NHS Lothian’s own theatre and, only then, would external providers be used. He commented it was important to remember no other Health Board had attempted to recover from such a difficult position and this would require a unique and innovative approach.

25.14 Mr Whyte commented the key issue was to ensure patients were treated within guarantee times and the quality of treatment was equitable. He felt the options around reasonable alternatives in other hospitals was acceptable and felt the map was useful and should be published in the public domain. Dr Farquharson would arrange. Mr Whyte commented a key issue whilst NHS Lothian was building its own capacity was to ensure it obtained value for money from other providers. Mrs Goldsmith advised NHS Lothian had already secured a discount because of the volume and future discounts would become available if downstream thresholds were tripped. She advised NHS Lothian would be going out to tender, as this was the only true way of securing best value and this would happen later in the year possibly through a national procurement process.

25.15 Professor Murray, as Chair of the Healthcare Governance and Risk Management Committee, commented she felt a pragmatic solution to a difficult position was being taken forward. She advised she would seek re-assurance that Medinet staff would follow NHS Lothian’s own policies, and it would be important to consider the impact on AHPs and underpinning requirements to ensure patients recovered as quickly as they would under NHS treatment. Professor Murray commented she was also concerned about possible issues around the migration of staff.

25.16 Mrs Donnelly advised follow-up and ongoing care had been discussed with Medinet and this would be detailed as part of the patient pathway. Dr Farquharson advised an induction programme would be put in place for Medinet staff, who would adhere to local policies and procedures with there being strong links put in place with NHS Lothian senior clinical and medical staff. He reminded the Board an exercise of verifying CVs had been undertaken to ensure practitioners were adequately qualified and experienced.

25.17 Dr Bryce recognised and welcomed the expediency of the response, although she commented it would be important to capture the experience of patients to ensure they obtained optimal pain relief. She commented it was important people had an equitable experience. Mrs Sansbury advised all external sites had been visited and governance aspects approved by the acute services Director of Nursing with a framework document having been put in place. Mrs Hornett advised patients would be closely tracked and complaints sent to NHS Lothian would be looked at closely to ensure equity of service. She advised pain control was important and would be followed up.

25.18 Mr Johnston advised he was concerned about the situation that NHS Lothian was facing. He advised resources available to the public sector would not increase significantly in the next decade and, in that context, questioned how NHS Lothian could continue to build its own capacity and use the private sector at the same time. He commented there was a need to look at the balance between solving the waiting times issue and investing in core capacity.
25.19 The Interim Chief Executive commented there were two issues to be considered. The first of those was addressing the backlog and the other was the building of the recovery capacity. He advised each Board meeting would receive a report against the recovery plan. He advised a second aspect of the reporting would also be on developments in respect of creating core capacity. He commented, at this stage, he could not give an assurance around the time lag for having the core capacity in place, although a reasonable estimate would be between 2-3 years.

25.20 The Interim Chief Executive commented some early decisions had been taken and referred back to the recruitment to eight anaesthetists posts and advised discussions were also underway in respect of extra theatre capacity. He reminded the Board spend in the private sector was non-recurring, while spend in developing core capacity was recurrent. The Interim Chief Executive advised the waiting times backlog position required to be largely resolved over the next 4-6 months.

25.21 Mr Burley commented during this period of crisis there was an opportunity to learn how NHS Scotland could help to support capacity. The Interim Chief Executive commented the Scottish Government Health Directorates were absolutely engaged in the debates around the core capacity. He advised the Board seminar to be held immediately following the Board meeting on integration was linked to the point about redesigning the way in which services were provided in Scotland to prevent demographic issues from drowning the system. He advised the Scottish Government Health Directorates were intrinsically involved in addressing issues around demographics.

25.22 Mr Walker commented the capacity plan would be critical and stressed the private sector cost versus NHS costs were not comparable and the disparity would be less then initially perceived as a consequence of costing issues.

25.23 The Board agreed to receive detailed monthly progress reports outlining progress against the action plan and amendments to it and to support the proposals that the travel time to the Golden Jubilee Hospital be used to determine which sites were appropriate to be considered part of a reasonable offer with a wider definition to paediatric units in the UK for the elective element of children. The Board also agreed the associated financial framework.

26. Royal Hospital for Sick Children/ Department of Clinical Neurosciences Reprovision – Little France

26.1 Mrs Goldsmith commented at the previous Board meeting she had been unable to provide assurance around the agreement to Supplemental Agreement 6 (SA 6) by the eleventh lender, in order to allow NHS Lothian to secure the land for the building of the Royal Hospital for Sick Children/ Department of Clinical Neurosciences (RHSC/DCN). She advised since the previous Board meeting, and following detailed negotiations and the involvement of Scottish Futures Trust (SFT) directly with the outstanding lender that their position had moved to a conditional agreement to proceed. She advised NHS Lothian was currently working with Consort and the legal advisers to resolve the conditions, which should be deliverable in early course. Mrs Goldsmith advised this should secure the overall lender approval and conclusion of SA 6. She advised the overall programme
26.2 Mrs Goldsmith commented at the previous meeting, she had been asked to re-visit options in respect of the original Business Case for the Royal Hospital for Sick Children and the circulated paper set out the reasons and confirmed the only suitable location for the RHSC/DCN was the Little France site based on the interests of clinical synergy.

26.3 Mrs Goldsmith advised she would expect the OJEU release to tender to happen in September and workshops had been held to consider some of the detail for submission to the market.

26.4 The Vice-Chair commented he was pleased any option B was being dismissed as this had previously been excluded. He commented this also re-assured staff about the direction of travel of the project and would be supported. He remained concerned about the growing gap in finances because of the length of time the project was taking and sought clarification about the source of this additional funding. Mrs Goldsmith advised she had received a revised technical cost report and because of the market position and the change in inflation, the project was still in balance although if this position moved there would be a need for further discussions.

26.5 The Board noted the progress made on SA 6 and agreed the preferred option of a joint build on the Little France site as set out in the Outline Business Case approved by the Board in January 2012.

27. **Directors’ Report and Annual Accounts for the Year ended 31 March 2012**

27.1 Mrs Goldsmith presented the Directors’ report and annual accounts for the year ended 31 March 2012 to the Board for approval.

27.2 The Board approved and adopted the Directors’ report and annual accounts for the year ended 31 March 2012 and noted the proposed arrangements for resolution of minor matters in relation to the accounts, up until the date of submissions to the Scottish Government Health and Social Care Directorates.

27.3 Mrs Goldsmith commented the NHS Lothian Audit Committee had met the previous day to consider the accounts and the layers of assurance. She commented there had been detailed discussions around the governance assurance statement to ensure this was correct, given that the Interim Chief Executive required to sign this, and it was important this expressed appropriate assurances around the waiting times position and the review of management culture, both of which preceded his appointment. Mrs Goldsmith advised following this debate it had been agreed to add an additional statement to the governance assurance statement.

27.4 Mr Renwick confirmed a detailed Audit Committee meeting had been held the previous day. He felt it was important to recognise NHS Lothian and its staff had delivered on its £1.3bn target and this was to be commended. He reported the Audit Scotland team had been fulsome in their praise of NHS Lothian staff and their
engagement in the process and had issued an Unqualified Audit Opinion. He advised the governance statement was new for this year and this was to be welcomed in terms of openness and transparency. Mr Renwick commented the focal point of the Audit Committee meeting had been a willingness to be open about the waiting times position. He advised he was happy as Chair of the Audit Committee to ask the Board to approve the annual accounts.

28. **Chair's Report to Lothian NHS Board**

28.1 The Chair advised the Scottish Government Health Directorates would be seeking an update on progress in respect of the Management Culture and Governance Information Implementation Group. He advised the Group consisted of a wide-range of membership, including partnership colleagues who would be key to the ongoing process. He advised the remit would go beyond the two reports referred to in his paper and would look at issues around management capacity and competency. He expected the Group would meet for the next 12-18 months.

28.2 The Chair advised a Lothian Medical Committee (LMC)/ NHS Lothian workshop for GPs had been convened jointly by the LMC and the Health Board on 20 June and invited GP involvement in the planning and delivery of the Clinical Strategy. Dr Williams confirmed this had been a useful event and a follow-up event was being arranged to include secondary care input.

28.3 The Board noted the Chair's report.

29. **Improving Care for Older People in Acute Hospitals, Announced Inspection - Western General Hospital, 11-13 April 2012**

29.1 Mrs Hornett advised she had reported at the previous Board meeting that an announced inspection had been held at the Western General Hospital on 11-13 April 2012, although the report had not been available for issue at that point.

29.2 Mrs Hornett advised the focus of the visit was on the overall care provision and staff behaviours/ patient interaction, with a particular emphasis on patients with a cognitive impairment and nutritional and hydration care requirements. She advised high-level post-inspection feedback had been provided verbally and in writing on 13 April 2012. Areas of strength identified included positive and caring patient interactions, family involvement in medicine of the elderly wards, team 65 which provided expert advice on the management of elderly people and wards described as calm despite being very busy.

29.3 Mrs Hornett advised areas for improvement included inconsistent mental health screening and documentation of people with cognitive impairment, an inability to track patients moved or boarded, limited use of supporting risk assessments for people with cognitive impairment, individualised care planning and some aspects of legal documentation, in particular relating to patients who lacked capacity.

29.4 Mrs Hornett advised a site level action plan had been developed to address the specific local issues with a pan-Lothian action plan being in place to pick up
generic issues in order that the system could move forward on a standardised approach. She advised HEI had now moved to a programme of unannounced, as well as announced inspections.

29.5 Mrs Douglas commented patient boarding was detrimental to people’s health and she questioned what the timeline was for addressing this. Mrs Hornett advised this would be part of the unscheduled care and capacity work previously referred to and already underway.

29.6 The Interim Chief Executive commented the specific question around timescales could not be answered at this point. He reminded the Board core capacity was currently insufficient and NHS Lothian’s performance against the 4-hour target was amongst the worst in Scotland. He had established and chaired and Unscheduled Care Group similar to the Waiting Times Group referred to earlier with three key over-arching aims. The first was to eradicate patient boarders, the second was to develop community older people services to prevent admission and encourage early discharge with the third aspect being that acute hospitals should discharge patients 7-days per week.

29.7 Mrs Allan commented in respect of screening and assessment, particularly around cognitive impairment, care needed to be taken not to go against age discrimination legislation. Mrs Hornett agreed this was an issue being considered with the assistance of clinical colleagues.

29.8 The Board noted the key findings from the inspection, including areas of good practice identified and noted the development of an over-arching vulnerable people’s improvement plan and the specific older people in acute care action plan for the Western General site.

30. **Financial Position to 31 May 2012**

30.1 Mrs Goldsmith provided the Board with an overview of the financial position of NHS Lothian to the end of May 2012. She commented NHS Lothian was reporting an overspend of £1.2m for the first 2 months of the financial year. This largely comprised of an operational overspend of £0.8m and non-delivery of £0.3m against the efficiency savings target.

30.2 Mrs Goldsmith commented the Local Reinvestment Plan (LRP) had significantly improved in month 2 and was now at £4.5m with a full year impact of £28.1m. She commented this represented good progress and risks were being assessed on an ongoing basis.

30.3 Mrs Goldsmith commented in respect of capacity, she was now looking at the financial impact, some of which was currently being funded. She commented non-recurrent support would be provided in the current financial year and short-term flexible capacity work was being undertaken by Professor McMahon and further funds would not be released until this exercise had been concluded.

30.4 Mr Renwick welcomed the inclusion of income streams in the finance report. He questioned whether the time was right to undertake a zero-based budgeting
exercise on areas such as Facilities, which were consistently overspent. Mrs Goldsmith commented she would discuss this with Mr Boyter.

30.5 The Board noted the overspend for the 2 months to the end of May 2012 and noted the Corporate Management Team would undertaken a detailed scrutiny of the overspend, savings delivery and required actions to deliver financial balance.

31. **Tackling Delayed Discharge**

31.1 Professor McMahon advised a change to the ISD delayed discharge definitions from May 2012 had removed the 3-day rule which excluded patients who had been added within 3 working days of census dates. He advised, therefore, this rule change had resulted in more patients being counted within the monthly census. He commented one of the actions already underway and referred to earlier in the meeting to ameliorate the delayed discharge position was the introduction of 7-day discharging for patients, as well as reducing patient boarding. He commented the introduction of a community older people’s team would also assist in pulling patients out of the acute sector and link intrinsically with the integration discussion that would be held immediately following the Board.

31.2 Professor McMahon commented further focus was needed in respect of complex care patients in the Royal Edinburgh Hospital, particularly in respect of those with the longest delays. He advised benefits were now being experienced from the introduction of additional packages of care. He advised discussions had been held with local authority colleagues around winter and surge capacity that needed to be built into the system via the Change Fund arrangements.

31.3 Professor McMahon commented trend charts would feature in the next iteration of the paper and would show trajectory against national targets.

31.4 The Vice-Chair commented the bottom line was NHS Lothian was not meeting its waiting time targets and in addition had over 100 people in hospital who should be accommodated elsewhere. He commented there was a need for a step change in performance and, in that regard, it would be important to ensure local authorities were geared up to support 7-day discharge from hospital. Professor McMahon reported on a positive recent meeting held to look at alternatives to opening more beds.

31.5 The Chair requested future reports should show the shape of the position in respect of patients waiting more than 6-weeks. Professor McMahon would progress.

31.6 Mr Walker suggested NHS Lothian should consider the use of step-down facilities as utilised by other Health Boards. Mrs Sansbury advised this had been discussed at a recent meeting of the Finance and Performance Review Committee and Professor McMahon and Dr Farquharson were taking this forward. Professor McMahon advised hotel accommodation was generally not suitable as an alternative unless for residential accommodation. He advised step-down opportunities were being discussed with the City of Edinburgh Council, particularly around Change Fund opportunities. Mr Gabbitas advised he had opened up at
short notice a step-up, step-down capacity at the Elizabeth Maginnis Court and had agreed this would be a priority area for Change Fund investment. Mr Gabbitas undertook to report the outcome of this to the Finance and Performance Review Committee in due course.

31.7 Dr Williams commented in respect of 7-day discharge, it would be important not to lose sight of patient needs if discharge occurred in the evening or weekends. It would also be important to consider the implications for primary care.

31.8 The Board noted the result of the May 2012 census in relation to the local targets and the national 6-week standard.

32. Healthcare Associated Infection Update

32.1 Dr McCallum provided the Board with an update on progress and actions to manage and reduce healthcare associated infection across NHS Lothian advising this was part of her regular routine reporting to the Board.

32.2 Dr McCallum commented NHS Lothian was back on trajectory in respect of staphylococcus aureus bacteraemia and clostridium difficile. She advised the Scottish Government Health Directorates were consulting on a revised HEAT target for HAI and this was being discussed with clinical colleagues.

32.3 Dr McCallum drew the Board’s attention to the section in the report which highlighted key incidents occurring over the previous 2 months.

32.4 Dr McCallum commented in respect of a previously reported meticillin resistance staphylococcus aureus (MRSA) screening sustainability issue that additional non-recurrent funding had been received to retain posts and provide additional nursing staff capacity.

32.5 The Board noted the progress being made in respect of meeting the healthcare associated infection targets.

33. Communications Received

33.1 The Interim Chief Executive drew the Board’s attention to circular CEL 17 (2012) – Patient Rights (Scotland) Act 2011 – Secondary Legislation on the Treatment, Time Guarantees and the Patient Rights (Treatment Time Guarantee) (Scotland) Directions 2012 advising as from 1 October 2012 it would be a legal requirement for NHS Boards to ensure patients listed for treatment received this within 12-weeks.

34. Date and Time of Next Meeting

34.1 The next meeting of Lothian NHS Board would be held on Wednesday, 25 July 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 6 June 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (Chair); Mr R Aitken; Dr M Bryce; Mr R Burley (until 11.15am); Dr D Farquharson (from 10.30am); Mrs S Goldsmith; Mr P Johnston; Mrs J K Sansbury (until 11.30am) and Dr C J Winstanley

In Attendance: Mr I Graham; Mrs L Khindria and Mr C Graham; Mr H Purser (Item 19.1); Ms T Rapson (Item 19.1)

Apologies for absence were received from Mr T Davison; Mr A Boyter and Mr E Egan

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.

15. Minutes of the Previous Meeting

15.1 The previously circulated Minutes of the meeting held on 18 April 2012 were approved.

16. Matters Arising

16.1 North West Edinburgh Partnership Centre, Muirhouse - Mrs Goldsmith advised the Committee that development was progressing but that there was still work to do. Mr I Graham explained that in relation to the Hub, this was one of three projects receiving revenue support. Council planning officials were due to meet today to discuss progressing this towards a business case.

16.1.1 Dr Winstanley asked for clarification on the costs associated with Hub Partnership Projects. Mrs Goldsmith stated that where there was a need to replace primary care and community facilities which were not fit for purpose, developments through the Hub allowed other partners to share costs. However it can be a struggle to achieve joint facilities in order to mitigate increased costs. Mr I Graham added that the Scottish Government provided support of 50% of facilities costs and 100% of end costs of running a centrally covered project. It was noted that this was the preferred option to capital charges and that there were opportunities across the region for joint development.
Mr Burley stated that there needed to be refreshing of the CH(C)Ps Premises Strategies and that these should come through F&PR, as this was a role previously carried out by the Primary and Community Partnerships Committee. The Chair suggested that this should also be part of a wider Estates Strategy. Dr Winstanley suggested that the CH(C)Ps be invited to submit their strategies to F&PR. The Chair asked about the timeframe for this and Mrs Goldsmith stated that the draft Capital Investment paper would come to the October F&PR Meeting.

Capital Investment Programme – RIE Lifecycle Maintenance - Mrs Goldsmith informed the Committee that the Consort Lifecycle Programme for the following year had now been received. It was noted that this was previously provided retrospectively. Mrs Goldsmith had met with Mr Curley and Mr I Graham to discuss bringing in independent technical advice to review the programme.

Capital Investment Programme – Statutory Standards - Mrs Goldsmith reported that the report would come back to the next meeting once work was finalised.

Prison Healthcare Transfer - Transitional Finance and Accounting Arrangements – The Committee noted the paper clarifying arrangements for service financing and the accounting for the impact of the healthcare service transfer of the prison facilities to NHS Lothian. Mrs Goldsmith covered the funding from Scottish Government; revenue costs transfers and balance sheet transfers. It was noted that it could not yet be confirmed that these funds will be enough and that there was an opportunity to review at the end of the first year of operation. There was discussion on Agenda for Change assimilation and the costs involved in transferring staff over to NHS Lothian and the training this may involve.

Planning

Business Case Update - The Chair reported that it had been agreed between himself, Mrs Goldsmith and Mrs Sansbury that there would be a regular paper to the meeting on whether or not Business Cases were meeting their trajectories. This report was the first version and comments were welcomed.

Mrs Goldsmith stated that it was useful to see this report for internal management as it supported forward planning and would be useful for planning the Committee agenda. The Chair added that this was a good start but for tracking purposes, anticipated dates were needed along with more detail on overspends. Mr Burley stated that currently four Business Cases were over budget and six were under budget. Mr I Graham highlighted that the generous donation from the Teenage Cancer Trust for the creation of the Teenage & Young Adult Cancer Unit at the Western General Hospital had been increased from £1M to £3.5M.

The Committee noted that a revised report would come to the next meeting.
18. **Business Cases**

18.1 **Upgrade and Extension of the Mammography Unit, Western General Hospital**  
**Replacement of 16 Slice CT Scanner, Western General Hospital** - Mrs Sansbury reported that the costs had now been confirmed, funding was through charitable sources and support was now requested for the continued move on this. Dr Winstanley asked for clarification on why mammography could not be carried out in a community setting such as an equipped GP practice. Mrs Sansbury stated that routine screening had been done this way before but the highly technical and specialist secondary stage could not be and would be more appropriate to locate as part of the one-stop service.

18.1.1 Dr Bryce stated that this was a helpful and well thought out paper. The Chair suggested that there should be clarity on the Board’s policy with regards to charitable donations and its funding uses. It was noted that this work was separate from the work of the Foundation as corporate donations do not go through the Foundation Advisory Committee whereas donations from individuals must do.

18.1.2 The Committee agreed that this did not have to go through Foundation Advisory Committee and the paper was noted and approved.

18.2 **Replacement of 16 Slice CT Scanner, Western General Hospital** - Mrs Sansbury reported that this Business Case was part of the normal equipment replacement programme; this was included in the Capital Plan and funding for the replacement CT Scanner was already set aside. The replacement Scanner would be procured as opposed to rented.

18.2.1 The Chair noted the increase in scanning demand – 13.7% over last two years, and asked if the new Scanner would handle this capacity. Mrs Sansbury stated that work was underway looking at imaging capacity for the future across NHS Lothian; this included the future usage of the Department of Clinical Neurosciences (DCN) Scanner as part of an Imaging Strategy.

18.2.2 Mr Johnston asked why the new Scanner was being procured rather than leased. Mrs Goldsmith replied that since new accounting rules dictated that leased equipment must be shown on the balance sheet it was generally the case that procuring was more cost effective.

18.2.3 The Committee noted that the proposal had been approved by Lothian Medical Equipment Review Group (LMERG) and the Lothian Capital Investment Group. The Committee approved the expenditure of £550k for the CT scanner from the existing approved LMERG budget, for replacement of this essential equipment.

18.3 **Endoscopy Suite Royal Infirmary of Edinburgh: Upgrade of Decontamination Facilities** - Mrs Sansbury explained to the Committee the requirement to upgrade and redesign the decontamination facilities at both the Western General Hospital and Royal Infirmary of Edinburgh. Following a Joint Advisory Group (JAG) Accreditation pre-visit in December 2011 a critical report was received advising that these two sites would not currently meet the standards required for full accreditation. The Committee noted the potential complication due to the University of Edinburgh’s
planned move of a MRI Scanner from the Western General to the Royal Infirmary; this was now being resolved in conjunction with the University’s Project Manager but could impact on plans and programme but could also bring financial benefits as well.

18.3.1 The Committee noted the plans for advancing the Decontamination Facilities Upgrade Project at the RIE and approved the plans to submit separate Business Case’s for the RIE and WGH upgrade projects. The Committee also approved the plan to include a Recovery Bay within the physical changes in the Endoscopy Suite and noted that the changed programme leads to expenditure for the RIE project now expected to be required through to October 2014. The release of funds (£207,509.00) was also approved to allow the design to be developed through to tender which will allow accurate costs to be included with the Business Case when it comes to the Committee.

18.3.2 Mrs Sansbury to bring a written update on developments to the next meeting. JKS

18.4 Burns Unit, St John’s Hospital - Mrs Sansbury reported that after discussions with the Scottish Government and NHS Greater Glasgow and Clyde, having only one burns unit within NHS Scotland is not the preferred option as Glasgow could not absorb all Lothian’s additional activity. Therefore there was a need to progress with the previous option as outlined in the previous F&PR report that was considered at the April 2012 meeting.

18.4.1 The Committee noted that relocating Ward 20 will free up some space and there was discussion on the opportunities to best utilise this space. Mrs Sansbury stated that there was interest to use the area specifically for hand surgery as most is already done at St John’s but there is not currently a dedicated space. There was also a suggestion to run elective surgery six days a week at St John’s to help with access and waiting times targets. The Chair stated that it was important the best use of the space was considered and that it fits in with NHS Lothian’s Clinical Strategy.

18.4.2 Mrs Sansbury highlighted the medical staff limitations, out of hours at St John’s. There are no general surgical junior medical staff working overnight. Mrs Sansbury would pick this up with Dr Farquharson as a formal workstream of the Clinical Strategy which could be run parallel with the Ward 19 and 20 works. Mr Johnston added that it would be helpful to have GP and CHCP input also.

18.4.3 The Committee approved the completion of a Business Case for the associated upgrade of Ward 19, in order to move Ward 20 into this facility, before the Labour Ward is decanted into Ward 20. The Chair asked that the action note be flagged up to the Medical Director and the completed Business Case would come to the next meeting. JKS

18.5 Initial Agreement: Upgrade and Extension to the Macmillan Centre, St John’s Hospital, Livingston - Mrs Sansbury reported on the progress of the plan to upgrade & extend the Macmillan Centre at St Johns Hospital. The Committee noted that the funds would be provided via MacMillan Cancer Support and follows models used elsewhere. Mr Johnston added that MacMillan Cancer Support and the CHCP have
a good working relationship and West Lothian Council are also providing additional funding for MacMillan Nurses.

18.5.1 The Committee supported the proposals and agreed to note the report’s recommendations.

19. Performance

19.1 F&PR Dashboard - The Chair introduced the Dashboard which was a starting point for discussion. The Committee noted the dashboard and welcomed Harry Purser and Tracey Rapson to the meeting.

19.1.1 There was discussion on verified data that can be automated or pulled of TRAK. The Chair highlighted the DCN Project Dashboard as an excellent example which the Committee would wish to aim for as this Dashboard shows relevant data feeds and key issues.

19.1.2 Mrs Sansbury stated that a key question was what is the data source and did the Committee want to see something as it happens or after it has happened. It was noted that any validated data had a time lag. It was suggested that invalidated data could come to the Committee and the validated data would go to the Corporate Management Team. Harry Purser stated that this Dashboard was a trial version which had been produced from National Data which Lothian had submitted to ISD. This is from a live database from which analysis snapshots can be taken which would allow data for the Committee that was only 24 hours old.

19.1.3 Dr Bryce asked if this report would highlight problems such as the previous ones. Harry Purser stated that the waiting times problem had been found last November purely by chance as a report had been run between ISD publishing dates. Harry assured the Committee that a problem such as this would not happen again.

19.1.4 The Committee considered whether it would need to see both sets of data which could then be worked through to identify key risk areas. Headline numbers could be explored further to better show any trends. Dr Winstanley added that there was a danger of measuring the symptom rather that the cause.

Dr Farquharson joins the meeting at 10.30am

19.1.5 The Chair asked how data to move us forward could be obtained and presented in an appropriate form. There was discussion on what a normal position or equilibrium looks like. Dr Winstanley stated that this was a good start as a subset but more detail on areas such as delayed discharge was needed. Dr Bryce added that the ability to talk to the HIU team and their analytical ability presented a great opportunity and may be an item for a future workshop. There was also a need for greater narrative to be included with the dashboard and that this would need to come from Service Managers, Programme Manager and other Leads. Mr Johnston informed the Committee that West Lothian has a Scrutiny Panel which looks at exceptions and targets not being met and asks for explanations and how targets will be delivered in the future.
19.1.6 Dr Winstanley suggested that there was a role here for the Committee for commissioning data in consultation with Harry Purser’s team alongside what is being provided for Corporate Management Team. The Chair suggested that development of the dashboard and these other issues could be the subject for a future workshop.

*Harry Purser and Tracey Rapson leave the meeting.*

19.2 **Financial Position to 30 April 2012** - Mrs Goldsmith reported that an overspend of £0.56m was being reported for the first month of the financial year. This is made up of an operational overspend of £0.32m and an under delivery of £0.24m against the efficiency savings target.

19.2.1 Mrs Goldsmith outlined significant pressures being caused with capacity, with winter beds remaining open.

19.2.2 The Committee noted that the slow progress on efficiency and productivity had been raised with the Corporate Management Team and acknowledged the risk in this area. This was due to be discussed at the upcoming Finance Away Day.

19.2.3 There was discussion on waiting times and capacity planning. Mrs Goldsmith added that a meeting with the Scottish Government was planned for the end of June to look at additional resourcing; a position for reporting would be available after this meeting.

19.2.4 The Committee noted the financial position to 30 April 2012.

19.3 **Performance Management** - Dr Farquharson updated the Committee on the NHS Lothian performance data as reported through local and national systems.

19.3.1 Dr Farquharson drew the following areas to the Committee’s attention:

- *Reduction in the Rate of Emergency Inpatient Bed Days for Patients age over 75 years* – currently on trajectory

- *New Outpatient Standard, Inpatient/Day Case Standard and Cataract Standard* – The Committee noted the figures shown

- *Access to Treatment for Drug and Alcohol Misuse* – It was noted that there was good progress with this but it was still slightly behind the target

- *4 hour Emergency Access* – It was noted that there had been an adverse impact caused by high numbers of delayed discharges

- *A&E Attendances* – The Committee noted the reduction in numbers to 2275 per 100,000.

- *Delayed Discharges* – Bed days continue to be monitored, with March 2012 showing a total number of bed days of 8912.
19.3.2 There was discussion on options for step down facilities to tackle delayed discharges and pressure on the front door. Mrs Sansbury stated that it was important to consider what patient group the facilities would be for and who the patients would be. It was noted that the biggest issue currently was access to short stay packages of care for less than 14 hours per week.

*Mr Burley left the meeting at 11.15am*

19.3.3 The Committee discussed the packages of care issue and the engagement required with local authority partners to address this. Mr Johnston recommended that local authority colleagues be invited to comment on this report as part of the ongoing integration discussions.

19.3.4 The Committee considered interim measures. Whilst acknowledging that hospital beds were a bad place for old people to wait, the option of a step-down facility lower intensity bed was seen as the less of two evils. Mrs Goldsmith added that the Change Fund needed to be looked at again.

19.3.5 The Committee agreed that a paper should come back to the next meeting for consideration.

*DF/JKS*

19.4 Workforce Efficiencies within NHS Lothian - Mrs Khindria introduced the report and commented that the position reflects Mrs Goldsmith previous finance paper in that there has been increased staff in both Nursing and Allied Health Professions. This was leaving the workforce efficiency targets significantly behind, however, once the capacity plan was known both the financial plan and workforce plan could be put in place. There was still reasonable turnover in posts to make this situation manageable.

19.4.1 The Committee noted that there had been a reduction in sickness absence with the average rate now at 3.96%, compared to 4.38% for the same period last year. It was also noted that whilst sickness levels were being achieved, they still remained high in some staff groups. With regards to the headcount target of 2000 over 2 years it was noted that this was standing at 1712 posts as at end of March 2012. The 4 year target for a 25% reduction in senior management currently stood at 73%. There was also a list of severance packages for next year for consideration.

19.4.2 Mrs Khindria reported that next year there would be work with individual areas looking at skill mix. It was hoped to grow bands 1-4 and also bring in modern apprenticeships.

19.4.3 The Chair stated that it would be interesting to see more detail on the new developments being funded through NRAC. The Committee noted the paper.

19.5 Shared Services Position Update - Mr Aitken provided an update on the emerging workstreams and partnerships within the umbrella of shared services look to achieve “quick wins” during fiscal year 2012/13. Mr Aitken reported that it was anticipated that “quick wins” would be identified and implemented by the end of the summer.
19.5.1 There was discussion on engagement with partners and the good progress with City of Edinburgh Council since the policy change was noted, there was now a real opportunity to work in partnership. There was also good initiative being shown in Midlothian with pilots. Emerging models were around the areas of procurement, subcontracting and estates type work.

19.5.2 The Committee welcomed the progress being made on this and noted that it was important to also focus on longer term strategy issues not just “quick wins”.

20. Draft Chair’s Annual Report

20.1 The Committee noted the draft report.

21. Date of Next Meeting

21.1 It was noted that the next meeting of the Committee would be held on Wednesday, 15 August 2012 from 9.00 a.m. to 11.30 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.

Dates of Future Meetings  
10 October 2012  
12 December 2012
DRAFT

NHS LOTHIAN

SERVICE REDESIGN COMMITTEE

Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday, 11 June 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Professor J Iredale; Dr B Agrawal; Ms J Anderson; Mrs L D’Arcy; Mr D Forbes; Dr B McKinstry; and Ms L Tait.

In Attendance: Miss L Baird; Mrs P Dawson; Dr R Hardie and Dr C Williamson.

Apologies for absence were received from Mr A Boyter; Dr D Farquharson; Mr J Forrest; Mrs S Goldsmith; Mrs M Hornett; Dr S Mackenzie; Dr A K McCallum; Professor P Murray; Dr J Steyn and Ms S Westwick.

Declaration of Financial and Non-Financial Interest

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

1. Minutes of the Previous Meeting

1.1 The Minutes of the Service Redesign Committee meeting held on 16 April 2012 were approved subject to the following minor amendments:

- Dr McCallum gave a detailed presentation highlighting the challenges that NHS Lothian faces in tackling obesity, in particular managing access to services for obese and overweight residents in Lothian.
- The Committee noted that obesity was not solely related to deprivation but linked to interaction between food policy, availability, portion size and physical activity. There is a genetic element to the risk of obesity but it is more that, given an obese genetic environment, some people do not gain weight. Dr Gorman advised that there was evidence that the social environment and availability of convenience food affect residents who move to the area.

2. Matters Arising from these Minutes

2.1 The Obesity Challenge in Lothian and Our Plans to Address – The Chair advised that following discussions with Dr McCallum they had agreed that it would be timely to present the case for a national approach to tackling obesity through Scottish Government and Westminster.
2.1.1 Dr Agrawal reiterated a previous request in respect of obtaining copies of Dr McCallum’s presentation on The Obesity Challenge in Lothian and Our Plans to Address. The Committee Administrator explained that she had requested a copy of the presentation to circulate with no response as yet from Dr McCallum’s office. The Chair requested that the Committee Administrator follow this action up with Dr McCallum’s Office out with the meeting.

2.2 June Agenda - Mrs Tait explained that Mr Boyter had requested that the report on workforce planning be deferred until October 2012.

2.2.1 The Committee noted that the update on telehealth and the revised remit were detailed later on the agenda for consideration. The Chair noted that all other items on the action note were ongoing.

3. Telehealth and Telecare in Lothian

3.1 Dr Hardie gave a detailed overview of the previously circulated report on telehealth and telecare in Lothian. The Chair commented that the request to support the key role of these services as detailed within the paper appeared to be retrospective, since there were detailed plans in place. The need for a separate telehealth and telecare strategy was questioned given the context of the clinical strategy and integration proposals.

The Chair welcomed Dr Hardie’s comments on the savings in respect of the reduction of bed days however he encouraged colleagues to be cautious in approving the recommendation around the evidence base detailed in item 2.2 without the proviso of a matched hard economic analysis of the costs. Members agreed that it was imperative that investment in Telehealth and Telecare fulfilled the needs of the service whilst producing better results at the same or a reduced cost.

3.2 Ms Tait explained that NHS Lothian should take advantage of this opportunity to build the use of technology into new models of care and identify the services that would benefit most from using telehealth and telecare.

3.3 The Committee discussed lessons learnt from other Boards in particular the DALLAS project and smart phone applications. The Chair suggested that there needs to be some way of weeding out inappropriate and harmful applications being marketed.

3.4 The Committee agreed to support the recommendations subject to the inclusion of the following additional points:
  - The inclusion of a matched hard economic analysis of costs under item 2.2.
  - The addition of linkages with the integration agenda and the clinical strategy under item 2.4.

Dr McKinstry left the meeting.
4. Integration of Health and Social Care

4.1 Ms Tait spoke to the previously circulated report. She commented that the changes to council composition following recent elections may impact on the plans determined by the previous office bearers. She went on to note the establishment of the NHS Lothian co-ordinating group led by Dr Farquharson with input from the CH(C)P Joint Directors and General Manager, and the challenges that both NHS and Local Authorities partners would face in determining how the budgets would be integrated.

4.2 Mr Forbes expressed concerns that the report was not explicit in relation to whether services were free in line with NHS principles. Members agreed that a clear statement was needed in the final proposals regarding free care. Further work was also required in respect of the management structure, consultation process and unforeseen consequences resulting from integration of services. DF

4.3 The Committee discussed the need for an overarching body to promote a standardised approach to different solutions for services proposed by the individual local authorities. Members agreed to suggest that NHS Lothian endorses all pan Lothian approaches to ensure consistency across the board. DF

4.4 Mrs Dawson advised the Committee that they needed to be mindful that St. John’s was one of the 3 acute hospitals within Lothian which provides a number of Lothian wide and regional services.

4.5 Dr Hardie noted on behalf of Dr McCallum that the Committee needed to be cautious in terms of the risk related to deprivation and inequalities when integrating services at local authority level and the consequences of doing so.

4.6 The Committee agreed to support the recommendation subject to their previous comments.

5. Clinical Strategy

5.1 The Committee agreed to defer the update on the Clinical Strategy to the next meeting.

5.2 Ms Tait advised the Committee that the draft framework had been superseded by discussions surrounding the development of a Board framework. Members noted that the Board framework would encompass the integration agenda, telehealth etc. Further work to reaffirm the Board’s principles in taking services forward was ongoing. Dr Farquharson would take forward reworking the strategy into a framework and engage staff and stakeholder groups in further consultation prior to bringing the framework back for consideration at the September 2012 Board meeting.

5.3 The Chair agreed to write to Dr Farquharson copying in Mr Walker, Chair of Finance and Performance Review Committee and Professor Murray, Chair of the Healthcare Governance and Risk Management Committee to request the following:
• a brief paper on waiting times for the next meeting detailing the Board’s approach to developing long term sustainable solutions to meet waiting times.
• An analysis of the organisation’s response to the current Legionella incident, and what lessons there were from this for service redesign. 

Ms Anderson left the meeting.

6. Revised Remit of the Service Redesign Committee and Draft Statement of Assurance

6.1 The Chair spoke to the previously circulated report on the remit of the Service Redesign Committee and the Draft Statement of Assurance specifically raising actions requiring the Committee to consider expanding their membership to include another General Practitioner and Edinburgh CHP Representation. The Chair agreed to liaise with Ms Tait to consider the representation and clarify the details of the list out with the meeting.

6.2 The Committee discussed the lack of evidence in relation to development of best practice through the organisation. The Chair advised that throughout his term as the Chair of the Committee he had determined that the only way to ensure that this duty was discharged was for him to bring up key action or areas of good work that need to be disseminated across the Board at the Board meeting under the review of the Committee minutes. Following a brief debate the Committee concurred with the Chair’s proposal to add “to share and drive good practice throughout the organisation” to the remit.

6.3 Dr Hardie explained that Dr McCallum had requested the following amendments to the proposed remit:
- include in the first point “the equitable provision of prevention, treatment and care”.
- include “provide assurance that feedback from patients and public representatives was regularly sought on the outcome of service redesign.”

6.4 The Committee debated the management of NHS services and the consequences of failing to meet targets in comparison to the management arrangements of private sector businesses. The Committee agreed that the size of the organisation meant it was not easy to ensure that reviews of services were being undertaken on a regular basis. Mr Forbes noted that risks NHS Lothian faced were not directly comparable to those of private sector businesses.

6.5 The Committee agreed to support the recommendations detailed within the report.

8. Items for Information

8.1 Lean in Lothian Annual Report – The Committee noted the good examples of work detailed within the previously circulated Lean in Lothian Annual Report. The Committee requested that the Modernisation Team bring forward a report on the progress of LEAN and its sustainability for the future.
8.2 Minutes of the Transport Meetings held on 15 March 2012 – The Committee noted the previously circulated minutes of the Transport meetings held on 15 March 2012 and the information detailed therein.

9. Date of Next Meeting

9.1 It was noted that the next meeting of the Committee would be held on Monday, 8 October 2012 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
NHS LOTHIAN
EAST LOTHIAN COMMUNITY HEALTH PARTNERSHIP

Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday 23rd February 2012 at 2.30p.m. in Conference Room 1 & 2, John Muir House, Haddington.

Present: Cllr Paul McLennan, East Lothian Councillor (PM) (in the chair) 
David Small, General Manager (DS) 
Dr Graham Alexander, GP Representative (GA) 
Ann McCarthy, PPF Representative (AM) 
Gill Colston, PPF Representative (GC) 
Tony Segal, Carers of East Lothian (TS) 
Ronnie Hill, East Lothian Council (RH) 
Fiona Mitchell, Acute Sector (FM) 
Dr Jane Hopton, Assistant General Manager (JH) 
Dr Ian Johnston, Medical Director (IJ). 
Lorraine Cowan (LC) for Liz Cregan, Chief Nurse 
Mike Porteous (MP) for Lynne Hollis, Associate Director of Finance 
Sheena Wight (SW) for Morag Barrow, Allied Health Professional Manager 
David Heaney, Strategy & Policy, East Lothian Council (DH)

In Attendance: Les Malone, Minutes (LM) 
Peter Gilfoyle, Programmes & Projects Manager (PG) 
Dr Neil Murray, GP Ormiston Medical Centre (NM) 
Duncan Miller, Primary Care Contracts (DM) 
John Boyce, Public Health Practitioner (JB) 
Aileen Muir, Consultant in Pharmaceutical Public Health (AM) 
Joy Tomlinson, Consultant in Public Health Medicine (JT) 
Moyra Burns, Health Promotion (MB)

Apologies: Iain Whyte, Chair of the CHP 
Liz Cregan, Chief Nurse 
Lynne Hollis, Associate Director of Finance 
Morag Barrow, Allied Health Professional Manager 
Thomas Miller, Staff Representative 
Murray Leys, East Lothian Council

69. Welcome and Apologies

Apologies were noted as above.

70. Minutes of the Previous Meeting Held on 14th December 2011

70.1 The minutes were agreed as being a true and accurate record of the meeting subject to the following amendment:
- In attendance – Moyra Burns, Health Promotion

71. Matters Arising / Action Note

71.1 Matters Arising
All business was covered via the meeting agenda.

71.2 Action Note

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

72. Items for Decision

72.1 Keep Well Proposals

A paper on the ‘Keep Well Plans 2012/13’ had been circulated to members prior to the meeting. Joy Tomlinson provided an update.

The following key points were noted:

- The Keep Well programme has been funded nationally by the Scottish Government since 2007.
- 14 Practices serving the most deprived communities in Edinburgh were initially targeted as part of the pilot.
- There have been positive measures indicating that the pilot has been reaching large numbers of individuals.
- Scottish Government has reviewed the outcomes from the pilot and has asked that the model be refined and that individuals in the other CHPs within the 15% most deprived areas be targeted.
- The programme will be extended to additional vulnerable groups i.e. substance misuse, carers.
- Work was underway to revise the current model.
- The programme has started in Prestonpans and Tranent.
- There is a requirement for suitable venues to support the programme in East Lothian.

Paul McLennan commented that there was an opportunity for joint working with Council colleagues in deprived areas.

Ian Johnston referred to the new Primary Care Centre in Musselburgh and commented that this was due to open in May 2012 and would have suitable facilities to support the programme.

Decisions

The report was noted and recommendations approved.

72.2 Edenhall Reprovision Phase 2

A report on the ‘Edenhall Vacation Project (Phase 2) – Esk Medical Centre Lease Assignation’ was circulated to members prior to the meeting. Ian Johnston declared an interest in the issue since he is a partner in one of the practices that currently occupy the building. Peter Gilfoyle presented the paper.

It was noted that the Esk Medical Centre practices would be relocated to the new Musselburgh Primary Care Centre in May 2012. Peter Gilfoyle explained that the primary care centre business case included the proposal that the CHP should take over the lease for substance misuse and child and adolescent mental health services once Esk Medical
Centre practices had vacated the premises.

David Small added that there were no additional revenue costs since the funding for the lease was already reimbursed by the NHS to the practices.

It was noted that legal and property advice had been obtained from the Central Legal Office and the District Valuer respectively.

The CHP Sub-Committee was invited to support the recommendations in the paper. It was noted that the proposal would require subsequent approval in accordance with the NHS Property Transactions Handbook.

Decisions

The report was noted and recommendations approved.

72.3 East Lothian Community Hospital Project Initiation Document

A paper on the ‘East Lothian Community Hospital – Project Initiation Document’ was circulated to members prior to the meeting. Peter Gilfoyle presented the paper.

Peter Gilfoyle explained that this was the first step of the process which indicated the direction of travel for the CHP. The paper highlights the need for the reprovision of Roodlands and Herdmanflat Hospitals.

The paper will be amended to include all GP Practices in East Lothian as key stakeholders.

It was agreed that it would be helpful to have timescales for the project. It was noted that a Reference Group would be established once the work on the initial agreement had begun.

Decisions

The report was noted and recommendations approved.

72.4 Pharmaceutical Care Services Plan

A paper on the ‘Pharmaceutical Care Services Plan 2012’ was circulated to members prior to the meeting. Aileen Muir presented the paper.

Aileen Muir explained that this was a Lothian wide document which would be presented to NHS Lothian Board on 28 March 2012 for approval. The information within the document was split by CHPs.

Decisions

The report was noted and recommendations approved.

72.5 Ormiston Medical Centre / Section 17c

A paper on the ‘Ormiston Medical Practice – Change of Contract’ was
circulated to members prior to the meeting. Duncan Miller and Neil Murray presented the paper.

Duncan Miller explained that the Ormiston Medical Practice split from the Tranent Medical Practice in April 2009. The CHP Sub-Committee was invited to approve the change in contract. It was proposed that the Practice move to a Section 17C contract from 1 April 2012. A copy of the draft contract was included within the papers.

The new contract would include meeting with the Practice on an annual basis with an interactive process for reviewing and developing services. There was no financial risk to the CHP or resource implications arising from the proposed contractual arrangement.

Neil Murray explained that the Practice currently has 3,000 patients registered. Practice development plans included new premises to increase the practice capacity to approximately 5,000 patients. The practice has developed robust clinical and administrative systems over the past few years. Under the new contract the Practice will be aiming to improve health promotion, falls prevention, robust processes for prescribing, prevent readmissions, reduce inappropriate referrals, management of chronic pain etc.

Ian Johnston commented that new premises would provide a platform for the Practice to provide an excellent service to the community.

It was noted that the CHP was working with the practice on a premises proposal which would be presented to the sub committee in the future.

**Decisions**

The CHP Sub-Committee approved the recommendations to change the contract to Section 17C.

### 73. Items for Discussion

#### 73.1 Feedback from the Joint meeting of Sub-Committee 06.02.12

A paper on ‘Feedback from Joint East and Midlothian CHP Sub-Committees meeting 6th February 2012’ was circulated to members prior to the meeting.

David Small introduced the paper and explained that the meeting focused on the Scottish Government integration announcement.

It was noted that it was agreed to hold a follow up meeting in June 2012 to discuss the integration consultation document which is expected to be issued in May 2012.

**Decisions**

The report was noted and recommendations approved.

#### 73.2 Scottish Focused GMS Contract
A paper on ‘General Medical Services - Moving Towards a More Scottish Focused Contract’ was circulated to members prior to the meeting.

Duncan Miller introduced the paper and explained that Cabinet Secretary had asked that the Section 17J contract be reviewed to ensure that there was a more Scottish focussed contract in place.

The fundamental changes would impact on the GMS Contract. It was noted that this was being discussed with GP Forums. Ian Johnston commented that motions had been put forward to the Scottish LMC Conference supporting this.

Paul McLennan suggested that this topic would merit further discussion at a future meeting. It was agreed that a presentation would be made at the start of the next meeting.

Decisions

The report was noted. DS to arrange presentation for next meeting.

### 73.3. East Lothian Cabinet Paper & Change Fund

A paper on the ‘Change Fund Change Plan’ was circulated to members prior to the meeting. David Heaney introduced the paper and highlighted the following points:

- Proposed Plan for 2012/13 has been submitted and approved by the Cabinet.
- It was noted that the CHP Sub-Committee and the Community Planning Board had approved the proposals via email.
- There were 33 projects in a range of sectors.
- Focus on better integration with Health and Social Care.
- Delivery Group would review impact of each project.

Graham Alexander highlighted the need for further investment for GP Practices and District Nurses. They play an important role in supporting elderly and frail patients and minimising the need for hospital admission.

David Heaney commented that it was important to identify any gaps and prioritise funding accordingly.

Fiona Mitchell commented that the Acute Sector support a range of activities which could be delivered in the community.

Decisions

The report was noted and recommendations approved.

### 74. Performance Reports

#### 74.1. General Managers Report

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

The January 2012 validated figure was 7 with no-one delayed over 6 weeks. The February 2012 validated figure for East Lothian was not yet available. It was noted that the targets for March 2013 were 4 weeks and March 2014 2 weeks. Within the current figures there were some people waiting between 4-6 weeks. Murray Leys would organise a “summit” on delayed discharges to map out the actions needed to achieve the new targets.

Capital Projects

Musselburgh Primary Care Centre remains on track for opening in May 2012.

The final costings for the Gullane Medical Practice have been received. A date for commencement of construction was still awaited.

Edenhall Hospital – planning work is proceeding with the final reprovision of services.

The Initial Agreement for the Tranent Health Centre extension has been approved by the Finance and Performance Review Committee.

The Project Initiation Document for East Lothian Community Hospital was on the agenda.

Review Groups for Bellhaven and Edington Hospitals

It was noted that the next meetings of the forums for each of the hospitals would be taking place in March.

Older Peoples Mental Health Services

It was noted that the usage of the bus service from Haddington to Midlothian Community Hospital would be reviewed. It was agreed that a survey of relatives and visitors who have travelled to Rossbank Ward would be helpful.

Decisions

The report was noted and a survey would be conducted.

Staff Governance Report

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

The staff turnover rate for December 2011 was 1.07% (annualised rate of 9).

The sickness absence rate for December 2011 was 5.58%. Of this, 3.45% was long term sick and 2.13% was short term.
David Small commented that the sickness absence performance would be discussed further by the Management Team and that an Action Plan would be put in place to address the ‘hotspots’. An update on the action plan will be included with the next report.

Decisions

The report was noted and David Small will include the action plan in the next report.

74.3 Financial Report

A copy of the report on ‘Financial Performance to 31st January 2012’ was circulated to members prior to the meeting.

In the 10 months to 31st January 2012 the CHP had an overspend of £558k. Of this £329k related to Prescribing.

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

The information relating to Prescribing was 2 months in arrears. An overall overspend for Lothian was projected and the East Lothian overspend was an element of that. Management Actions have been put in place to address the issues. The CHP was close to 100% achievement on its prescribing LRP target. Pressure was resulting from volume and price changes.

It was noted that a briefing paper on the Pharmacy Budget had been submitted to the NHS Lothian Board. It was agreed that David Small would arrange for a copy of this paper to be circulated to the next CHP Sub-Committee meeting.

Decisions

The report was noted. David Small to circulated Pharmacy Budget paper.

Payment Verification in Primary Care – Financial Year 2011-12

A paper was circulated to members prior to the meeting.

David Small explained that Practitioner Services produced a quarterly report detailing information on payments to all four independent contractor groups. It was noted that this was a Lothian-wide report.

Duncan Miller commented that there were no issues highlighted during this period.

Decisions

The report was noted and recommendations approved.

PMS Expenditure Month 9
A paper was circulated to members prior to the meeting.

David Small introduced the paper and explained that the main issue in East Lothian was premises where the spend per head was less than the rest of Lothian. This reflected the age and constraints of some of the current premises. It was noted that the Musselburgh Primary Care Centre would improve the situation for three practices and that planned work in Gullane, Tranent, Ormiston and Cockenzie would lead to further improvements. Premises in East Linton, Haddington, North Berwick and Prestonpans also required improvement. It was noted that a more detailed report on premises would be provided at a future meeting once the primary care premises strategy had been updated.

Decisions

The report was noted.

74.4 Clinical Director’s Report

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

Roodlands Services

It was noted that colleagues from the Local Authority and Social Work travelled with East Lothian CHP staff to Newport, Gwent to look at a model of care for frail elderly patients. It was a very positive visit and work will commence on looking at the model in more detail.

Clinical Support Services

Work was ongoing in relation to how the Change Fund will be used to support services in the community.

Herdmanflat Services

It was noted that the long stay ward (Lammerlaw) at Herdmanflat would be refurbished over the next 4-6 weeks.

Primary Care

It was reported that some GPs had met with Murray Leys to discuss the allocation of the Change Fund for 2012/13. The GPs were pleased to be involved and happy to be included in future discussions.

Decisions

The report was noted.

74.5 Chief Nurse Report

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

Lorraine Cowan introduced the paper. The following points were noted:
There were 62 children recorded on the Child Protection Register as at 30th September 2011, living in 40 families.

A new data collection system has been introduced – work is ongoing to ensure the accuracy of the information.

Refurbishment programme underway at Lammerlaw Ward.

The redesign of the School Nursing Service was underway.

Skill mix and cluster working was progressing as part of modernising Community Nursing.

The School Nursing Service within East Lothian has gone live with TRAK.

The Leg Club pilot in Ormiston was continuing and was well received by the Community.

The management of the night District Nurse Service for East and Midlothian has now moved to the Lothian Unscheduled Care Service.

New technologies were supporting early discharge from hospital and a reduction in readmissions.

**Decisions**

The report was noted.

**74.6 AHP Manager Report**

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

Sheena Wight introduced the paper and highlighted the following points:

- The recruitment process was underway for the East Lothian Response and Rehabilitation Service. This was being funded through the East Lothian Change Fund.
- A LEAN event for this service was being arranged for the end of April 2012.
- The development of East Lothian Telecare for individuals with dementia was underway. This was being funded through the East Lothian Change Fund.
- The development of the East Lothian Challenging Behaviour Service for older people with dementia was submitted as a project bid to the East Lothian Change Fund and subsequently approved. The recruitment process was underway.
- Amendment to 3.13 – should read ‘Carer Mentor’.

**Prison Healthcare**

A paper was circulated to members prior to the meeting. Ian Johnston introduced the paper. The following points were noted:

- It was noted that 12 complaints had been received during the period 12/12/11 to 24/01/12. This compared with an average of 60 complaints per month prior to transition.
- Sickness and absence rates have been reduced.
- Following transfer of funding both prisons were forecasting a breakeven position.
- Agenda for Change bandings were to be completed – this might cause financial pressures should the banding be higher than
The Mental Welfare Commission had visited Addiewell.

- A Level 2 incident had occurred on 2nd January 2012 at Addiewell. The CHP had attended the de-brief session and business continuity planning was being arranged to take account of the lessons.
- A Clinical Lead would be placed in each prison for consistency and to ensure robust procedures were in place.

**Decisions**

The report was noted.

### 74.7 Hosted Services

#### 74.7.1 LUCS

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

Jane Hopton introduced the report and highlighted the following points:

- The new LUCS Senior Management Team was now in place.
- A detailed report has been prepared on the performance over the festive period.
- Activity levels had been lower over the festive period this year with no specific issues.
- The work and support of Staff during the festive period was acknowledged.
- There were issues regarding the availability of Pharmacists during the festive period.
- It was noted that there would be an overspend within LUCS.
- 6 patient complaints had been reviewed by the LUCS Senior Management Team on 24th January.
- Details and outcome from a critical incident which took place in December 2011 was noted.

**Decisions**

The report was noted.

### 74.7.2 Health Promotion

A paper on the ‘Health Promotion Service’ was circulated to members prior to the meeting. Moyra Burns introduced the paper.

It was noted that the work on Alcohol Brief Interventions had been successful. Other work around organisational and partnership development was progressing with proposals for working with children and families affected by a parent in prison.

There has also been significant work on developing capacity and capability. A range of programmes has been introduced to support the development.
Decisions

The report was noted.

NHS Lothian Health Promotion Service Annual Report 2010/11

A copy of the report was circulated to members prior to the meeting.

Decisions

The report was noted.

74.8 Public Health Team Interim Update

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

John Boyce introduced the paper and commented that the purpose of the paper was to update the CHP Sub-Committee on progress since June 2011. The following points were noted:

- Child Healthy Weight – working with Cockenzie School.
- A number of activities including improved knowledge of health eating, diet and weight have been introduced.
- Baby Friendly Accreditation initiative has been introduced to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.
- Funding has been allocated by NHS Lothian to help support this programme.
- A bibliotherapy or book prescribing service has been established since 2007 with over 5,000 books available for loan.

Decisions

The report was noted.

75. Carers Forum

There was nothing to update.

76. Public Partnership Forum

The minutes of the PPF meeting held on 24th January 2012 were circulated in advance of the meeting.

It was noted that discussion took place on the relocation of older peoples’ mental health assessment beds to the new Midlothian Community Hospital.

Decisions

The Minutes were noted.

77. Community Health Partnership Committee Appointments
There was no business raised under this item.

78. **A.O.C.B.**

78.1 **Information for Private Foster Carers**

Ronnie Hill circulated a leaflet on ‘Information for Private Foster Carers’ and information for all Health Professionals. There was a campaign underway to raise awareness on the legal responsibilities of Private Fostering.

Ronnie Hill commented that the information would be widely circulated and would include private nurseries, schools and GP Practices.

Graham Alexander commented that it was important to be clear on consent issues and that details on this would require to be resolved. It was agreed that Ronnie Hill would attend the GP Representatives meeting to discuss this further. RH

**Decision**

The CHP Sub-Committee supported this initiative. Ronnie Hill to attend GP Representative meeting.

78.2 **Future CHP Sub-Committee Agendas**

Fiona Mitchell suggested that it would be helpful to rotate the order of business on the agenda. David Small agreed that this would be useful and agreed to change this for future meetings. DS

**Decision**

David Small would arrange future agendas accordingly.

79. **Date of next meeting**

It was agreed that the next meeting would take place on **Wednesday, 25th April 2012 at 2.00pm** in ‘The Quay’, Musselburgh.
Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Wednesday 25th April 2012 at 2.00p.m. in The Quay, Musselburgh.

Present: Cllr Paul McLennan, East Lothian Councillor (PM) (in the chair)
David Small, General Manager (DS)
Ann McCarthy, PPF Representative (AM)
Tony Segal, Carers of East Lothian (TS)
Fiona Mitchell, Acute Sector (FM)
Dr Jane Hopton, Assistant General Manager (JH)
Dr Ian Johnston, Medical Director (IJ).
Mike Porteous (MP) for Lynne Hollis, Associate Director of Finance
David Heaney, Strategy & Policy, East Lothian Council (DH)
Liz Cregan, Chief Nurse
Lynne Hollis, Associate Director of Finance
Thomas Miller, Staff Representative
Murray Leys, East Lothian Council
Sharon Saunders, East Lothian Council
Gill Colston, Public Partnership Forum Representative

In Attendance: Wendy Michael, Minutes (WM)
Duncan Miller, Primary Care Contracts (DM)
Frank Strang (FS)
Fraser McJannett, NHS Lothian Management Trainee (FMc)

Apologies: Morag Barrow, Allied Health Professional Manager
Dr Graham Alexander, GP Representative (GA)
Moyra Burns, Health Promotion Representative (MBu)
Meriel Deans, Public & Community Involvement Co-Ordinator (MD)
Judith Gaskell, ER Manager, NHS Lothian (JG)

1.0 Welcome and Apologies
Apologies were noted as above.

2.0 Minutes of the Previous Meeting Held on 23rd February 2012
2.1 The minutes were agreed as being a true and accurate record.

3.0 Matters Arising / Action Note
3.1 Matters Arising
All business was covered on the agenda.
3.2 Action Note
The action note will be updated to reflect issues completed and updated.

4.0 Items for Decision

No items were noted for decision.

5.0 Items for Discussion

5.1 Scottish Focused GMS Contract

A presentation on ‘GP Contract in Scotland “The way ahead” was shown and circulated to members at the meeting.

Frank Strang gave the presentation on the vision for sustainable care for 2020.

General Practice role and contract has to be right to help to achieve the vision for 2020.

Within NHS Lothian the Section 17C Practices review on A&E attendances was highlighted as an example.

Questions asked by Frank and Duncan for groups views were:-

What are the principles we should be following?

Iain Whyte asked Duncan to give the group an update on what Lothian had done previously. Duncan summarised the move from PMS Contracts to 17c Contracts and the differences brought in with the 2004 contract.

Ian Johnston said that behaviours are also important but these changes are an opportunity to help with the engagement of GPs and Primary Care.

Jane Hopton mentioned that she felt the new version of the GP contract should see development of general practice around in hours/out of hours out with Primary Care e.g. Prison Services/Care Homes.

Tony Segall asked about the enhanced Services – Duncan mentioned that there are 23 different enhanced services and they are trying to streamline these.

Decisions

The Presentation was welcomed by the group.

5.2 Gender Based Violence & Health Programme – EMT 14.02.12 6.10

Report was circulated in advance of the meeting for noting.

Decisions

Report was noted by the Group.
6.0 Performance Reports

6.0 General Managers Report

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

Delayed Discharges

The April 2012 validated figure was 10 with no-one delayed over 6 weeks.

Capital Projects

Musselburgh Primary Care Centre – Services have started moving in this week and the centre will be fully open by middle of next month. A formal opening will be planned for later in the year.

Gullane Medical Practice. A date for commencement of construction was still awaited.

Edenhall Hospital – planning work is proceeding with the final reprovision of services.

Tranent Health Centre extension. Still awaiting Hubco costings.

East Lothian Community Hospital – Project Board to meet to discuss.

Review Groups for Bellhaven and Edington Hospitals

It was noted that the next meetings of the forums for each of the hospitals would be taking place in June. Depending on the outcome of the local elections, it is planned to bring a report to the sub committee on the way forward.

Older Peoples Mental Health Services

Tony raised concerns that the OPS Mental health strategy was noted in previous minutes. Lengthy discussions were had but it seems that the “Bus” issue has taken over from the whole review.

Murray Leys suggested a way forward. David Small agreed to review progress with Linda Irvine and to ensure this was discussed at the Joint Mental Health Group. Murray also said that if it would help he would convene a meeting with Eibhlin McHugh, himself and David.

Decisions

The report was noted and the actions log updated.

6.1 Staff Governance Report

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

David Small commented that the sickness absence performance would be discussed further by the Management Team and that an Action Plan would be put in place to address the ‘hotspots’. An update on the action plan will be included with the next report. Discussions have been held with Human Resources and Partnership around a training programme for Band 7s who deal on a day to day basis with the management of sickness/absence.

Ann McCarthy requested a more detailed report around workforce planning for East Lothian CHP.

**Decisions**

The report was noted.

David Small to request the WTE analysis.

6.2 **Financial Report**

A copy of the report on ‘Financial Performance to 31st March 2012’ was circulated to members prior to the meeting.

A break even position was achieved at year end. The report highlights good financial control within East Lothian CHP.

Iain Whyte advised that it would be helpful to have more detailed reporting for future meetings for the forthcoming year.

David Heaney asked about using IRF for prescribing budgets/Practice level analysis.

**Decisions**

The report was noted. Action Log to be updated.

6.3 **Clinical Director’s Report**

The Sub Committee considered a verbal report from the Clinical Director.

**Decisions**

The update was noted.

6.4 **Chief Nurse Report**

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

- Adult Protection/Child Protection reporting for noting.

- Mental Health Services
  A phased re-opening of Lammerlaw is being planned, looking at a new nursing model and staffing levels. Opening Lammerlaw on a reduced number of beds, 12 beds initially,

  Murray requested that a more detailed discussion be held around the long term future of this service and a fixed time scale to be agreed around.

- Community Nursing (District Nursing, Health Visiting & School Nursing)

- Adult & Older People’s Services (Hospitals)

- HAI

- Unicef Baby Friendly Accreditation

- Families of Prisoners
  58 residents of EL in Edinburgh and Addiewell Prisons Services

- MMR Immunisation

- Clinical Nurse Manager Integrated Children’s Health EL & ML
  CHPs – Mairi McMillan is moving to a new post. The Group wished to thank Mairi for her Services

  Ann asked about the Hospital acquired infections –Ian Johnston confirmed that these were mostly people who had been in acute hospital and had transferred to local hospitals.

Decisions

The report was noted.

6.3 AHP Manager Report

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

- AHP Review – the proposal that the AHP manager manages the dietetics Services for Lothian.

- Iain Whyte asked how easily the Community Health Partnership can manage this given prisons

- Iain Whyte asked about unidentified issues; direct resources for members of staff. Terms of support there will be dietetics managers. MB is comfortable to take this on. East Lothian & Midlothian currently are being managed by Edinburgh.
• Lynne Hollis asked how this review fits with the integration agenda.

• Ann mentioned the recent podiatry review where the current service seems to have been centralised. David advised that Review was carried out more as an HAI recommendation to ensure clinics were held in an HAI compliant facility.

• David Heaney mentioned the Hosted Services as a whole and how they will be interlinked with the Integration Agenda.

• Fiona Mitchell – small dietetic department within the Sick Kids. AHP Services are not all the same and they shouldn’t be viewed or lumped as if they are.

Decisions
Group agreed in principle once the budget is clarified.

Prison Healthcare
A paper was circulated to members prior to the meeting. Ian Johnston introduced the paper. The following points were noted:

• There had been some difficulties with GP cover but the team managed to rise to the challenge and cover was provided.

• Physiotherapy now provided at Addiewell Prison.

• Iain Whyte raised the questions around roles and responsibilities. The main questions being are staff taking on roles they are not trained for - Reassurances had been given by both Prison Healthcare managers. Ian felt confident that this was not the case. – This issue is on the risk register. A review is being carried out around this issue.

• Risk Register – to be updated and brought back to the group.

Decisions
The report and progress was noted.

6.6 Hosted Services

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

Jane Hopton introduced the report and highlighted the following points:

• The Easter 4 day break is always really busy and future cover needs to be reviewed.
• Clinical co-ordinators are required within the Hub at busy times.

• Public Health also requested a visit be carried out due to a flu outbreak. A meeting has been organised to discuss this with the Director of Public Health, Dr Alison McCallum.

Decisions

The report was noted by the group.

6.6.2 Health Promotion

A paper on the ‘Health Promotion Service’ was circulated to members prior to the meeting. This was noted.

Iain Whyte raised the question on longer term measurement of outcomes i.e. heat targets, inequalities etc. Jane Hopton confirmed that attempts are made to measure this and a report on this is due at the next sub committee meeting.

Decisions

The report was noted.

6.6.2.1 Lothian Sexual Health & HIV Group Activity 2011

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

Decisions

The report was noted.

7.0 Carers Forum

The Sub Committee considered a report on Carer Information Strategies (CIS) 2012-13 which had been circulated in advance of the meeting which was noted.

Tony Segall delivered the report to the group.

Decisions

The report was noted.

8.0 Public Partnership Forum

The minutes of the PPF meeting held on 20th March 2012 were circulated in advance of the meeting.
Gill had asked for the working agreement to be reviewed on the issue of PPF members speaking to the Press. Stuart Wilson had asked that prior to members speaking to the Press he receives what the member is going to say/discuss.

Decisions

The Minutes were noted. Further discussion to be had around PPF Members Speaking to the Press.

9.0 Community Health Partnership Committee Appointments

Highlighted proposal at the June Meeting, formal thanks were noted for Ronnie Hill participation in the committee.

Sharon Saunders was welcomed to her first meeting.

10.0 A.O.C.B.

No items were raised

Date of next meeting

It was agreed that the next meeting would take place on Wednesday 27th June 2012 at 2.00pm in Town House, Haddington
CHAIRMAN’S REPORT TO LOTHIAN NHS BOARD

1. Internal

1.1 During this period I was on holiday for two weeks.

1.2 Chief Executive Recruitment - During this period I agreed the final information pack and spoke to two candidates on the phone. Shortlisting will take place on 23 July for the final interviews on 31 July. Shortlisted candidates will be psychometrically evaluated, principally to assure the panel that leadership styles are not at odds with NHS Lothian's desired management behaviours.

1.3 Community Gardens - I chaired a meeting of the NHS community gardens steering group on 12 July. Community gardens are now in place at the Royal Edinburgh Hospital and Midlothian Community Hospital. They are under construction at Belhaven Hospital, and in planning at Tippethill Hospital.

2. External

2.1 Evening News - At their request, I gave an extensive interview to the Evening News’ health reporter on 12 July. The focus was the implementation of the recommendations of the Bowles and governance information reports.

Charles Winstanley
Chairman
1 Purpose of the Report

1.1 The purpose of this report is to provide the NHS Board with an overview of the financial position of NHS Lothian to the end of June 2012.

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 NHS Board are asked to:

- note the overspend of £1.609m for the three months to the end of June 2012;
- note the Corporate Management Team will undertake the detailed scrutiny of the overspends, savings delivery and required actions to deliver financial balance.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an overspend of £1.6m for the first three months of the financial year. This comprises an operational overspend of £1.2m and under delivery of £0.4m against the efficiency savings target; as detailed below; an adverse variance of £0.4m in the month.

Table 1 - Financial Position to 31st June 2012

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Baseline</th>
<th>Outstanding Efficiency Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>University Hospital Division</td>
<td>(102)</td>
<td>(82)</td>
<td>20</td>
</tr>
<tr>
<td>CHPs/CHCP/PCCO</td>
<td>(669)</td>
<td>(550)</td>
<td>119</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>(427)</td>
<td>(171)</td>
<td>256</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(411)</td>
<td>(411)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Under/(Over) Spend</strong></td>
<td>(1,609)</td>
<td>(1,213)</td>
<td>(396)</td>
</tr>
</tbody>
</table>

3.2 A summary of the financial position by operational unit is included in Appendix 1 and a breakdown of income in Appendix 2.
3.3 The operational financial position worsened by £0.4m during the month (£1.2m overspend at end of June, compared to £0.8 in May). This is as a result of increases in medical/clinical supplies, equipment costs and an adverse movement in facilities costs. In terms of supplies and equipment costs each of these issues is subject to close review to ensure they are not early signs of cost increases. The adverse movement within facilities relates to maintenance and double running costs, an exercise is underway to better understand this increase for the Q1 review, and to identify what management action is required. Offsetting the above adverse movements is the release of drugs funding previously held in reserves.

3.4 System wide pressure on core capacity continues to be the key driver of the operational financial position. A combination of winter funded wards which have remained open beyond 31 March to cope with activity levels; and capacity opened to address short term flow, downstream pressure and delayed discharge issues, led to expenditure of £1.1m during April to June. This was partly offset by funding agreed for nursing, medical staff and supplies costs for beds opened in wards 104 at RIE and 25 at WGH. The details are given in table 2 below:

**Table 2 - Financial impact of capacity pressures**

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>No of Beds</th>
<th>Costs to June</th>
<th>Funding agreed</th>
<th>Net Impact on Financial Position</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td></td>
</tr>
<tr>
<td><strong>Long Term Additional Bed Capacity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RIE</td>
<td>Ward 104</td>
<td>26</td>
<td>360</td>
<td>367</td>
<td>7</td>
<td>Open</td>
</tr>
<tr>
<td>WGH</td>
<td>Ward 25</td>
<td>12</td>
<td>150</td>
<td>159</td>
<td>9</td>
<td>Open</td>
</tr>
<tr>
<td><strong>Short Term Additional Flexible Capacity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RIE</td>
<td>Primary Assessment Area</td>
<td>-</td>
<td>24</td>
<td>(24)</td>
<td>When Required</td>
<td></td>
</tr>
<tr>
<td>SJH</td>
<td>Ward 22</td>
<td>12</td>
<td>63</td>
<td>(63)</td>
<td>Closed</td>
<td></td>
</tr>
<tr>
<td>WGH</td>
<td>Ward 12</td>
<td>7</td>
<td>6</td>
<td>(6)</td>
<td>Closed</td>
<td></td>
</tr>
<tr>
<td>Liberton</td>
<td>Ward 1/2/4/8</td>
<td>16</td>
<td>71</td>
<td>(71)</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>RVH</td>
<td>Ward 7</td>
<td>23</td>
<td>98</td>
<td>(98)</td>
<td>Transferred</td>
<td></td>
</tr>
<tr>
<td>RVB</td>
<td>Ward 75</td>
<td>17</td>
<td>31</td>
<td>(31)</td>
<td>Closed mid June</td>
<td></td>
</tr>
<tr>
<td>Corstorphine</td>
<td>Ward 1</td>
<td>5</td>
<td>43</td>
<td>(43)</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Corstorphine</td>
<td>Ward 3</td>
<td>20</td>
<td>36</td>
<td>(36)</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Corstorphine</td>
<td>Ward 4</td>
<td>20</td>
<td>173</td>
<td>(173)</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>AAH</td>
<td>Fraser</td>
<td>10</td>
<td>87</td>
<td>(87)</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>1,142</td>
<td>526</td>
<td>(616)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For the three month period, efficiencies of £5.7m have been delivered against a plan of £6.1m, an under delivery of £0.4m. The level of savings identified increased by £1.2m in June.

On a full year basis, specific schemes totalling £28.1m have been identified against the £37.5m target. This represents around 75% of the annual target; further work is required to identify schemes to deliver the targets for Acute Flow & Capacity, Procurement, and Nursing, as well as the overall residual gap. Delivery of LRP remains a key risk.

The year to date and full year position against plan is set out in Table 3 below.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target</th>
<th>Schemes identified</th>
<th>April - June</th>
<th>Full Year Savings Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>Target £k</td>
<td>Actuals £k</td>
</tr>
<tr>
<td>Reduction in Interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Clinical Value</td>
<td>537</td>
<td>537</td>
<td>7</td>
<td>0 (7)</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Reduction</td>
<td>650</td>
<td>650</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity Management</td>
<td>3,233</td>
<td>2,767</td>
<td>191</td>
<td>191 0</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>1,894</td>
<td>291</td>
<td>237 (54)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>6,211</td>
<td>6,211</td>
<td>387</td>
<td>515 128</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>1,010</td>
<td>368</td>
<td>364 (4)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>198</td>
<td>198</td>
<td>197 (1)</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td>1,945</td>
<td>1,945</td>
<td>629</td>
<td>413 (216)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,779</td>
<td>1,779</td>
<td>275</td>
<td>235 (40)</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>5,171</td>
<td>5,169</td>
<td>1,095</td>
<td>977 (118)</td>
</tr>
<tr>
<td>UHD Local</td>
<td>3,893</td>
<td>3,899</td>
<td>828</td>
<td>745 (83)</td>
</tr>
<tr>
<td>LAMS</td>
<td>2,000</td>
<td>2,000</td>
<td>1,800</td>
<td>1,800 0</td>
</tr>
<tr>
<td>Total Planned Savings</td>
<td>32,702</td>
<td>28,059</td>
<td>6,069</td>
<td>5,674 (395)</td>
</tr>
<tr>
<td>Residual Gap</td>
<td>4,838</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>37,540</td>
<td>28,059</td>
<td>6,069</td>
<td>5,674 (395)</td>
</tr>
</tbody>
</table>

Ongoing discussion, detailed reporting and agreement of further management action required, particularly for those workstreams where there is little evidence of delivery to date, will continue to be taken forward by the monthly Efficiency & Productivity Group, under the leadership of the Director of Finance. In addition work is underway to assess what further options there are for LRP schemes.
Waiting times

3.9 The total cost of delivering additional waiting times activity over the three months to end June was £5m. This includes increases to internal capacity (£2m) as well as the use of independent sector providers and the Golden Jubilee National Hospital (£3m). Expenditure is below forecast for Quarter One (£6m) however no variance is reported in anticipation that this expenditure will be incurred in future periods.

3.10 The slippage against forecast is largely in relation to acceptance of offers at independent sector hospitals; the establishment of an External Provider Office is expected to improve takeup over the next quarter. In addition, Medinet will be used to further support increases to internal capacity. The overall forecast position for 2012/13 remains at £20m as previously reported.

Capital

3.11 The capital programme for the year continues to show a potential over commitment of £5.7m. However, as a number of projects have not yet received full governance approval, this is a manageable position and may require the timing of unapproved projects to be reviewed.

3.12 Expenditure of £4m was incurred for the first 3 months of the financial year, the majority relating to the new Royal Victoria Building which opened to patients in June. Appendix 3 includes details of the programme on a scheme by scheme basis.

4 Key Risks

4.1 The key risks include:

- The agreement of a pan Lothian solution to the ongoing system wide capacity pressures;
- Delivery of the agreed recurrent efficiency schemes and the need to identify further plans to address the shortfall; and
- Continued management of the financial exposure on waiting times’ related additional activity delivery

5 Risk Register

5.1 There is nothing to add to the risk register at this stage.

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
25 July 2012
Susan.goldsmith@nhlothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Expenditure Summary June 2012
Appendix 2: NHS Lothian Income Summary June 2012
Appendix 3: NHS Lothian Capital Expenditure Programme June 2012
## NHS Lothian Expenditure Summary to June 2012

### Appendix 1

<table>
<thead>
<tr>
<th>Annual Budget</th>
<th>Budget</th>
<th>Actuals</th>
<th>Variance</th>
<th>Baseline Variance</th>
<th>LRP Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
<td></td>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
</tr>
<tr>
<td><strong>UNIVERSITY HOSPITALS DIVISION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Associated Services</td>
<td>120,877</td>
<td>29,146</td>
<td>29,567</td>
<td>(420)</td>
<td>(279)</td>
</tr>
<tr>
<td>REAS &amp; MOE</td>
<td>65,290</td>
<td>15,511</td>
<td>15,704</td>
<td>(193)</td>
<td>(184)</td>
</tr>
<tr>
<td>Surgical Directorate</td>
<td>76,256</td>
<td>21,144</td>
<td>21,151</td>
<td>(7)</td>
<td>133</td>
</tr>
<tr>
<td>Labs, A&amp;T, Critical Care &amp; HSDU</td>
<td>118,884</td>
<td>30,256</td>
<td>30,069</td>
<td>187</td>
<td>178</td>
</tr>
<tr>
<td>Women, Children &amp; Neuroscience</td>
<td>89,682</td>
<td>22,178</td>
<td>22,488</td>
<td>(311)</td>
<td>(214)</td>
</tr>
<tr>
<td>Radiology, Cancer, Head &amp; Neck</td>
<td>97,325</td>
<td>23,867</td>
<td>23,247</td>
<td>620</td>
<td>248</td>
</tr>
<tr>
<td>Corporate</td>
<td>(7,862)</td>
<td>(6,135)</td>
<td>(6,156)</td>
<td>21</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>560,452</td>
<td>135,967</td>
<td>136,069</td>
<td>(102)</td>
<td>(82)</td>
</tr>
<tr>
<td><strong>CHPs/CHCP/PCCO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>68,506</td>
<td>17,855</td>
<td>18,005</td>
<td>(150)</td>
<td>(119)</td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>239,516</td>
<td>61,779</td>
<td>62,300</td>
<td>(521)</td>
<td>(433)</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>69,553</td>
<td>18,007</td>
<td>17,993</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>96,096</td>
<td>23,421</td>
<td>23,413</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Primary Care Contractor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>11,632</td>
<td>23,256</td>
<td>23,275</td>
<td>(19)</td>
<td>(19)</td>
</tr>
<tr>
<td>Corporate</td>
<td>9,715</td>
<td>(7,572)</td>
<td>(7,571)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>495,018</td>
<td>136,746</td>
<td>137,415</td>
<td>(669)</td>
<td>(550)</td>
</tr>
<tr>
<td><strong>CORPORATE BUDGETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive</td>
<td>607</td>
<td>218</td>
<td>195</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Consort</td>
<td>45,703</td>
<td>10,774</td>
<td>10,845</td>
<td>(71)</td>
<td>(71)</td>
</tr>
<tr>
<td>Communications</td>
<td>576</td>
<td>143</td>
<td>141</td>
<td>2</td>
<td>17</td>
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<tr>
<td>Ehealth</td>
<td>20,268</td>
<td>4,552</td>
<td>4,521</td>
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<td>31</td>
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<td>Facilities Management</td>
<td>78,993</td>
<td>17,575</td>
<td>18,168</td>
<td>(593)</td>
<td>(552)</td>
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<tr>
<td>Finance &amp; Capital Planning</td>
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<td>2,653</td>
<td>2,675</td>
<td>(22)</td>
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<td>Human Resources</td>
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<td>2,348</td>
<td>2,354</td>
<td>(5)</td>
<td>36</td>
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<tr>
<td>Medical Director</td>
<td>975</td>
<td>(21)</td>
<td>(41)</td>
<td>20</td>
<td>20</td>
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<tr>
<td>Nursing</td>
<td>4,384</td>
<td>(1,475)</td>
<td>(1,499)</td>
<td>25</td>
<td>25</td>
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<tr>
<td>Pharmacy</td>
<td>12,088</td>
<td>2,809</td>
<td>2,713</td>
<td>96</td>
<td>188</td>
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<tr>
<td>Planning</td>
<td>2,720</td>
<td>490</td>
<td>429</td>
<td>61</td>
<td>61</td>
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<tr>
<td>Public Health</td>
<td>3,247</td>
<td>756</td>
<td>749</td>
<td>7</td>
<td>8</td>
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<tr>
<td>Other</td>
<td>155</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td>191,533</td>
<td>40,824</td>
<td>41,250</td>
<td>(427)</td>
<td>(171)</td>
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<tr>
<td><strong>STRATEGIC BUDGETS</strong></td>
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<tr>
<td>SLAs/UNPACs/NCA</td>
<td>10,051</td>
<td>2,513</td>
<td>2,986</td>
<td>(473)</td>
<td>(473)</td>
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<tr>
<td>Depreciation, Capital Grants &amp; Asset Impairment</td>
<td>38,739</td>
<td>9,774</td>
<td>9,764</td>
<td>10</td>
<td>10</td>
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<tr>
<td>Third Party Providers</td>
<td>12,992</td>
<td>3,207</td>
<td>3,210</td>
<td>(3)</td>
<td>(3)</td>
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<tr>
<td>Reserves &amp; Allocations</td>
<td>20,944</td>
<td>(2,955)</td>
<td>(3,016)</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>95,872</td>
<td>13,302</td>
<td>13,713</td>
<td>(411)</td>
<td>(411)</td>
</tr>
</tbody>
</table>

**TOTAL** | 1,342,875 | 326,839 | 328,448 | (1,609) | (1,213)
## NHS Lothian Income Summary June 2012

### Appendix 2

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
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<tbody>
<tr>
<td>Income from other health systems</td>
<td>(113,645)</td>
<td>(19,732)</td>
<td>(20,165)</td>
<td>432</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(54,302)</td>
<td>(14,493)</td>
<td>(14,358)</td>
<td>(134)</td>
</tr>
<tr>
<td>National services</td>
<td>(30,409)</td>
<td>(13,737)</td>
<td>(13,694)</td>
<td>(43)</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,735)</td>
<td>(702)</td>
<td>(478)</td>
<td>(225)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(2,401)</td>
<td>(600)</td>
<td>(604)</td>
<td>4</td>
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<tr>
<td>Other income</td>
<td>(32,982)</td>
<td>(14,170)</td>
<td>(13,873)</td>
<td>(297)</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td><strong>(236,474)</strong></td>
<td><strong>(63,435)</strong></td>
<td><strong>(63,172)</strong></td>
<td><strong>(263)</strong></td>
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<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,248,526)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>(1,485,001)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheme Description</td>
<td>Agreed Programme</td>
<td>Actual Expenditure</td>
<td>Remaining Anticipated Expenditure</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Committed</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>2,456</td>
<td>2,077</td>
<td>379</td>
<td></td>
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<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>10,000</td>
<td>(217)</td>
<td>10,217</td>
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<tr>
<td>Musselburgh Primary Care Centre</td>
<td>277</td>
<td>(12)</td>
<td>288</td>
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<tr>
<td>GDP dental premises</td>
<td>2,000</td>
<td>89</td>
<td>1,911</td>
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<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>4,343</td>
<td>23</td>
<td>4,321</td>
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<tr>
<td>RIE Lifecycle Costs</td>
<td>4,602</td>
<td>1,117</td>
<td>3,485</td>
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<tr>
<td>Radiotherapy - Phase 7</td>
<td>11</td>
<td>(16)</td>
<td>27</td>
<td></td>
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<tr>
<td>Radiotherapy - Phase 8</td>
<td>2,101</td>
<td>4</td>
<td>2,097</td>
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<tr>
<td>Radiotherapy - Other</td>
<td>226</td>
<td>0</td>
<td>226</td>
<td></td>
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<tr>
<td>West End Medical Practice</td>
<td>1,467</td>
<td>60</td>
<td>1,407</td>
<td></td>
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<tr>
<td><strong>TOTAL - SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td>28,856</td>
<td>3,125</td>
<td>25,731</td>
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<tr>
<td><strong>Over/Under Commitment on Specific Funding</strong></td>
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<td>0</td>
<td>0</td>
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<tr>
<td><strong>NHS LOTHIAN FORMULA &amp; OTHER FUNDING PROGRAMME</strong></td>
<td>(25,593)</td>
<td>0</td>
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<tr>
<td>Statutory Compliance</td>
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<td>3,597</td>
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<td>Medical Equipment</td>
<td>4,000</td>
<td>253</td>
<td>3,747</td>
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<tr>
<td>E-Health Strategic Priorities</td>
<td>2,000</td>
<td>214</td>
<td>1,786</td>
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<tr>
<td>Invest to Save</td>
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<td>4</td>
<td>996</td>
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<tr>
<td>National PACS Refresh 2007-17</td>
<td>84</td>
<td>85</td>
<td>(1)</td>
<td></td>
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<tr>
<td>Expansion of renal capacity RIE</td>
<td>(297)</td>
<td>84</td>
<td>(382)</td>
<td></td>
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<tr>
<td>Laboratory Equipment</td>
<td>712</td>
<td>(6)</td>
<td>718</td>
<td></td>
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<tr>
<td>Observation Ward A&amp;E RIE</td>
<td>(16)</td>
<td>0</td>
<td>(16)</td>
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<tr>
<td>Birthing suite (RIE)</td>
<td>(367)</td>
<td>12</td>
<td>(379)</td>
<td></td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>0</td>
<td>11</td>
<td>(11)</td>
<td></td>
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<tr>
<td>Gullane Medical Centre</td>
<td>2,461</td>
<td>0</td>
<td>2,461</td>
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<tr>
<td>RVH Ward 1 to Jardine Clinic REH</td>
<td>752</td>
<td>150</td>
<td>601</td>
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<tr>
<td>Other Donations</td>
<td>430</td>
<td>67</td>
<td>363</td>
<td></td>
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<tr>
<td>Maternity Unit (SJH)</td>
<td>30</td>
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<td>30</td>
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<tr>
<td>BCI Mammography Upgrade WGH</td>
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<tr>
<td>Tranent</td>
<td>1,163</td>
<td>2</td>
<td>1,161</td>
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<tr>
<td>HEI</td>
<td>500</td>
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<td>500</td>
<td></td>
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<tr>
<td>Purchase of Items for Cancer Treatments</td>
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<td>0</td>
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<td>Traffic Management</td>
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<td>(10)</td>
<td>10</td>
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<tr>
<td>Endoscopy RIE</td>
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<td>Endoscopy WGH</td>
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<td>200</td>
<td></td>
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<tr>
<td>Balfour Pavilion</td>
<td>2,305</td>
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<td>2,305</td>
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<tr>
<td>13 Crewe Road South</td>
<td>435</td>
<td>0</td>
<td>435</td>
<td></td>
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<tr>
<td>Dental transfer to HSDU RIE</td>
<td>2,000</td>
<td>0</td>
<td>2,000</td>
<td></td>
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<tr>
<td>Greenbank</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>RIE Bed Capacity - OPD 6</td>
<td>3,500</td>
<td>0</td>
<td>3,500</td>
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<tr>
<td>RIE Bed Capacity - HR Corridor and Patient Hotel</td>
<td>2,100</td>
<td>0</td>
<td>2,100</td>
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<tr>
<td>Macmillan Centre SJH</td>
<td>541</td>
<td>2</td>
<td>539</td>
<td></td>
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<tr>
<td>Teenage Cancer Trust WGH</td>
<td>1,000</td>
<td>10</td>
<td>990</td>
<td></td>
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<tr>
<td>Completed Schemes under Review</td>
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<td>(152)</td>
<td>152</td>
<td></td>
</tr>
<tr>
<td><strong>Over/Under Commitment on Formula</strong></td>
<td>5,718</td>
<td></td>
<td></td>
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<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>60,168</td>
<td>4,014</td>
<td>56,154</td>
<td></td>
</tr>
<tr>
<td><strong>Over/Under Commitment</strong></td>
<td>5,718</td>
<td></td>
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</table>
PERFORMANCE MANAGEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the NHS Lothian Board on the most recently available NHS Lothian performance data as reported through local and national systems. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Receive this update on the current performance against each of the current HEAT targets, standards and a number of other local and national targets, as outlined in Appendix 1. Where performance is currently off trajectory, further remedial actions being taken are outlined in the ‘Risks’ section of this report.

2.2 Note that the data in Appendix 1 on waiting times for Inpatients, Outpatients and Diagnostics is the most up to date data at the point of writing – May 2012. June data will be available in a separate paper specifically for these waiting times so there will be no further narrative within the risks section of this paper.

2.3 Note that in order to inform the Board of the current position across the range of targets and standards as set out in this paper, the source of the data provided is from local management systems within NHS Lothian. This means that some information is only available quarterly or annually. Where local systems are reporting potential difficulties with any of these targets, exception reports will be provided as part of this paper.

2.4 Appendix 2 outlines all the targets and standards that will be included in this report, together with the frequency of available data. For the next report to the Board other services that will be reported include Invetro Fertilisation (IVF), Vasectomy, Scoliosis and Wheelchairs.

2.5 Note that as previously reported, the Health Intelligence Unit is continuing to develop Dashboards for Board members and these will ultimately be used as the source of data for Performance Reports.
3 Discussion of Key Issues

3.1 Of the 38 items monitored within Appendix 1, the most recent data indicates NHS Lothian:
- **Meets** the overall target on nine occasions (table key: ✔✔)
- **Is on trajectory to meet**, but has not yet met the final target, on seven occasions (table key: ✔)
- **Is off trajectory** on four occasions (table key: ✗)
- **Does not meet** the overall target on twelve occasions (table key: ✗✗)
- **No data available yet** (new or revised target) on six occasions (Blank)

3.2 Further information is available in the key risks section for those areas currently off trajectory or where no performance data is included in the table.

4 Key Risks

The following performance measures are those where NHS Lothian are currently off trajectory and therefore are considered risks to the organisation. Responsible Directors have been asked for actions being taken to mitigate these risks.

4.1 HEAT Targets

4.1.1 Child Healthy Weight (Responsible Director: Director of Public Health and Health Policy)

The stated trajectory for the 2011/12 Local Delivery Plan was 680 completed interventions in overweight and obese children (at or above the 91st centile for body mass index), with at least 40% of interventions to be completed in the two most deprived quintiles. The total of completed interventions for 2011/12 was 679, almost matching the trajectory of 680. Furthermore, 77% of interventions were in the two most deprived quintiles, greatly exceeding Scottish Government requirements. The timing of the interventions in 12/13, which are designed to complement the school timetable rather than being spread throughout the year, will also show variable in-year performance.

4.1.2 Suicide Reduction (Responsible Director: Director of Strategic Planning & Primary Care)

The national target is to reduce the suicide rate in Scotland by 20% between 2000-02 and 2011-13. The five year rates for 2006-10 for both genders and all Lothian local authority areas are lower than the Scottish average and lower than the previous five year rates, reflecting the national decline in the suicide rate. Based on three-year rolling averages between 2000-02 and 2008-10 there was a 14% fall in suicide rates overall.
4.1.3 **Fluoride Varnishing** (Responsible Director: Director of Public Health and Health Policy)

Work has been taking place to address problems with the data collection from community dentists. A permanent solution has now been found though won't show through in the data until the next reporting period. We still await the publication of data following the inclusion of fluoride varnishing into the mainstream general dental practice payment system on 1 October 2011. Efforts to date in Lothian have focused on delivering fluoride varnishing to children in the communities with the highest levels of deprivation as this group has the highest risk of dental caries and poor oral health.

The Scottish Government have acknowledged the concerns from a number of Boards about the complexity of measuring and explaining this target. As a result a change will be introduced as follows:

*The target measurement will be simplified by treating 3 and 4 year olds as just 2 cohorts. Under this proposal on the 31 March each year ISD would look at all children who were aged either 3 or 4 on the 1st April the previous year and count the number that had at least 2 applications of Fluoride Varnishing in the intervening 12 months.*

4.1.4 **CO2 emissions** (Responsible Director: Director of Human Resources & Organisational Development)

The latest figures which are reported by Health Facilities Scotland (HFS) to Scottish Government, at the end of Q4 of 2011/12 are: CO2 target reduction 5.91% vs actual reduction of 2.77% and Energy target reduction of 1.99% vs actual reduction of 2.17%.
On the face of it this may be disappointing; however NHS Lothian has made its targets if the original base line and a simpler and more logical methodology is adopted. It can be quite easily demonstrated, using the data that is held on the HFS database, that NHS Lothian has met its target for energy and CO2 reduction:

- CO2 benchmark in 2007/08 was 32,316 tonnes vs 2011/12 emission of 28,165 tonnes which represents a reduction of 12.8%.
- Energy benchmark in 2007/08 was 937,565GJ vs 2011/12 consumption of 856,792GJ which represents a reduction of 8.6%.

Reasons for the difference in outcomes between HFS report and NHS Lothian scrutiny include:

- Moving of benchmark year from 2007/08 to 2009/10 - original HEAT benchmark was 2007/08 and the consequent arbitrary move was at a disadvantage to NHS Lothian since it removed the benefit of the early action savings.
- The CO2 emissions data reported by HEAT is only related to the consumption of fossil fuels for hospitals heating and hot water. This is only 30% of the emissions reported by NHS Lothian in its carbon management programmes and NHS Lothian has strategies to reduce CO2 emissions from the whole of its activities, all of its electricity consumption and also its waste to landfill and business transport.

Despite these actions there are challenges ahead for NHS Lothian in that the future targets related to the Climate Change Scotland Act, cannot be met without major investment. We have supplied a £20 million pound investment programme to HFS for them to pursue with the Scottish Government and with a view to utilising the UK Carbon and Energy Fund. Presently HFS is promoting a quarter of this through a potential £5 million investment at St John’s Hospital which includes complete boiler refurbishment, solar photovoltaic array and electricity supply voltage optimisation.

4.1.5 Psychological Therapies (18 weeks RTT by December 2014) (Responsible Director: (Director, West Lothian Community Health and Care Partnership) and CAMHs (26 weeks RTT by March 2013) (Nurse Director)

Guidance on the application of “New Ways of Working” in the mental health context was awaited from the Scottish Government, relevant to both the CAMHs and the Psychological Therapies targets. This guidance has now been issued (as of 25 June 2012) with the Scottish Government confirming that further work will be undertaken to explore the implications of applying New Ways.

In the interim, they have requested that the figures being reported for the CAMHS HEAT target now be unadjusted, i.e. without the application of New Ways. Accordingly the May 2012 CAMHs Monthly Management Information report has been produced without New Ways adjustments and it reports that there were 145 patients waiting over 26 weeks, against a trajectory position of 91 (77% of patients having been seen within 26 weeks).

With the CAMHs service concerned about the delivery of this HEAT Target, the opportunity was taken when bidding against the 2012/13 QUEST monies allocated
to NHS Lothian (£419k), for funding to revisit and update the Capacity modeling for the delivery of the target, in order to further develop monthly access performance reports to:

- Monitor demand against available capacity.
- Monitor activity versus available capacity.
- Monitor access times against the planned HEAT trajectory.
- Forecast future access times based on DCAQ analysis.
- Recommend planned actions to address any variances that will impact upon the delivery of the HEAT trajectory.

The allocation of the QUEST monies is expected in July.

In addition, NHS Lothian will be working closely with the Scottish Government Mental Health Division to obtain information on the successful delivery approaches that are being adopted elsewhere in Scotland.

4.1.6 A&E Attendances (Responsible Director: Director of Strategic Planning & Primary Care)

The previous 4 months of data for February, March, April and May 2012 shows fluctuations in target attainment.

In February, Lothian performance hit trajectory for the first time in 11 months. This performance rebounded during March 2012 to reach an all-time high level of attendances at 2,275 per 100,000. A March 2012 increase was experienced in the majority of Boards, with two of the larger boards, NHS Greater Glasgow and Clyde and NHS Lanarkshire experiencing activity of 3,120 and 3,141 per 10,000 respectively.

It has been suggested that country-wide good weather in March and the increase in the numbers of people spending time spent outdoors may have led to more minor injuries presenting at A&E. However, no national data has been supplied to support this hypothesis and local data has not been interrogated to see if this cause is reflected locally. A sharp increase in presentations in Lothian between February and March was also experienced in 2010 and 2011 though not at the same levels of attendance as 2012.

While the April 2012 data showed a reduction to 2,051 per 100,000, the most recent data for May shows an increase to 2,183. This is 231 above trajectory.

Meetings are taking place between the Clinical Lead, Dr Andrew Coull, and those colleagues responsible for progressing the HEAT milestones. However the establishment of the Unscheduled Care Group as sighted above now requires the alignment of the work to be reconsidered and the Director will undertake this in discussion with other Corporate Management Team and senior colleagues to ensure alignment and appropriate and effective utilisation of staff time and expertise.
4.2 HEAT Standards

4.2.1 4-hour Emergency Access (Responsible Director: Nurse Director)

A number of actions have been taken in order to support this target and the work associated with it:
- The Interim Chief Executive has set up an Unscheduled Care Group
- It has been agreed that the initial focus of this group will be around older people and pathways of care
- The initial work will look at setting up community older people teams, reduce boarding and work towards 7 day discharging, whilst having have clear metrics for measuring success
- CH(C)P Directors and General Managers will lead work strands listed above, building on change fund work to date and bring plans to the next meeting of the group in mid-July
- The group will meet monthly with strategic planning supporting the approach being taken

4.3 Other Local / National Targets

4.3.1 Delayed Discharges (Responsible Director: Director of Strategic Planning & Primary Care)

Within the national rules set out by ISD, the Lothian Partnership reported 103 delays in June, an increase of some 20% from the 81 in May. In May the national rules changed slightly to include patients delayed three or less working days; these were previously excluded from the census count. This accounted for 24 of our 103 delays.

The table gives a summary of headline figures from the May 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 as a delayed discharge Days (non-x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June</td>
<td>162</td>
<td>103</td>
<td>59</td>
<td>4</td>
<td>6</td>
<td>17</td>
</tr>
</tbody>
</table>

- 103 delays after X codes removed (81 May, 58 Apr, 84 Mar)
- 162 overall including X codes (135 May, 109 Apr, 130 Mar)
- 2 Edinburgh and 2 non-Lothian patients were delayed >6wks (5 May, 2 Apr, 2 Mar)
- 17 days is the average length of stay (19 May, 19 Apr, 22 Mar)
- 3 Non-Lothian delays (2 May, 3 Apr, 4 Mar)

The table below sets out the performance across the Partnership areas for May. 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>
<th>Non-Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>77</td>
<td>10</td>
<td>11</td>
<td>≤5</td>
<td>≤5</td>
</tr>
</tbody>
</table>
In City of Edinburgh, the single largest pressure is care homes, with two-thirds of delays being care home placements. Package of Care delays continue to improve in the speed of pick up by City of Edinburgh’s in-house service and its contracted suppliers. Smaller packages arranged via Hospital Occupational Therapists are running at 4 days, down from 10 days 3 months ago. Larger social work assessed packages have similarly come down in length of wait, from 28 days to currently 10 days.

East Lothian, Midlothian and West Lothian continue to have no delays over six weeks, reflecting the continued effective partnership working locally to ensure timely discharge from hospital.

Whilst progress against the national standard continues to be measured, there are further developments to monitor bed days occupied due to delayed discharge in order to demonstrate the wider impact on the hospital system. This will be reported nationally on a quarterly basis by ISD Scotland, with the data for Lothian for Jan – Mar set out below for all delays. As data on this area develops, trend charts will be produced to demonstrate performance across the year.

<table>
<thead>
<tr>
<th>January 2012</th>
<th>February 2012</th>
<th>March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 74 years</td>
<td>1,966</td>
<td>2,638</td>
</tr>
<tr>
<td>75+ years</td>
<td>5,424</td>
<td>4,933</td>
</tr>
<tr>
<td>Total bed days</td>
<td>7,390</td>
<td>7,571</td>
</tr>
</tbody>
</table>

The number of patients who are coded as complex has increased in June to 59 from 54 in May and 51 in April. This is our highest number of complex delayed discharges, since May 2009 (64). The rise in the number of complex delays is mainly patients aged under 65 years within the Royal Edinburgh Hospital who require supported accommodation in the community. Our 14 patients coded as 71X are all frail/dementia whom it is deemed clinically not viable to move other than to their chosen placement; interim moves are not an option. Our Guardianship cases (51X) continue to progress reasonably quickly.

The table below sets out the delays across Partnership areas at May.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Non-Lothian</th>
<th>Average length of stay as a delayed discharge Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex codes</td>
<td>41</td>
<td>≤5</td>
<td>≤5</td>
<td>6</td>
<td>≤5</td>
<td>135</td>
</tr>
</tbody>
</table>
Overall number of patients delayed in hospital

Whilst performance based on ISD reporting processes has shown some improvements over the previous six months, there are still significant pressures within the hospital system due to increased numbers of patients delayed.

There were 329 patients recorded on EDISON whose discharge was delayed; however following the application of ISD reporting rules, Lothian reported 162 delays. 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, although some more detailed work for the under 65s looking for specialist residential accommodation coming out of the Royal Edinburgh Hospital will need to be commenced.

The table below presents the information over the previous 13 months 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. The gap had increased since March 2012 due to the effect of recording the Hospital OT arranged <14Hrs Packages of Care on the EDISON delayed discharge database, circa 25 at any one time. From May 2012 there is a narrowing of the gap as the inclusion of the 0-3 days delay increase the returnable number to ISD. However, irrespective of ISD rule changes we are now running with circa 330 patients who have been declared ready for discharge, but remain in hospital.

![Graph showing delayed patients over time]

4.3.2 Audiology waits over 12 weeks – Adults and Paediatrics (Responsible Director: Medical Director)

The numbers waiting longer than the 12 week target in both Adult and Paediatric Audiology increased in May -139 in adult services and 84 in Paediatrics.

Within Adult services, plans are in place to get back on target with:
- Closer monitoring of booking activity to ensure everyone is booked within nine weeks for assessment and treatment.
- Daily and weekly checks in place to ensure that if any patient is booked outwith the appointment time they will be rebooked within time.
Within paediatrics, a number of things have affected the position including staff maternity leave and an increase in referrals to audiology. There has also been an increase in pre-op ENT requests impacting on availability.

This continues to be monitored and reported. Recruitment is underway for a band 5 audiologist which will address some of the issues and with the return of the audiologist from maternity leave it is hoped that the wait times reduce to a much more acceptable level.

5 Risk Register

5.1 Responsible Directors have been asked to ensure that any risks associated with their targets have been clearly identified within the risk register. Risks are escalated to the corporate risk register as appropriate.

6 Impact on Inequality, including Health Inequalities

6.1 As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall. These assessments focus on underlying content of targets, e.g. both smoking cessation and cardiovascular health checks are examples of specific targets related to health inequalities.

7 Involving People

7.1 This paper does not propose any strategy / policy or service change.

8 Resource Implications

8.1 There are no resource implications relating directly to the provision of this report.

Andrew Jackson
Associate Director – Strategic Planning
12 July 2012
andrew.c.jackson@nhslothian.scot.nhs.uk

Diane Stewart
Business Manager
12 July 2012
diane.stewart@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: Performance Management Scorecard
Appendix 2: HEAT Targets, Standards and other Local / National Targets reported
<table>
<thead>
<tr>
<th>HEAT Target</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAT Target</td>
<td>Target Date</td>
<td>Target</td>
<td>Lothian Performance Current Period</td>
<td>Lothian Performance Current Period</td>
<td>Assessment</td>
<td>Lead Drtr</td>
<td>Comments</td>
</tr>
<tr>
<td>Health Improvement</td>
<td>Mar-14</td>
<td>2,668</td>
<td>679</td>
<td>680</td>
<td>X</td>
<td>AKM</td>
<td>Total overweight/ obese completing programme for 2011/12 = 679. Worked with 2,964 children, mainly in primary school. In total, 2,806 completed the programme, with data entered on national Child Health Surveillance Programme - School Database.</td>
</tr>
<tr>
<td>Suicide Reduction - % of suicides per yr per 100,000 pplt</td>
<td>2013</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td>AMcM</td>
<td>No trajectory set; target is for 2012-14 rate to be less than or equal to 80% of the 2001-2003 rate.</td>
</tr>
<tr>
<td>Smoking Cessation - to deliver universal smoking cessation services to achieve at least 7,011 successful quits (at one month post quit) including 4,207 in the 40% most-deprived within-Board SIMD areas over the period 2011/12 to 2013/14</td>
<td>Mar-14</td>
<td>7,011</td>
<td>Mar-12 2,899</td>
<td>Apr-12 3,125</td>
<td>2,685</td>
<td>JF</td>
<td>Target has been simplified; data will be available for the next reporting period.</td>
</tr>
<tr>
<td>Child Fluoride Varnishing - achieve at least 60 per cent of 3 and 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td>Mar-14</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 80% are to be diagnosed while in the first stage of the disease</td>
<td>Mar-15</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td>AKM</td>
<td>Detail still being agreed with the Scottish Government</td>
</tr>
<tr>
<td>Early Access to Antenatal Care - at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation by March 2015</td>
<td>Mar-15</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Mar-15</td>
<td>5.28%</td>
<td>2.77%</td>
<td>5.91%</td>
<td>X</td>
<td>JKS</td>
<td>Performance is above trajectory for 3 weeks RTT in May. Also the 1st month where services in Lothian collectively started treatment for over 90% of patients within 5 weeks (interim target for April 2012). A detailed briefing is circulated on a monthly basis as appropriate.</td>
</tr>
<tr>
<td>Reduce Energy Consumption - % reduction year-on-year (Energy GJ)</td>
<td>Mar-15</td>
<td>3.86%</td>
<td>2.17%</td>
<td>1.99%</td>
<td>✔ ✔</td>
<td>JKS</td>
<td>Performance is above trajectory for 3 weeks RTT in May. Also the 1st month where services in Lothian collectively started treatment for over 90% of patients within 5 weeks (interim target for April 2012). A detailed briefing is circulated on a monthly basis as appropriate.</td>
</tr>
<tr>
<td>Access to Services</td>
<td>Mar-13</td>
<td>90%</td>
<td>Apr-12 71.00%</td>
<td>May-12 76.60%</td>
<td>74%</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Drug and Alcohol waiting times - 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</td>
<td>Mar-13</td>
<td>0</td>
<td>Apr-12 108</td>
<td>May-12 145</td>
<td>91</td>
<td>JKS</td>
<td>Above trajectory for the last two months. SG have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for SG QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td>Faster access to CAMHS - deliver 26 wks Referral to Treatment</td>
<td>Dec-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>JKS</td>
<td></td>
</tr>
<tr>
<td>Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Treatment Appropriate for Patient</td>
<td>Mar-14</td>
<td>1,911</td>
<td>2,051</td>
<td>2,183</td>
<td>1,952</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Attendances - rate of A&amp;E attendances per 100,000 population</td>
<td>Mar-13</td>
<td>0.26</td>
<td>Mar-12 0.32</td>
<td>May-12 0.30</td>
<td>0.32</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>MRSA / MSSA Reductions - achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MRSA) cases to 0.26 or less per 1,000 acute occupied bed days</td>
<td>Mar-13</td>
<td>0.39</td>
<td>Mar-12 0.34</td>
<td>May-12 0.30</td>
<td>0.48</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>C.diff Infections - achieve a reduction of the rate of Clostridium difficile infections in patients aged 65 and over to 0.30 cases or less per 1,000 total occupied bed days</td>
<td>Mar-13</td>
<td>5,143</td>
<td>Nov-11 5,189</td>
<td>Dec-11 5,126</td>
<td>5,248</td>
<td>AMcM</td>
<td>Monthly figures are likely to change as verification process becomes more robust.</td>
</tr>
<tr>
<td>Reduction in emergency bed day rates for patients aged 75+</td>
<td>Apr-13</td>
<td>0</td>
<td>May-12 18</td>
<td>Jun-12 18</td>
<td>24</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Delayed Discharges - no people to wait more than 28 days to be discharged from hospital into a more appropriate care setting from April 2013</td>
<td>Apr-13</td>
<td>0</td>
<td>May-12 37</td>
<td>Jun-12 46</td>
<td>n/a</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Stroke Unit - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Mar-13</td>
<td>90%</td>
<td>Feb-12 73%</td>
<td>Mar-12 84%</td>
<td>80%</td>
<td>JKS</td>
<td>Data available monthly (from SSSCA at TIS), one month in arrears. Non validated &amp; may not be complete data till following month. April/May 2012 - data is being exported to new wSSSCA system so no data available. Expecting data at the end of June.</td>
</tr>
<tr>
<td>HEAT Standard</td>
<td>Target</td>
<td>Lothian Performance Previous Period</td>
<td>Lothian Performance Current Period</td>
<td>Assessment</td>
<td>Lead Drtr</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>--------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>------------</td>
<td>----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Alcohol Brief Interventions - maintain the same total level of delivery of ABIs as under the HEAT H4 target for 2011-12 - at least 90% of delivery to be in priority settings.</td>
<td>Standard 9,938</td>
<td>2011-12</td>
<td>17,093</td>
<td>April &amp; May 2012</td>
<td>1,883</td>
<td>1,656</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer Waiting Times - 62 day referral to treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 62 days if urgently referred with a suspicion of cancer, referred through A&amp;E, or referred from one of the national cancer screening programmes</td>
<td>Standard</td>
<td>Breast 100.00%</td>
<td>2011-12</td>
<td>17,093</td>
<td>2012</td>
<td>1,883</td>
<td>1,656</td>
</tr>
<tr>
<td>Cancer Waiting Times - 31-day decision to treat to first treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat, irrespective of the source or urgency of the referral.</td>
<td>Standard</td>
<td>Breast 100.00%</td>
<td>2011-12</td>
<td>17,093</td>
<td>2012</td>
<td>1,883</td>
<td>1,656</td>
</tr>
<tr>
<td>18 weeks Referral To Treatment - 90 per cent of patients to wait no longer than 18 weeks from referral to treatment</td>
<td>Standard</td>
<td>90%</td>
<td>Apr-12</td>
<td>87.10%</td>
<td>May-12</td>
<td>87.30%</td>
<td>90%</td>
</tr>
<tr>
<td>12 week Outpatients - no patient to wait longer than 12 weeks from referral to a first outpatient appointment</td>
<td>Standard</td>
<td>0</td>
<td>Apr-12</td>
<td>4418</td>
<td>May-12</td>
<td>4601</td>
<td>0</td>
</tr>
<tr>
<td>4-hour A&amp;E - % of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&amp;E treatment</td>
<td>Standard</td>
<td>98%</td>
<td>Apr-12</td>
<td>RSE - 87.6%</td>
<td>May-12</td>
<td>RSE - 89.3%</td>
<td>98%</td>
</tr>
<tr>
<td>Dementia - number of people on QOF dementia register - improvements in the early diagnosis and management of patients with Dementia</td>
<td>Standard</td>
<td>5,795</td>
<td>Mar-11</td>
<td>6,198</td>
<td>Mar-12</td>
<td>6,465</td>
<td>5,795</td>
</tr>
<tr>
<td>GP Access - patients reporting they had GP access within 48 hours</td>
<td>Standard</td>
<td>90%</td>
<td>10/11</td>
<td>94.3%</td>
<td>11/12</td>
<td>91.8%</td>
<td>90%</td>
</tr>
<tr>
<td>GP Access - advance booking more than 2 days in advance</td>
<td>Standard</td>
<td>90%</td>
<td>n/a</td>
<td>n/a</td>
<td>11/12</td>
<td>80.6%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Assessment**

- ✓ Meets the overall target
- ✓ is on trajectory to meet, but has not yet met, the final target
- X is off trajectory
- XX Does not meet the overall target
<table>
<thead>
<tr>
<th>Other Local / National Target</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Delayed Discharges over 6 weeks (monitor nationally)</td>
<td>Ongoing</td>
<td>0</td>
<td>May-12 5</td>
<td>Jun-12 4</td>
<td>0</td>
<td>XX</td>
<td>AMcM</td>
</tr>
<tr>
<td>Total number of Delayed Discharge in Short-Stay setting (monitor locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>May-12 4</td>
<td>Jun-12 6</td>
<td>0</td>
<td>XX</td>
<td>AMcM</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 9 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Apr-12 2670</td>
<td>May-12 2671</td>
<td>0</td>
<td>XX</td>
<td>JKS</td>
</tr>
<tr>
<td>Cataract Waiting Times - max wait 12 wks outpatient and inpatient combined (Monitor Locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Apr-12 150 day cases and 10 outpatients</td>
<td>May-12 121 day cases and 98 outpatients</td>
<td>0</td>
<td>XX</td>
<td>JKS</td>
</tr>
<tr>
<td>Hip Surgery - waiting times % of Hip Fracture operations within 24 safe operating hours (Monitor Locally)</td>
<td>Ongoing</td>
<td>98%</td>
<td>Apr-12 100.0%</td>
<td>May-12 90.5%</td>
<td>98%</td>
<td>XX</td>
<td>JKS</td>
</tr>
<tr>
<td>Wait for cardiac intervention to be &lt; 15 weeks (angiography, angioplasty and CABG) (Monitor Locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Apr-12 0</td>
<td>May-12 0</td>
<td>0</td>
<td>✔ ✔</td>
<td>JKS</td>
</tr>
<tr>
<td>Audiology (Adults) - nos. waiting over 12 weeks from referral to assessment or from assessment to hearing aid fitting</td>
<td>Ongoing</td>
<td>0</td>
<td>Apr-12 16</td>
<td>May-12 139</td>
<td>0</td>
<td>XX</td>
<td>JKS</td>
</tr>
<tr>
<td>Audiology (Paediatrics) - nos. waiting over 12 weeks from referral to assessment or from assessment to hearing aid fitting</td>
<td>Ongoing</td>
<td>0</td>
<td>Apr-12 16</td>
<td>May-12 84</td>
<td>0</td>
<td>XX</td>
<td>JKS</td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in acute hospital</td>
<td>Dec-15</td>
<td>38%</td>
<td>Oct 3 2011/12</td>
<td>Oct 4 2011/12</td>
<td>40.2%</td>
<td>✔</td>
<td>AMcM</td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in community residential settings</td>
<td>Dec-15</td>
<td>39%</td>
<td>Oct 3 2011/12</td>
<td>Oct 4 2011/12</td>
<td>37.3%</td>
<td>✔ ✔</td>
<td>AMcM</td>
</tr>
</tbody>
</table>

**Assessment**

- ✔ ✔ Meets the overall target
- ✔ Is on trajectory to meet, but has not yet met, the final target
- X Is off trajectory
- XX Does not meet the overall target
HEAT Targets, Standards and other Local / National Targets reported within monthly Performance Paper

### HEAT Targets due for delivery in 2012/13

<table>
<thead>
<tr>
<th>HEAT PRIORITY</th>
<th>TARGET</th>
<th>TARGET DUE DATE</th>
<th>FREQUENCY OF DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Financial Performance</td>
<td>2012/13</td>
<td>Reported separately</td>
</tr>
<tr>
<td>E</td>
<td>Reduce Carbon Emissions and Energy Consumption</td>
<td>2012/13</td>
<td>Quarterly</td>
</tr>
<tr>
<td>A</td>
<td>CAMHS (26 weeks referral to treatment)</td>
<td>Mar 2013</td>
<td>Monthly</td>
</tr>
<tr>
<td>A</td>
<td>Drug and Alcohol treatment waiting times (3 weeks referral to treatment)</td>
<td>Mar 2013</td>
<td>Monthly</td>
</tr>
<tr>
<td>T</td>
<td>Stroke Unit</td>
<td>Mar 2013</td>
<td>Monthly</td>
</tr>
<tr>
<td>T</td>
<td>MRSA/MSSA Reductions</td>
<td>Mar 2013</td>
<td>Monthly</td>
</tr>
<tr>
<td>T</td>
<td>C. Diff Infections</td>
<td>Mar 2013</td>
<td>Monthly</td>
</tr>
<tr>
<td>T</td>
<td>Delayed Discharge (28 days)</td>
<td>2013</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

### HEAT Targets due for delivery after March 2013

<table>
<thead>
<tr>
<th>HEAT PRIORITY</th>
<th>TARGET</th>
<th>TARGET DUE DATE</th>
<th>FREQUENCY OF DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Suicide Reduction</td>
<td>2013</td>
<td>Annually</td>
</tr>
<tr>
<td>H</td>
<td>SIMD Fluoride Varnishing</td>
<td>Mar 2014</td>
<td>Monthly</td>
</tr>
<tr>
<td>H</td>
<td>Child Healthy Weight Interventions</td>
<td>Mar 2014</td>
<td>Monthly</td>
</tr>
<tr>
<td>H</td>
<td>Smoking Cessation</td>
<td>Mar 2014</td>
<td>Monthly</td>
</tr>
<tr>
<td>H</td>
<td>Detect Cancer Early</td>
<td>2014/15</td>
<td>tbc</td>
</tr>
<tr>
<td>H</td>
<td>Antenatal Access</td>
<td>Mar 2015</td>
<td>tbc</td>
</tr>
<tr>
<td>E</td>
<td>Reduce Carbon Emissions and Energy Consumption</td>
<td>2014/15</td>
<td>Quarterly</td>
</tr>
<tr>
<td>A</td>
<td>Psychological Therapies Waiting Times</td>
<td>Dec 2014</td>
<td>tbc</td>
</tr>
<tr>
<td>T</td>
<td>Accident &amp; Emergency (A&amp;E) Attendances</td>
<td>2013/14</td>
<td>Monthly</td>
</tr>
<tr>
<td>T</td>
<td>Delayed Discharge (14 days)</td>
<td>2015</td>
<td>Monthly</td>
</tr>
<tr>
<td>T</td>
<td>Emergency Bed Days for 75+</td>
<td>2014/15</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

### HEAT Standards

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>FREQUENCY OF DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Hour A&amp;E</td>
<td>Monthly</td>
</tr>
<tr>
<td>12 weeks Outpatients</td>
<td>Monthly</td>
</tr>
<tr>
<td>18 weeks referral to treatment</td>
<td>Monthly</td>
</tr>
<tr>
<td>Alcohol Brief Interventions</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Cancer Waiting Times (31 day & 62 day) | Quarterly  
---|---  
Dementia | Quarterly  
GP Access | Annually  
Sickness Absence | Reported separately  

**Other Local / National Targets routinely reported**

<table>
<thead>
<tr>
<th>TARGET</th>
<th>TARGET DUE DATE</th>
<th>FREQUENCY OF DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 weeks Inpatient / Day Case</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>4 week Diagnostic Tests (Endoscopic procedures &amp; Imaging)</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Cataract waiting times – 18 weeks</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Hip Surgery – within 24 safe operating hours</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Cardiac Intervention – less than 15 weeks</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Audiology – over 12 weeks</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Delayed Discharges – over 6 weeks</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Delayed Discharges – in short stay settings</td>
<td>Ongoing</td>
<td>Monthly</td>
</tr>
<tr>
<td>Palliative Care – deaths in acute</td>
<td>Dec 2015</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Palliative Care – deaths in community residential settings</td>
<td>Dec 2015</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for July 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 of safe and person-centred care and effectiveness measures for child and maternal health (with supporting technical appendix 1).

3.2 Over the course of the year it has been agreed that effectiveness measures for priority areas will be considered at each board meeting (diabetes, stroke, CHD, cancer, mental health and child and maternal health).

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.

3.4 This report also includes details on the recent Healthcare Improvement Scotland (HIS) review on the management of significant adverse events in NHS Ayrshire & Arran.

3.5 In the next report to the Board it is intended to incorporate the ‘Hospital Scorecard’ measures which are due to be released by the Scottish Government; this has some overlap with the current quality report core measures.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Aim/target</th>
<th>Summary Results at July 2012</th>
</tr>
</thead>
</table>
| **Safe: HSMR** | HSMR less than one.  
SPSP *national* target to reduce HSMR by 20% by December 2015. | HSMR remains stable at less than one for all three acute sites.  
Latest data from Oct-Dec 2011:  
RIE HSMR=0.82  
SJHL HSMR=0.90  
WGH HSMR=0.70  
*Figures 1a-1c.* |
| **Safe: Adverse Events** | SPSP target to reduce by 30% by December 2012. | Significant sustained reduction in adverse events – 46% from baseline (2007).  
*Figure 2*  
*Note that these data currently cover the period to March 2011; this time lag should decrease for the next report.* |
| **Safe: Hospital Associated Infection (HAI)** | HEAT targets for SABs and CDI relate to episodes/acute occupied bed days.  
HEAT target for hand hygiene is 90% compliance. Local stretch target of 95%. | S. *aureus* Bacteraemia - on HEAT target.  
*Figure 3a*  
C. *difficile* Infection – not currently on HEAT target. The underlying trend is downwards.  
*Figure 3b*  
Hand Hygiene – achieving HEAT target and local stretch target (95%). |
| **Safe: Incidents with associated harm** | Reporting of incidents with harm should not increase. | The reporting of incidents with associated harm remains stable.  
*Figure 4* |
| **Person-centred: Complaints** | National target to acknowledge 100% of complaints within 3 days and to respond to 85% of complaints within 20 days | The number of complaints are increasing – *Figure 5a.*  
3-day compliance 68%  
20-day compliance 76% (Scotland 2010-11: 67.6%)  
*Figure 5b* |
| **Person-centred: Fast frequent feedback on patient experience** | Establish and use fast frequent patient feedback to improve patient experience across NHS Lothian | Inpatient results – overall how would you rate your care you received – 98% excellent/very good/good (n=885) compared with Lothian Better Together results 88%.  
Day Case/Day Surgery – 99% (n=315) overall rating excellent, very good or good |
Figure 1a - Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – December 2011

Figure 2 - Rate of Adverse Events per 1000 patient days. November 2008 to March 2011

13 data points below baseline median = a sustained shift in the data.
New median = 28 per 1000. This is a 46% reduction from baseline

Figure 1b - Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – December 2011

Figure 3a – Progress against HEAT Target for S.aureus Bacteraemia (SAB)

Figure 1c - Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – December 2011

Figure 3b – Progress against HEAT Target for C.difficile Infection (CDI)
Figure 4: Number of incidents associated with serious harm reported per month in NHS Lothian (Apr 2010-Mar 2012)

Figure 5b – 20-Day Response Target across NHS Lothian, Quarterly (Apr 2009-Mar 2012)

Figure 5a – Formal Complaints per quarter across NHS Lothian (Apr 2009-Mar 2012)
3.6 **Person-centeredness Measures**

**Fast Frequent Feedback Patient Experience**

3.6.1 NHS Lothian has been implementing a tool to measure patient experience in adult services, at the point of discharge, with results web accessible to frontline teams within two weeks.

The overall results for rating the quality of care in inpatient wards were very positive at 98% excellent/very good/good. For day case/day surgery the overall rating was excellent/very good/good for 99%. Respondents are also asked for free text comments which are set out in Appendix 2 and illustrate both positive experience and areas for improvement.

3.6.2 The key areas for action for both inpatient and day cases/day surgery are:-

- Pain management needs to be improved with 15% of inpatients reporting being in pain "all or most of the time". 63% described pain as "moderate or severe". For Day Surgery cases 30% of patients reported moderate or severe pain.
- Quality of the food, especially at the RIE, is consistently rated as poor. Free text responses from WGH also say this.
- Responses relating to involvement in decisions and information in wards and day care need local improvement.

3.6.3 In summary, the survey tool is yielding interesting and some varying results from the large 2011 national survey. Results and information to guide improvement are available within two weeks and can be accessed locally at Charge Nurse, Chief Nurse, Director of Operations (site and speciality levels and above). Local action plans are being put in place to address areas for improvement.

3.6.4 Work to improve response rates, local distribution mechanisms, uptake of the survey tools on the NHS Lothian website, will be lead by the Divisional Nurse Director for UHD and by the Associate Nurse Director and CH(C)P Chief Nurses for other inpatient sites. Raising publicity and awareness with support from councils and public partners is being addressed via local health teams.

3.7 **Clinical Effectiveness Measures – Child & Maternal Health**

3.7.1 As per the agreed timetable, the clinical effectiveness measures for this report are for Child & Maternal Health. It should be noted that other indicators of quality and safety, for example the Confidential Enquiry into Maternal Deaths are reviewed at the NHS Board Healthcare Governance and Risk Management Committee. There is a time lag in the production of several of these data items; this report therefore covers a mix of 2010 and 2011 data.

3.7.2 The measures are as follows; several of them are influenced by a range of factors outwith the NHS:

1. Pregnancy screening: uptake rates, sensitivity and false positive rates for Down’s Syndrome screening
2. Percentage of babies born with Low Birth Weight at term
3. Caesarean section & other intervention rates
4. Perinatal mortality rates
5. Percentage of babies exclusively breast fed at 6-8 weeks
6. Percentage of children to complete all childhood immunisations at 24 months of age

1. Pregnancy screening: uptake rates, sensitivity and false positive rates for Down’s Syndrome screening

Pregnant women who book before 20 weeks are offered serum screening for Down’s syndrome. Since January 2011 women booking before 14 weeks have been offered combined ultrasound and biochemical screening. Results of these tests are combined to provide a score and there is an agreed ‘cut off’ for when screening is considered to be positive. This cut off changed (to a higher risk) of 1 in 150 in September 2011 (previously 1 in 250). Pregnant women make the decision whether or not to accept the screening test based on informed consent – as a result there are no targets for the uptake of screening.

The uptake of Down’s syndrome screening fell between 2007 and 2009 but increased substantially in 2010 (Table 2). It is likely that the uptake will increase further with the introduction of first trimester screening in 2011 (the presented data do not cover this period).

The sensitivity (detection rate) and false positive rate (percentage of women without a Down’s syndrome pregnancy with an “increased chance” result) provide a measure of the quality of the screening process. These remained at a similar level between 2007 and 2010 (three year rolling averages shown in Table 2) and were at or around the level expected for a two marker second trimester test. Both measures are expected to improve following the introduction of enhanced second trimester screening (four biochemistry markers, July 2010), first trimester combined ultrasound and biochemical screening (January 2011) and the introduction of a higher risk cut off. The data here include six months of screening using the four biochemistry markers, but do not include first trimester combined screening.

Table 2: Uptake and performance of Down’s syndrome screening (Lothian 2006-10)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Uptake</td>
<td>61.6%</td>
<td>59.6%</td>
<td>58.7%</td>
<td>66.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Sensitivity (3 year rolling average)</td>
<td>69.8%</td>
<td>61.9%</td>
<td>66.7%</td>
<td>68.5%</td>
<td>&gt;60%</td>
</tr>
<tr>
<td>False positive rate (3 year rolling average)</td>
<td>7.2%</td>
<td>6.8%</td>
<td>7.1%</td>
<td>6.9%</td>
<td>5-7%</td>
</tr>
</tbody>
</table>


The Quality Improvement Scotland (now Healthcare Improvement Scotland) standards shown in Table 2 are relevant to practice for the period covered; Lothian met the sensitivity and false positive standard for the period 2008-10 (three year rolling average).

Stricter targets will apply with the introduction of Combined Ultrasound and Biochemical Screening for which the UK National Screening committee has set an age standardised target of >90% sensitivity and <2% false positive rate. It is possible that this target will not be met without introducing an integrated test which combines first and second trimester results. That approach, however, delays the reporting of results to the woman and is not currently planned in Scotland.
2. Percentage of babies born with Low Birth Weight

Low birth weight is associated with a number of medical conditions and maternal factors. These include previous obstetric problems, hypertensive disorders, number of previous pregnancies, maternal age, socio-economic status, and smoking. Overall, preterm or low birth weight babies have higher rates of morbidity, infant mortality and disability.

Data at a Scottish and Lothian level are available for comparison up to 2010. There is no significant difference between the proportion of low birth weight babies between Scotland and Lothian, and the figures have remained stable over time (Table 3).

Figure 6 shows the rates for low and very low birth weight as a percentage of all singleton births (combined data for preterm and full term and babies) by Scottish Index of Multiple Deprivation (SIMD) for financial year ending 31 March 2010. Nationally, a mother living in an area of high deprivation is almost three times as likely to have a low birth weight baby (1500g to 2499g) compared to a mother living in an area of low deprivation. In Lothian there is not such a marked difference between the most and least deprived. The difference in the pattern by SIMD between Scottish and Lothian figures may be explained by the older age of pregnant women in Lothian compared to the national average, as increasing maternal age is a risk factor for both prematurity and low birth weight and is more likely to be associated with relative affluence.

Table 3. Births by birth weight (Scotland and Lothian 2005-10)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Scotland</th>
<th></th>
<th></th>
<th></th>
<th>Lothian</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Under</td>
<td>1500-2499</td>
<td>2500g+</td>
<td>Number</td>
<td>Under</td>
<td>1500-2499</td>
<td>2500g+</td>
</tr>
<tr>
<td></td>
<td>of births</td>
<td>1500g</td>
<td>(%)</td>
<td>(%)</td>
<td>of births</td>
<td>1500g</td>
<td>(%)</td>
<td>(%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(very low birth weight)</td>
<td>(%)</td>
<td></td>
<td></td>
<td>(very low birth weight)</td>
<td>(%)</td>
<td></td>
</tr>
<tr>
<td>2010P</td>
<td>58,356</td>
<td>1.2</td>
<td>5.8</td>
<td>92.9</td>
<td>9,245</td>
<td>1.2</td>
<td>6.0</td>
<td>92.8</td>
</tr>
<tr>
<td>2009</td>
<td>58,668</td>
<td>1.3</td>
<td>6.0</td>
<td>92.6</td>
<td>9,560</td>
<td>1.3</td>
<td>6.0</td>
<td>92.7</td>
</tr>
<tr>
<td>2008</td>
<td>58,135</td>
<td>1.4</td>
<td>5.9</td>
<td>92.5</td>
<td>9,510</td>
<td>1.2</td>
<td>5.8</td>
<td>93.0</td>
</tr>
<tr>
<td>2007</td>
<td>55,136</td>
<td>1.2</td>
<td>5.9</td>
<td>92.7</td>
<td>8,739</td>
<td>1.1</td>
<td>6.3</td>
<td>92.6</td>
</tr>
<tr>
<td>2006</td>
<td>53,092</td>
<td>1.4</td>
<td>6.6</td>
<td>92.0</td>
<td>8,480</td>
<td>1.5</td>
<td>6.5</td>
<td>92.0</td>
</tr>
<tr>
<td>2005</td>
<td>53,425</td>
<td>1.3</td>
<td>6.1</td>
<td>92.6</td>
<td>8,315</td>
<td>1.5</td>
<td>6.1</td>
<td>92.5</td>
</tr>
</tbody>
</table>

Source: ISD Scotland August 2011 (SMR02 – Maternity Inpatient and Day Case). P provisional (complete data are not yet available; the total number of births in Lothian for that period was close to 10,000 babies).
3. Caesarean section & other intervention rates

There is an increasing move to “normality” in pregnancy, including the Scottish Government/Healthcare Improvement Scotland programme Keeping Childbirth Natural and Dynamic. There is also a place for interventional delivery for the safety of mother and child.

The caesarean section (CS) rates (elective and emergency) in Lothian between 2005 and 2009 showed a slight downward trend with rates also slightly lower than the national rate. This has not continued in 2010 (provisional data, Table 4).

There is a higher usage of forceps in Lothian than in Scotland overall. This suggests that the total instrumental delivery rate is also higher in Lothian than Scotland overall. These routinely collected data do not allow an assessment of the appropriateness of delivery method overall, nor are there agreed limits for optimal practice around instrumental delivery. Nonetheless, it is reassuring that while the total instrumental delivery rate is higher than Scotland overall, perinatal mortality rates (next section) are lower than the Scottish average, though such information does not provide evidence for a causal link.
Table 4: Percentage of live births by mode of delivery (Scotland and Lothian 2005-10)

<table>
<thead>
<tr>
<th>Financial Year ending 31 March</th>
<th>Scotland % live births</th>
<th>Lothian % of live births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vacuum</td>
<td>Forceps</td>
</tr>
<tr>
<td>2010p</td>
<td>2.9</td>
<td>9.7</td>
</tr>
<tr>
<td>2009</td>
<td>3.3</td>
<td>9.7</td>
</tr>
<tr>
<td>2008</td>
<td>3.5</td>
<td>9.3</td>
</tr>
<tr>
<td>2007</td>
<td>3.7</td>
<td>8.4</td>
</tr>
<tr>
<td>2006</td>
<td>4.2</td>
<td>7.6</td>
</tr>
<tr>
<td>2005</td>
<td>4.9</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Source: ISD Scotland August 2011 (SMR02 – Maternity Inpatient and Day Case P provisional)

4. Perinatal mortality
Perinatal mortality (stillbirths and deaths in the first week of life) reflects a variety of factors including antenatal, obstetric and neonatal care and maternal risk factors such as smoking, obesity and substance misuse. Perinatal mortality rates were lower than the Scottish average in 2010 at 6.5 per 1,000 in NHS Lothian and 6.9 per 1,000 in Scotland (Figure 7).

There is regular multi-disciplinary review of perinatal deaths; with recommendations for improvements to maternity and neonatal care. Developments in pregnancy screening and health improvement (e.g. smoking cessation, maternal nutrition, weight management) would be expected to bring about further improvements in perinatal outcomes.

5. Maternal mortality
The NHS Board Healthcare Governance and Risk Management Committee has recently received a report on a cluster of seven maternal deaths that occurred between January 2011 and January 2012. The committee accepted that an appropriate review had taken place and in one case a significant incident investigation completed.
5. Breastfeeding

The national target for Exclusive Breastfeeding rates at 6-8 weeks is 33.3% for 2010/11. The NHS Lothian target is 43.7% for the same period. NHS Lothian continues to exceed the national average and remains the best performing mainland Health Board in Scotland (Figure 8).

It is important to note that as the target is a percentage, it is affected by the change in actual numbers of births. When the HEAT target was set in 2006/2007 the actual number of live births was 9,241 and in 2010/11 it had increased to 9,855 (GROS). Breastfeeding rates are affected by a number of key factors, many of which are culturally and socially dependent. NHS Lothian actions and interventions are only one component of achieving the target; while we have in place a range of evidence based interventions to enable, encourage and support women, the choice to breastfeed is an individual one.

Figure 7: Perinatal mortality rates (Lothian and Scotland, 2007-11)

![Perinatal Mortality rates](chart)

Source: General Register Office for Scotland – Vital Events

Figure 8: Percentage babies exclusively breastfed at 6-8 weeks (Scotland and Lothian 2006/7-2010/11)

![Percentage babies exclusively breastfed at 6-8 weeks](chart)

Source: Child Health Surveillance Programme - ISD Scotland (Published October 2011)
Definitions
1. Breastfeeding information is recorded at the 6-8 week review by the public health/health visitor.
2. Among participating NHS Boards, there is some variation in the timing of the 6-8 week review, although the majority of 6-8 week reviews in Scotland are carried out before babies are 9 weeks old. The maximum age limit for the 6-8 week review is recommended as 12 weeks, some effect on the reported rates as there is a known drop-off in breastfeeding rates with time.
3. The system for recording the information is the Child Health Surveillance Programme (CHSP) and the number of NHS Boards participating in CHSP has increased since 1991. The most recent Scotland data in financial year 2009/10 accounts for approximately 89% of Scotland's pre-school population.

6. Childhood Immunisations
In Scotland the target of the national immunisation programme is for 95% of children to complete courses of the following routine childhood immunisations by 24 months of age: Diphtheria, Tetanus, Pertussis, Polio, Hib, Men C and Pneumococcal Conjugate Vaccine (PCV).

An additional target of 95% uptake of one dose of Measles, Mumps and Rubella (MMR) vaccine by 5 years old (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts to reduce the number of susceptible children entering primary school.

In 2011/12, NHS Lothian exceeded the 95% target for all but one primary immunisation at 24 months; the exception was MMR1 (Lothian: 93.9%, Scotland: 94.3%)\(^1\). NHS Lothian exceeded the 95% target for MMR1 at 5 years.\(^1\) Whilst meeting the overall target, there are differences in immunisation uptake rates within Lothian; targeted interventions are in place to address this.

3.8 HIS review on the management significant adverse events in NHS Ayrshire & Arran

3.8.1 A significant adverse event can be described as an unexpected or avoidable event that could have resulted, or did result in, unnecessary serious harm or death of a patient, staff, visitors or members of the public. The review and management of these events should enable NHS boards to learn from these events in order to minimise the risk of them happening again.

3.8.2 On 21 February 2012, the Scottish Information Commissioner published a Decision Notice (036/2012) that was highly critical of NHS Ayrshire & Arran’s response to a Freedom of Information (Scotland) Act appeal. As a result, the Cabinet Secretary for Health, Wellbeing and Cities Strategy instructed Healthcare Improvement Scotland to carry out, as a matter of urgency, a review of the clinical governance systems and processes in NHS Ayrshire & Arran, in particular those that related to their management of critical incidents, adverse events, action planning and local learning.

3.8.3 The report was published on 11\(^{th}\) June 2012 and set out 25 recommendations, of which 17 are for Ayrshire & Arran, 6 are for NHS Boards and 2 are for NHSScotland. The key findings from the report are summarised below:-

- The Review Group found a lack of clarity on the lines of accountability, reporting and ownership of significant adverse event review actions and learning. We found complex and unwieldy clinical governance structures.

\(^1\) Data source: Childhood Immunisation Statistics (Accessed 29 June 2012)
The Review Group found confusion about staff understanding of the scope to share information on significant adverse event reviews and a variation in interpretation of the policy. This hampered learning and improvement.

Although the Review Group found examples of comprehensive Significant Adverse Event Review Reports there was not a robust and systematic approach to implementing action plans and monitoring progress.

The Review Group found that NHS Ayrshire & Arran had a commitment to involve patients and families and raise awareness of the need to involve families. The system that tracks and responds to issues raised by families was an area of weakness and the Review Group found an inconsistent approach was used to family involvement.

The Review Group did not find evidence of a system to identify thematic learning to allow change and improvements to clinical practice.

There is strength in the potential of AthenA (NHS Ayrshire & Arran’s electronic document management system) to support the management of significant adverse events. However, the Review Group found weaknesses in: the logging and monitoring of significant adverse events; how NHS Ayrshire & Arran connects the information systems it uses; and the level of scrutiny applied to the information within Datix.

The Review Group also found that there were weaknesses in the way decisions to undertake significant adverse event reviews were evidenced and documented.

The criteria used to decide between desktop review or full significant adverse event review were not clear and the Review Group has also highlighted the risks associated with single person desktop reviews.

Although there were examples of timely local investigation, the performance management and progress chasing against timeline targets, in general, needs significant improvement.

The Critical Incident Stress Management resource is an area of strength to be sustained and developed. (This resource supports NHS Ayrshire & Arran’s staff and provides intervention designed to prevent potentially harmful psychological reactions often associated with traumatic incidents.)

3.8.4 Key risks for NHS Lothian

Following a review of the report and the current position in NHS Lothian our key areas for further improvement are:

- Timescales to completion of investigation from reporting of incident
- Sharing and learning lessons from incidents on a pan-Lothian basis
- Closing loop on action plans to ensure completion is verified
3.8.5 Board members are asked to note that the full report relating to the HIS review and implications and learning for NHS Lothian will be covered at the next Healthcare Governance & Risk Management Committee in August 2012.

4 Key Risks

4.1 Achieving the national 3-day and 20-day response rate target for complaints and achieving HAI C-Difficile Infection (CDI).

5 Risk Register

5.1 Maintaining the national complaints targets is captured on the Risk Register under Litigation Exposures (1082) and is identified as a high risk. Achieving HAI targets is also on the Corporate Risk Register (Risk 1076).

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 Members of the public, patients and carers have been actively included in standard setting at a local and national level as part of the Fast Frequent Feedback initiative.

9 Resource Implications

9.1 Resource implications associated with this report are related to individual programmes and are being progressed through current management systems.

Dr David Farquharson
Medical Director
12 July 2012
David.farquharson@nhslothian.scot.nhs.uk
List of Appendices

Appendix 1: Technical Appendix
Appendix 2: Rapid Patient Feedback Responses
Technical Appendix

Hospital Standardised Mortality Ratio (HSMR)
HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level ‘warnings’ for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

Adverse Events
Adverse events are currently measured at the three main acute sites using retrospective case note reviews using the ‘Global Trigger Tool’. An external review by the Institute for Healthcare Improvement (IHI) in February 2010 confirmed that NHS Lothian’s case note review process was robust and set the baseline for adverse event rates at 52 adverse events per 1,000 patient days.

*S.aureus Bacteraemia (SAB)* rate
This represents a HEAT target. From April 2011, new targets were set based on Acute Occupied Bed Days (AOBD). For NHS Lothian the target is to achieve a rate of less than 0.26 episodes of SABs per 1,000 AOBD by year ending March 2013.

*C.difficile Infection (CDI)* rate
This represents a HEAT target. From April 2011, new targets were set based on Total Occupied Bed Days (OBCD). For NHS Lothian the target is to achieve a rate of less than 0.39 episodes of CDI per 1000 AOBD by March 2013.

Incidents associated with harm
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.
**APPENDIX 2**

**Rapid Patient Feedback Responses**

Mean Rating Scores – Adult In-Patient (885 patients from 59 wards, August 2011 to January 2012)

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean Rating Score</th>
<th>National Better Together 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 In your opinion, how clean is the room or ward you are in?</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Q2 How clean are the toilets and bathrooms that you are using?</td>
<td>91%</td>
<td>87%</td>
</tr>
<tr>
<td>Q3 How would you rate the hospital food?</td>
<td>63%</td>
<td>67%</td>
</tr>
<tr>
<td>Q4 Did you get help with eating your meals if you needed it?</td>
<td>71%</td>
<td>65%</td>
</tr>
<tr>
<td>Q5 When you have important questions to ask a doctor, do you get answers you can understand?</td>
<td>85%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q6 Do you have confidence and trust in the doctors treating you?</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Q7 As far as you know do doctors wash or clean their hands before touching patients?</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>Q8 When you have important questions to ask a nurse do you get answers you can understand?</td>
<td>89%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9 Do you have confidence and trust in the nurses treating you?</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Q10 As far as you know do nurses wash or clean their hands before touching patients?</td>
<td>93%</td>
<td>91%</td>
</tr>
<tr>
<td>Q11 Sometimes in a hospital, one member of staff will say one thing and another will say something quite different. Has this happened to you?</td>
<td>76%</td>
<td>85%</td>
</tr>
<tr>
<td>Q12 Are you involved as much as you want to be in decisions about your care?</td>
<td>77%</td>
<td>88%</td>
</tr>
<tr>
<td>Q13 How much verbal information about your condition or treatment has been given to you?</td>
<td>83%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q14 How much written information about your condition or treatment has been given to you?</td>
<td>67%</td>
<td>N/A</td>
</tr>
<tr>
<td>Q15 Have you been given enough privacy when discussing your condition?</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>Q16 Have you found someone on the hospital staff to talk to about your worries or fears?</td>
<td>72%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Q17 During your time in hospital, how much of the time have you been in pain? 50%  N/A
Q18 How would you describe the level of pain you experienced? 44%  N/A
Q19 Do you think staff did everything they could to help control your pain? 80%  92%
Q20 Do you feel you were involved in decisions about your discharge from hospital? 77%  N/A
Q21 Overall, do you feel you were treated with respect and dignity while in the hospital? 94%  N/A
Q22 Overall, how would you rate how well the doctors and nurses work together? 85%  85%
Q23 Overall how would you rate the care you received? 89%  88%

Day Case/Surgery Day Care Patient Experience Results – captured over 3 months (n=315)

A snap shot from the 27 questions in the survey reveals:

- The courtesy of the receptionist was rated excellent or very good by 90% of patients.
- 90% of patients said the room/ward was “very clean”.
- 2% of patients waited more than 1 hour after appointment time with considerable variations between units.
- 14% of patients wanted more verbal information at 13% more written information.
- 20% of people were in pain all or most of the time/some of the time (4% all of the time).
- 30% reported severe or moderate pain.
- Between 53% → 45% had no pain.
- 12% of patients were not told who to contact if worried about condition after left hospital.
- Overall this is a very positive set of results, with 99% overall rating excellent, very good or good (96% excellent/very good).

Examples of respondents free text comments

<table>
<thead>
<tr>
<th>Anything Particularly Good?</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lothian</td>
<td>“The food, meals very good indeed” “Kindness sympathy and understanding – Happy nurses and kind” “Have not had any written information”</td>
</tr>
<tr>
<td>Edinburgh Cancer Centre</td>
<td>“Medical treatment excellent.” “Staff at all levels are helpful, caring and generally excellent”. “The food needs drastic action”</td>
</tr>
<tr>
<td>Ward 102, RIE</td>
<td>“The nurses and doctors” “Students and domestics” “Problem solved fairly quickly” “Noise at night, pain management non-existent”</td>
</tr>
<tr>
<td>Ward 209, RIE</td>
<td>“Charge nurse very kind and efficient” “Excellent care”</td>
</tr>
<tr>
<td>Stroke Unit, SJH</td>
<td>“Thanks to the physio who gave me confidence to go on, help me walk and was behind me all the time”</td>
</tr>
<tr>
<td>Ward 23, WGH</td>
<td>“The attitude of staff was exceptional from students through to domestic staff, to nurses and doctors”</td>
</tr>
</tbody>
</table>
NHS LOTHIAN’S QUALITY IMPROVEMENT STRATEGY 2011-14

1 Purpose of the Report

1.1 The purpose of this report is to present to the Board the annual report on the implementation of the NHS Lothian Quality Improvement Strategy 2011-14.

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 progress on the implementation of NHS Lothian’s Quality Improvement Strategy (2011-14)

3 Discussion of Key Issues

3.1 The NHS Lothian Quality Improvement Strategy 2011-14 was approved by the Board in May 2011. The strategy aimed to contribute to both the National Quality Strategy (2010) and NHS Lothian’s aim to be in the top 25 healthcare systems, by demonstrating a:-

- Reduction in mortality
- Reduction in avoidable harm
- Improved patient experience
- Improved delivery of evidence-based care
- Safe reduction in costs and improve efficiency

A measurement plan formed part of the strategy for monitoring purposes.

3.2 This report provides a high level summary of progress against the above outcomes and programme-specific measures. Detailed monitoring of individual programmes continues to sit with current governance structures. The strategy is intended to be a dynamic document and some of the quality improvement programmes set within the table are in a testing phase.
3.3 The following sets out progress to delivering the high level outcomes set out under paragraph 3.1 and is described in more detail in Table 1 of Appendix 1.

3.3.1 Reduction in mortality

The Hospital Standardised Mortality Rate (HSMR) remains below one for all three acute sites and there have been reductions in HSMR at the RIE, WGH and St. John’s. Scotland is on target to meet its 15% reduction in HSMR by December 2012.

3.3.2 Reduction in Avoidable Harm

There has been a reduction across a number of measures related to this aim. This includes a 46% sustained reduction in adverse events as measured by the Global Trigger Tool in acute hospitals. There has also been an overall reduction in infection rates across NHS Lothian. A 14% reduction in inpatient falls with harm, inpatient pressure ulcers reduced by 49% for grade 2 ulcers or above and nursing medication errors reduced by 14% for inpatients in 2011/12.

3.3.3 Improved Patient Experience

Results from the Better Together Adult Inpatient Survey 2011 showed NHS Lothian to be the most improved of any mainland Board.

NHS Lothian has been implementing a tool to measure patient experience in adult services, at the point of discharge, where the results are web accessible within two weeks. The approach has been put into place to provide timely patient experience information to support continuous improvement in frontline services.

The total responses in the national Better Together survey in 2011, was 1918 compared to a cumulative total to date of the Fast Frequent Feedback tool of 1200 (885 Adult in Patient 315 day case/surgery).

The overall results for rating the quality of care in inpatient wards were very positive at 98% excellent, very good or good and also very positive for day case/day surgery with 99% overall rating as excellent, very good or good.

Local action plans are in place to address areas for improvement which include improved pain management and patient information plus examining ways to enhance response rates.

3.3.4 Improved Delivery of Evidence-based Care

There has been sustained improvement in compliance with current Health Improvement Condition and Service Standards from May 2012 baseline against June 2011 review. Examples of areas that have seen improvement are Blood Transfusion and Anaesthetics standards compliance.
3.3.5 Safe Reduction in Costs and Efficiency

Many of the improvements above contribute to delivering efficient and effective healthcare from reducing the likelihood of complaints to reducing length of stay as a result of infections, falls and a range of other adverse events.

Of the 31 wards in scope for the Older Peoples Pathway Programme, 23 have demonstrated a continued reduction in average length of stay between April 2010 and March 2012, along with an increased number of morning and weekend discharges.

Releasing Time to Care seeks to improve processes to release time from unproductive tasks and enable nurses to spend more time giving care to patients. Currently Lothian has met its target of increased average direct patient contact time by over 50% by March 2012.

3.4 Reporting, Integration and Infrastructure

3.4.1 Person-centred, safe and effective measures now routinely reported to the Board and have been subject to continuous improvement both in terms of content and presentation. Work continues with Strategic Planning and Finance to integrate the measurement framework to develop a balanced scorecard.

3.4.2 A Quality Improvement Database System (QIDS) is now in place to ensure timely frontline access to data to support local improvement, measurement and reporting, along with a ward scorecard which uses data from a range of sources such as QIDS, Datix and finance systems. This makes it easier for staff to identify areas of good practice and provide an opportunity to their learning.

3.4.3 Extensive capacity and capability building has been taking place across NHS Lothian internally and externally. Internally this has included Lean, Leading Better Care training improvement clinics, workshops and mentoring staff at frontline to support the application of newly acquired learning. Externally staff have participated in quality improvement leadership programmes such as national events, SPSP Fellowship and Improvement Advisor courses. Central to the Harvard/Napier MBA is application of continuous quality improvement against the backdrop of strategic intent. Work has been initiated through the university to increase junior doctors’ knowledge of patient safety issues and mechanisms to address them through the Patient Safety Clinical Lead.

3.4.4 A significant amount of preparatory work has been undertaken over the last six months to enhance working across a range of functions from modernisation, Continuous Personal & Professional Development, Organisational Development and Clinical Governance & Risk Management to support new ways of working with respect to capacity building from the traditional class-based provision to ward based programmes.
3.5 Improvement Programmes

A number of the improvement programme measures (see Table 2 in Appendix 1) have met improvement goals or testing schedule.

Areas that are not on trajectory/schedule such as compliance with stroke standards and the management of the Deteriorating Patient have plans in place to rectify this current position. Plans are also in place to sustain falls reduction by the implementation of Care Rounding which is summarised below. The Compassionate Care and Patient Safety in Primary Care programme have been subject to evaluation which will be reported in detail at the HCGRM Committee.

3.6 New Improvement Plans and Goals/Targets

3.6.1 The new health improvement targets are informed by the 2012/13 HEAT targets and are set out below:-

- New 2012/13 - NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three established settings (primary care, A&E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.
- Reduce suicide rate between 2002 and 2013 by 20%.
- To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014.
- New 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.
- 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.

3.6.2 Delivering Better Care Targets

Building on achievements in 2011/12, the 2012/13 improvement plan for Nursing and Midwifery Care focuses on harm reduction, processes improvement underpinned by emerging patient policy and diversity and individual accountability for staff. The 2012/13 targets/goals are set out below:-

The focus for Harm Reduction remains unchanged but with some alteration in the desired outcomes. During 2012/13 the aims are to have:-

1. Zero avoidable hospital acquired pressure ulcers, grade 2 and above by March 2014 (From one a day to none a day). 20% reduction in pan-NHS Lothian inpatient falls and associated harm by March 2013
2. Increase direct patient care time to 55% in all inpatient areas by March 2013. Establish a baseline for direct patient care time in Community and Mental Health services.
3. 100% compliance with nutritional assessment within 24 hours of admission by March 2013
4. 10% reduction in all nursing and midwifery medication administration errors by March 2013
5. To have in place Care Rounding across NHS Lothian by March 2013. This structured approach aims to deliver timely, person-centred care. It is anticipatory and focused on essential aspects of patient comfort and safety. Its introduction across all inpatient areas will help achieve the harm reduction outcomes, particularly with respect to inpatient falls and pressure ulcer prevention, as well as improving the organisation and documentation of care.

3.6.3 Lean in Lothian 2012/13

NHS Lothian is currently developing its overall Clinical Strategy for service change to deliver the Scottish Government’s vision for health and healthcare by 2020. This will inform the Lean programme workplan.

Projects already agreed and underway in 2012/13 include:-
- HSDU process improvement
- RIE pharmacy aseptic workflow
- Supporting redesign of the RIE acute medical assessment model for Winter 2012
- Medication prescribing pathways at Edinburgh and Addiewell prisons
- Improving complaints response time

3.6.4 Patient Safety Programme

There are new workstreams for the Patient Safety Programme which are in the testing phase and have a measurement plan:-
- Venous Thrombotic Embolism prevention
- SEPSIS prevention programme
- Mental Health
- Maternity Services

In addition, the Patient Safety in Primary Care programme is spreading the Warfarin management bundle across General Practices in Lothian as part of a Scottish Enhanced Service Programme.

3.6.5 The above 2012/13 new targets/goals and supporting QI programmes will be incorporated into this strategy document and measurement framework.

4 Key Risks

4.1 Introducing new improvement programmes before robust testing and fully integrating and embedding current programmes, may impact negatively on a range of outcomes.
5 Risk Register

5.1 The QI programmes set out in the QI Strategy seek to mitigate a range of risks described in both the corporate and operational risk registers.

6 Impact on Health Inequalities

6.1 The improvement programmes within the strategy have undergone a Rapid Impact Assessment.

6.2 The final strategy was strengthened by the inclusion of a section on enhancing the use of equality and diversity data to improve service interventions and longer term aims of increasing health outcomes.

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 Patients, staff and carers are involved in a range of activities set out in this strategy.

9 Resource Implications

9.1 The resource implications are associated with a range of programmes set out in the strategy and are being examined through the current reporting structures for each individual programme.

Jo Bennett
Clinical Governance & Risk Manager
10 July 2012
Jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: System & QI Programme Measures Progress Reports
# System & QI Programme Measures

## Appendix 1

### Table 1

<table>
<thead>
<tr>
<th>System Measures</th>
<th>Goal/Target</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person-Centred</strong>&lt;br&gt;1. Complaints *</td>
<td>Achieve an average 20 day response time in 85% of complaints *&lt;br&gt;Achieve 100% compliance in response to all formal complaints within 3 working days</td>
<td>Not met. 76% Jan-Mar 2012&lt;br&gt;Not met. 68% Jan-Mar 2012</td>
</tr>
<tr>
<td><strong>Safe Care</strong>&lt;br&gt;3. Hospital Standardised Mortality Ratio (HSMR)</td>
<td>To achieve a 15% reduction in HSMR against 2006/07 baseline by Dec 2012 for Scotland</td>
<td>On trajectory for national target to be met. Latest HSMR figure is (Oct-Dec 2011) RIE (-7.3%), WGH (-5.9%) &amp; St. John’s (-3.8%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Adverse Events</th>
<th>To achieve a 30% reduction in adverse events by Dec 2012</th>
<th>Met target. 46% sustained reduction.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Incident Reports</td>
<td>To allow monitoring of incidents and associated harm across the organisation including specific QI programmes, e.g. Falls</td>
<td>On schedule</td>
</tr>
<tr>
<td><strong>6. Healthcare Associated Infection</strong></td>
<td>Reduce healthcare associated infections so that by March 2013, NHS Boards’ <em>staphylococcus aureus</em> bacteraemia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days&lt;br&gt;Reduce the rate of <em>clostridium difficile</em> infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days by March 2013&lt;br&gt;Local target - 95% compliance with hand hygiene. (National Target 90%)</td>
<td>On trajectory to meet target&lt;br&gt;On trajectory to meet target&lt;br&gt;Met target. Current position 96%</td>
</tr>
<tr>
<td>7. Clinical Effectiveness &amp; Efficiency</td>
<td>Rolling programme of clinically specific system levels to be reviewed to ensure compliance with relevant HIS standards and identify variation and where appropriate ensure action plans.</td>
<td>On schedule. Improved compliance with HIS standards.</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>QI Programme Measures</th>
<th>Goal/Target</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8. Health Improvement</strong>&lt;br&gt;8.1</td>
<td>To provide alcohol brief intervention to 23,594 by March 2011. <strong>New 2012/13 - NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three established settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</strong></td>
<td>Met target. To be replaced with 2012/13 target.</td>
</tr>
<tr>
<td><strong>8.2</strong></td>
<td>50% of frontline staff to have undergone suicide prevention training by Dec 2010. <strong>New 2012/13 - Reduce suicide rate between 2002 and 2013 by 20%.</strong></td>
<td>Met target. To be replaced with 2012/13 target.</td>
</tr>
</tbody>
</table>

---

7
<table>
<thead>
<tr>
<th>QI Programme Measures</th>
<th>Goal/Target</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.3</strong> To achieve 879 children (5-15yrs) successfully comply with child health weight intervention programme by March 2011. <strong>New 2012/13</strong> - To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014.</td>
<td>Met target. To be replaced with 2012/13 target.</td>
<td></td>
</tr>
<tr>
<td><strong>8.4</strong> 8% of smoking population successfully quit at one month by March 2011. <strong>New 2012/13</strong> - 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.</td>
<td>Met target. To be replaced with 2012/13 target.</td>
<td></td>
</tr>
<tr>
<td><strong>8.5</strong> HEAT 33.3% local. 43.7% of babies exclusively breast fed at their 6-8 week review. <strong>New 2012/13</strong> - 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.</td>
<td>Met target. To be replaced with 2012/13 target.</td>
<td></td>
</tr>
<tr>
<td><strong>8.6</strong> 60% of 3 and 4 year olds in each SIMD quarter received fluoride varnishing twice a year by March 2014 (new).</td>
<td>Issues regarding collection and reporting of data; working with ISD and Scot Gov</td>
<td></td>
</tr>
<tr>
<td><strong>8.7</strong> 95% at 5 years old have immunisations on an ongoing basis</td>
<td>Met target</td>
<td></td>
</tr>
<tr>
<td><strong>8.8</strong> 90% of inpatients and outpatients records state patient ethnicity by April 2012 *</td>
<td>Target met by April 2012.</td>
<td></td>
</tr>
<tr>
<td><strong>8.9</strong> 100% of actions identified in equality impact assessments are completed within 6 months by June 2012.</td>
<td>Target met by April 2012. 100% of achievable actions completed within 6 months</td>
<td></td>
</tr>
<tr>
<td><strong>10. Liverpool Care Pathway (LCP)</strong></td>
<td><strong>10.1</strong> 50% of all expected deaths, where LCP has been implemented, to have an LCP, in place to support end of life care (LUHD, CHCPs and LHPs) *</td>
<td>UHD: Target exceeded 2010-2012: post-implementation = 84% of all expected deaths on LCP. Further one year on in phase 1&amp;2 areas (Oncology, MOE, SJH) 78% expected deaths</td>
</tr>
<tr>
<td>QI Programme Measures</td>
<td>Goal/Target</td>
<td>Current Position</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>10.2</strong> Attitudes and perceptions of the impact of the LCP on clinical practice and end of life care will be sought from nursing and medical staff in a questionnaire one year post-introduction by end 2012. Target response rate 50% *</td>
<td>Questionnaire to LUHD phase 1 areas issued Nov 2011; positive feedback re impact on practice and patient care. Questionnaire to phase 2 areas planned for July 2012.</td>
<td></td>
</tr>
<tr>
<td><strong>10.3</strong> Implement the LCP within all relevant ward areas in UHD (n=83) by Dec 2012.</td>
<td>Target met- 78% to April 2012-06-15 On track for completion by Dec 2012.</td>
<td></td>
</tr>
<tr>
<td><strong>10.4</strong> Implement the LCP in all CHCPs (Hospitals n=7, GP clusters n=33) and Edinburgh LHPs (GP clusters n=13) by March 2012.</td>
<td>Targets met for 2011.</td>
<td></td>
</tr>
<tr>
<td><strong>10.5</strong> A minimum of 80% of RNs and CSWs to have undergone training prior to documentation being released on the LCP in all implementing areas * (+1 GP in CHCPs &amp; LHPs)</td>
<td>Target exceeded in 2010-12 80-100% achieved per area.</td>
<td></td>
</tr>
<tr>
<td><strong>11.1</strong> Ventilator Associated Pneumonia: 0 or 300 days between</td>
<td>Not met on all sites.</td>
<td></td>
</tr>
<tr>
<td><strong>11.2</strong> Central Line Blood stream Infection: 0 or 300 days between</td>
<td>Met.</td>
<td></td>
</tr>
<tr>
<td><strong>11.3</strong> Blood Sugars within range (ITU/HDU): 80%</td>
<td>Met.</td>
<td></td>
</tr>
<tr>
<td><strong>11.4</strong> MRSA Bloodstream Infection: 50% reduction</td>
<td>See HAI targets.</td>
<td></td>
</tr>
<tr>
<td><strong>11.5</strong> 30% reduction in cardiac/respiratory arrests</td>
<td>Not met. Behind schedule.</td>
<td></td>
</tr>
<tr>
<td><strong>11.6</strong> Harm from Anti-coagulation: 50% reduction in adverse drug events</td>
<td>Met in pilot site. Spread plan in development.</td>
<td></td>
</tr>
<tr>
<td><strong>11.7</strong> Surgical Site Infections: 50% reduction</td>
<td>Not met. Based on surveillance data. Currently 32%.</td>
<td></td>
</tr>
<tr>
<td><strong>12.1</strong> Reduction in the number of patients on Warfarin who have an INR of over 5 by 30% by 2012 *</td>
<td>Bundle compliance improved. No significant reduction in INR over 5. Reduced variation in no INR tests which reduced overall number per patient.</td>
<td></td>
</tr>
<tr>
<td><strong>12.2</strong> Improvement patient safety culture to baseline by 2012.</td>
<td>NES external evaluation showed improvement in patient safety culture.</td>
<td></td>
</tr>
<tr>
<td><strong>12.3</strong> Increased patient involvement at practice and programme teams by 2012.</td>
<td>Significant increase in patient involvement at practice level.</td>
<td></td>
</tr>
<tr>
<td>QI Programme Measures</td>
<td>Goal/Target</td>
<td>Current Position</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>14. Falls prevention and management programme</strong></td>
<td>20% reduction in inpatients falls and associated harm by May 2012. <strong>Target extended to March 2013.</strong></td>
<td>14% 2011/12</td>
</tr>
</tbody>
</table>
| **15. Lean in Lothian Programme Stroke & Older People’s Care Pathways 2011/12. New programme 2012/13 to replace 2011/12 programme** | **Stroke**  
15.1 60% admitted to a Stroke Unit on admission day (Day 0)  
15.2 80% admitted to a Stroke Unit within 1 day of admission (Day 1). **New target 90% by March 2013 (HEAT target)**  
15.3 100% swallow screen on day of admission (Day 0)  
15.4 80% Brain scan on day of admission (Day 0)  
15.5 100% Aspirin (ischaemic stroke) within 1 day of admission (Day 0)  
15.6 Neurovascular clinic available within 7 days  
15.7 Thrombolysis – 5 patients treated per 100,000 population per year  
15.8 Thrombolysis – door to needle time =<60 minutes – 80%  
15.9 Carotid Intervention – 80% undergoing carotid endarterectomy for symptomatic carotid stenosis have the operation within 14 days of most recent stroke event | Not met  
Met interim target (2012), but meeting future trajectory will be a challenge.  
Not met.  
Not met, currently achieving 74%.  
Not met, but clinical judgement used for alternative medication  
Met  
Not met  
No data available until summer/ autumn 2012 |
| **Older People’s Discharges before 11am:**  
15.10 40% of listed wards discharged before 11am. | Average number of discharges has increased |
| **Weekend discharges:**  
15.11 15% of discharges from wards at weekends | Average number of monthly discharges increased by 4 and weekend discharges at Roodlands from 6 in July 2011 to 30 in March 2012.  
23 of 31 wards sustained reduction in average length of stay |
| 15.12 Reduction in acute ward stay in MoE wards. | Met target March 2012 |
| **16 Releasing Time to Care** | Increase direct patient/client contact time by over 50% by end of 2012, extended to March 2012. **New 2012/13 target – 55%** | Met target March 2012 |
| **17 Delivering Better Care** | • 17.1 25% Reduction in pressure ulcers by March 2012. **New target is for zero pressure ulcers by March 2014.**  
• 17.2 95% compliance with protected meal time policy by March 2012. **New target of 100% compliance with nutritional assessment within 24 hrs of admission by March 2013.**  
• 17.3 100% compliance with 3 national clinical quality indicators. Met. To be reviewed and replaced with 2012/13 DBC targets. - **Completed**  
• 17.4 15% Reduction in nursing medication administration errors by March 2012. **New target– 10% reduction in all nursing and midwifery medication administration errors by March 2013** | Monitored through CQI. Met target  
Met target  
14% reduction on 2011/12 |
<table>
<thead>
<tr>
<th>Qi Programme Measures</th>
<th>Goal/Target</th>
<th>Current Position</th>
</tr>
</thead>
</table>
| 18 Compassionate Care Outcomes | - Staff involved in Compassionate Care Programme reported:  
  o Staff felt able to challenge poor practice  
  o Staff felt empowered and motivated to take forward change  
  o Staff actively gave specific positive feedback to colleagues  
  o Staff asked patients more direct questions such as ‘what matters to you while you are in hospital?’  
  o Patients felt more involved in decisions about care  
  o Relatives felt more supported and ‘kept in the loop’  
  o Patients and families were involved in service development  
  o Greater awareness of language that promotes person-centredness and dignity, e.g. inappropriate use of terms such as ‘boarders’, ‘feeders’ and ‘wanderers’. | Met agreed outcomes |
THE ROLE OF THE BOARDS IN QUALITY AND SAFETY
NHS LOTHIAN ACTION PLAN

1 Purpose of the Report

1.1 The purpose of this report is to set out NHS Lothian’s action plan to enhance the Board’s governance role in quality and safety.

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

2 Recommendations

The Board is recommended to:

2.1 To review NHS Lothian’s position with respect to actions identified at the recent national Board on Board event in February 2012.

2.2 To support planned areas of development and identify additional areas for ongoing development to enhance the Board’s governance role in quality and safety.

3 Discussion of Key Issues

3.1 The first Boards on Board two-day event was held in January 2011 and over 100 Executive and non-Executive Board members attended. The discussions identified that for effective quality improvement to be sustained, Board members should be able to:

• Align local policy and strategy for quality improvement to national priorities for improvement;
• Demonstrate commitment to a focus on quality across the organisation;
• Understand the business case for service improvement;
• Demonstrate knowledge of the science for improvement and its application to supporting improved quality of service;
• Promote a culture of continuous quality improvement across the organisation.

3.2 A follow-up event was held in February 2012 to share experience and to set new development goals. Executive teams were also asked to:

• Reflect on experience and celebrate progress to date in leading for quality and safety.
• Share experience about the role of the Boards in creating high-performing, learning organisations.
• Consider learning opportunities already available, and identify ongoing support required to fulfil the Board governance role in quality and safety.
• Consider further the effective use of existing improvement experts, for example Improvement Advisors and SPSP Fellows.

3.3 135 delegates from across NHSScotland attended the February 2012 event. From NHS Lothian Board, three non-executive directors attended plus the Nurse and Medical Directors.

3.4 At this event in February, delivered in collaboration with the Scottish Patient Safety Programme (SPSP), NHS Education for Scotland, the Institute for Healthcare Improvement (IHI) and other NHSS partners, Board teams were asked to develop action plans, detailing how they planned to take forward the quality and safety agenda.

3.5 A summary of agreed actions resulting from this event has been compiled by HIS within the context of key themes. HIS has asked NHS Boards to review their performance following the Boards on Board event against the agreed actions and themes set out in Appendix 1.

3.5.1 The Appendix 1 table has been populated with NHS Lothian’s current position and proposed plans for review, discussion and identification of additional areas for ongoing development.

3.6 The next whole country learning session will be held at the Glasgow SECC on 8th & 9th November 2012. The aim of the event is to summarise achievements in mortality and harm reduction to date. To prepare NHSScotland to deliver high impact interventions that will support the delivery of the Acute Scottish Patient Safety Programme outcome measures to reduce mortality by 20% and achieve 95% harm-free care by the end of 2015.

4 Key Risks

4.1 Active engagement of the Board in this agenda which is being led by the Scottish Government and partners on behalf of the Cabinet Secretary.

5 Risk Register

5.1 No current implications for NHS Lothian’s Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 This is a report of actions designed to improve patient safety. Systematic implementation of best practice will contribute to reductions in the level of adverse events in healthcare which have a disproportionate impact on the health of patients who are already deprived, disabled or disadvantaged in some other way.
6.2 It is likely that the proposals in this paper will have an impact on inequality. A full impact assessment is planned to take place once the plan is finalised in order that the positive impacts arising from this plan may be maximised.

7 Involving People

7.1 This paper contains no proposals relating to strategy, policy or service change.

8 Resource Implications

8.1 There are no known resource implications contained in this paper.

Jo Bennett
Clinical Governance & Risk Manager
10 July 2012
Jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: The Role of the Board in Quality & Safety Action Plan
<table>
<thead>
<tr>
<th><strong>Element</strong></th>
<th><strong>NHS Lothian Position</strong></th>
<th><strong>Proposed Plans</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation of the Quality Strategy</td>
<td>The organisation will review their induction process, linking their board strategy and vision more closely with the Scottish Government Quality Strategy Aims and Ambitions, and with. The organisation will involve Board members in the shaping of the vision and the plan for implementing the Quality Strategy. Consider how they can influence the development of policy, strategies and services more effectively.</td>
<td>• The Board has dedicated a development day on NHS Lothian’s Quality and Safety aims within the context of the Quality Strategy’s ambitions. This included consideration of Executive and Non-Executive role, responsibilities and direction of travel. • NHS Lothian’s HR &amp; OD Strategy has Delivering Quality as a key tenet along with Living Values and Engaging Leadership, all of which are required to deliver the National Quality Strategy ambitions. • NHS Lothian is developing a clinical strategy which will provide a framework for all its strategic activities. The strategies within the Board will clearly contribute to the Clinical Strategy’s outcomes which will be aligned with the NHSScotland Quality Strategy. • Consider a briefing session for new non-Executives on the role of non-Executives in taking forward the quality and safety agenda. • To ratify the Clinical Strategy and implement its delivery plans through NHS Lothian Service Redesign Committee.</td>
</tr>
<tr>
<td>2. Board Commitment to the Quality Improvement Agenda</td>
<td>The organisation will review their improvement priorities and allocate new responsibilities to support the delivery of work relating to these priorities. The organisation will make clear their commitment to quality improvement within their strategic or Board vision and ensure this is included in all Board discussions and is integral throughout the organisation. The organisation will improve the profile and understanding of the meaning of ‘Quality’ and to ensure that there is increased focus on quality improvement. The organisation will refresh their approach to quality and safety and develop a strategic approach to this work. Re-structure their Board meeting agenda</td>
<td>• In response to the Quality Strategy NHS Lothian has developed its Quality Improvement Strategy which was approved by the board in November 2011. The Quality Improvement Strategy defined quality as improved patient experience and outcome of care and set out high level aims, which are:- o Reduction in mortality o Reduction in adverse events o Improved patient experience o Improved evidence-based care o Safe reduction in costs and improved efficiency • The strategy also has within it programmes/goals which include Releasing Time to Care, SPSP and Lean in Lothian; all of which have capacity and capability building as a core component. • The Quality Improvement Strategy (2011-14) is a live document and now has in place new goals for delivery in 2012/13 which include:- o HEAT Health Improvement Targets o Further reductions in inpatient falls with harm and pressure ulcers, plus reduction in nursing medication errors o Lean in Lothian 2012/13 programme in place • Development of Corporate level dashboards to support decision-making in Board committees within the context of the Quality Strategy</td>
</tr>
</tbody>
</table>
| to focus on patient safety and quality | • The first annual report on the implementation of the Quality Improvement Strategy (2011-14) is to be presented to the Board at the July meeting. This is a living document and is reviewed and updated dependant on local and national priorities.  
• A Quality Report is a standing item on the Board agenda which provides a suite of measures at system level to assure the quality of care in NHS Lothian. This report is to be further enhanced to include measures not currently reported that are included in the Hospital Scorecard.  
• NHS Lothian is progressing actions identified by the Management and Culture Report.  
• The Board has commissioned an organisation-wide improvement programme with the aim of improving patient experience through better staff attitudes, behaviour and communication and an outcome of person-centred, caring and responsive services.  
• The action plan includes:-  
  o Define our values: safe, effective, person-centred?  
  o Engage with staff: develop simple statements of values and behaviours, applicable to all  
  o Executive leadership workshop: leading by example  
  o Embed in recruitment, induction, staff development, leadership competencies, performance management processes  
  o Continually reinforce through communications – internal and external – to staff and patients  
  o Provide accessible training and support in customer service, communication and giving, receiving, hearing and acting upon feedback – for all staff (start with senior staff)  
• NHS Lothian is reassessing the relevance/appropriateness of the top 25 ambitions. | (2010). This will be informed by the work relating to Board committee assurance requirements.  
• Implement the actions to address issues identified by the Management and Culture report. This would include the implementation of the 5x5x5 workstream on improving patient experience through better staff attitudes, behaviours and communication. |
### 3. Building Capacity and Capability

<table>
<thead>
<tr>
<th>The organisation will consider the capacity in their own areas for delivering Quality Improvement, by mapping capability and reviewing future education needs at every level.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation will consider how to link quality improvement programmes to workforce statistics and development plans.</td>
</tr>
<tr>
<td>Conduct a review of learning and education strategies in relation to quality improvement, and how this can be linked to the workforce development strategy.</td>
</tr>
<tr>
<td>Develop improvement groups to coordinate and prioritise improvement activity and provide support.</td>
</tr>
<tr>
<td>Review how to use staffs that are trained in Quality Improvement.</td>
</tr>
<tr>
<td>Consider how to include Quality Improvement as a core element of job descriptions and reviews for all levels of staff.</td>
</tr>
<tr>
<td>Review current use of SPSP Fellows and how to support those who have training in improvement methodology to work with the Board to deliver key quality objectives.</td>
</tr>
<tr>
<td>Map out the level of quality improvement understanding required at all levels of the organisation.</td>
</tr>
</tbody>
</table>

- **NHS Lothian through its committee structures assessed each committee’s assurance requirements including measurement frameworks to inform work on corporate dashboards.**

- **A central component of the Quality Improvement Strategy is the enhanced reporting, integration of programmes and infrastructure including capacity building. This includes explicit training and development of aligned educational programmes supported by improvement groups who co-ordinate and prioritise improvement activity.**

- **A hub of Fellows and Improvement Advisors has been put in place, led by the Clinical Lead for Patient Safety, to support the improvement programmes, matching skills and expertise to the work programmes to enable delivery of improvement programmes set out in the Quality Improvement Strategy.**

- **A significant amount of preparatory work has taken place over the last six months to enhance working across a range of functions from Modernisation, Continuous Personal & Professional Development, Organisational Development and Clinical Governance & Risk Management to support new ways of working with respect to capacity building from traditional classroom based programme to ward based programmes that involve coaching and mentoring.**

- **Extensive capacity and capability building has been taking place across NHS Lothian internally and externally. Internally this has included Lean, Leading Better Care training improvement clinics, workshops and mentoring staff at frontline to support the application of newly acquired learning. Externally staff have been released and participate in quality improvement leadership programmes such as national events, SPSP Fellowship and Improvement Advisor courses. Central to the**

- **Further development of Quality Improvement Teams both in terms of alignment with management structure and to support clinical service to deliver person-centred high quality care.**

- **Deliver integrated educational programmes to support harm free care with respect to Care Rounding, Release Time to Care and the Patient Safety Programme. A core component of all training through CPPD and clinical skills will be the Model for Improvement to support continuous improvement in frontline teams. This will include new ways of capacity building through coaching and mentoring for improvement.**

- **Deliver an educational programme for junior doctors with a focus on safety and service reliability.**

- **Embed the Fellows and Improvement Advisers Hub to maximise skills and expertise.**

- **Map out the quality improvement understanding at all levels of the organisation.**
Harvard/Napier MBA is application of continuous quality improvement against the backdrop of strategic intent. Work has been initiated through the university to increase junior doctors' knowledge of patient safety issues and mechanisms to address them through the Patient Safety Clinical Lead.

| 4. Patient and Relative Involvement | The organisation will increase the involvement of relatives in patient care. | The Compassionate Care Programme in Lothian has been subject to an evaluation which reported the following outcomes:-
- Staff felt able to challenge poor practice
- Staff felt empowered and motivated to take forward change
- Staff actively gave specific positive feedback to colleagues
- Staff asked patients more direct questions such as ‘what matters to you while you are in hospital?’
- Patients felt more involved in decisions about care
- Relatives felt more supported and ‘kept in the loop’
- Patients and families were involved in service development
- Greater awareness of language that promotes person-centredness and dignity, e.g. inappropriate use of terms such as ‘boarders’, ‘feeders’ and ‘wanderers’.

A central component of this work is creating an active dialogue between patients/relatives and staff.

- Patient stories have been used at the HCGRM Committee.
- Lothian has put in place fast frequent feedback and acting on feedback from patients.

| 5. Non-Executive Involvement | The organisation will look at ways to better utilise the wealth of knowledge held by Non-Executive directors. | Non-Executive currently not on SPSP Non-Executive Walkrounds.

For the Non-Executives to consider how they wish to utilise their wealth of knowledge and get involved in SPSP leadership walkrounds.

- For the Board to examine how it wishes to hear the patients’/families’ voice.
- To examine how to increase the use of patient stories through governance committees throughout the organisation harnessing the experience of the Compassionate Care programme.
| 6. Middle Management Engagement | Consider how to improve engagement with middle managers in the quality improvement agenda. | • NHS Lothian’s middle managers play an active role in quality improvement programmes and have a range of opportunities to engage: - o Napier/Harvard MBA o Lean in Lothian programme o New programmes for Clinical Nurse Managers being developed by Organisational Development | • Part of the mapping out of levels of quality improvement set out under item 3 would include middle management requirements. |
| 7. Understanding and Using Data | Utilise Quality Improvement leads to increase understanding of improvement data presented at Board level. Consider how to most effectively review the data presented at Board meetings. Board members should consider attending learning/education sessions to gain further understanding of data for improvement. The Board will support the improvement of data quality which should then result in improved confidence in reporting. Implement mechanisms for staff to have conversations about variation within a number of different forums, and for data on variation to be presented to the Board on a regular basis. | • The Quality Report is presented at each Board. The ‘core’ measures Healthcare Associated Infection (HAI), adverse events and Hospital Standardised Mortality Rate (HSMR) presented in the NHS Lothian Quality Improvement Report are already aligned with the Quality Strategy level 1 measures. Similarly, HSMR, HAI, complaints and incidents also feature in the draft NHS Scotland Quality Strategy measurement plan which is still in the evolutionary stage (but is likely to span 1-3 SG measurement framework) • In addition to the core measures we have agreed with clinical and management colleagues a small number of systems level clinical effectiveness measures across a pathway of care are reported to the board as a rolling programme. These include Cancer, Coronary Heart Disease, Stroke, Diabetes, Mental Health and Child & Maternal Health. • A Quality Improvement Database System (QIDS) is now in place to ensure timely frontline access to data to support local improvement, measurement and reporting, along with a ward scorecard which uses data from a range of sources such as QIDS, Datix and finance systems. This makes it easier for staff to identify areas of good practice and provide an opportunity to their learning. | • Fully implement Ward Scorecard and use service to Board data to enhance the Board’s quality reporting through Corporate Dashboards. This would include embedding the Quality Improvement Database. This work will provide easily accessed data on operational performance within the context of quality and safety. |
8. Adverse Events/Incidents

| Improve reporting processes surrounding these events, in particular the reporting process to senior staff. |
| Boards to put in place action plans to ensure that a systematic process is in place. |

9. Serious Adverse Events

| Mechanisms are in place to ensure learning by the Board, executive leadership, Area Clinical Forum, and across the organisation. |
| Ensure measurement systems are in place to assess the impact of communication, disclosure, and support on premiums, claims, cases, and payments. |
| Review processes and policies surrounding reviews of these events, to clarify roles, and improve processes surrounding communication with patients and families and how non-executives are informed. |
| Develop a consistent and proactive response to significant events. |
| Develop a Significant Event Response Bundle, use the Institute for Healthcare Improvement white paper on Respectful Management of Adverse Events as a basis for developing this. |
| Develop guidance on the role of the Board in Serious Adverse Event Reviews. |
| Ensure a process to feed back findings and action plans from Adverse Event Reviews to Board and Clinical Governance committees. |

- NHS Lothian’s Incident Management Policy and Procedure were developed based on best practice. This included the framework of the IHI Respectful Management of Serious Clinical Adverse Events Report (2011) and the National Patient Safety Agency National Framework for Reporting & Learning from Serious Incidents Requiring Investigation, and set within the context of effective governance.
  - Significant changes/additions were made to the new policy and procedure in June 2011 which acknowledged some of the weaknesses in the NHS Lothian system and are reflected in the Ayrshire & Arran review. These include:-
    - Lead Acute Director and CH(C)P General Managers is more clearly articulated.
    - Family liaison
    - Significant Adverse Events are signed-off by Chief Operating Officer and CH(C)P General Manager with final review and agreement by Medical and Nurse Director (submitted on a monthly basis)
  - The NHS Lothian approach to incident investigation was reviewed and developed based on a more rigorous and prescriptive evidence-based approach (London Protocol, Taylor-Adams, Vincent 2004). This led to Root Cause Analysis training being replaced by incident investigation training to support implementation of policy and procedure. This includes a standardised reporting template.
  - NHS Lothian has standard clinical documentation for incident investigation for Significant Adverse Events (SAEs) all of which are subject to a full investigation (NHS Lothian does not undertake table-top investigations for SAEs which was an option in Ayrshire & Arran). The completed reports and implementation plans are attached on the Datix Notepad to maintain confidentiality and provide ease of access. A bi-annual peer review of SAEs.

- Within the context of the current position and the findings of the Ayrshire & Arran report, the following is planned:-
  - A review of how NHS Lothian identifies thematic learning from significant adverse events (incidents and adverse events reviews) to support change and improvement in clinical practice.
  - A review of how NHS Lothian tracks and responds to issues raised by families, to ensure a robust process is in place as part of the overall management of SAEs.
  - Bi-annual review of SAEs to assess compliance with policy and sharing of learning across the system.
  - An external review of our Datix system against UK best practice to ensure ease of use and capture of themes at a local and system level has been commissioned.
  - The development of a Datix LearnPro module on incident investigation training. Its focus will be on the importance of incident reporting, the investigation process (including involvement of relatives) and escalation.
  - Scoping exercise to see how we can link claims/litigation/complaints and incidents to further identify themes and inform improvement plans.
  - Examine the Ayrshire & Arran approach to supporting staff to
has been initiated to examine compliance with the incident investigation policy and procedure and to share learning.

- SAEs are monitored and reported weekly through the senior management structure and escalated in line with the escalation and communication algorithm. All completed SAEs are submitted to the Nurse and Medical Directors on a monthly basis. The Board as part of a quality report are informed of trends in incident reporting and those with harm. More detailed reports are considered through clinical governance structures.

- The Incident Management Policy and Procedure has Key Performance Indicators (KPIs) which form part of the Incident Management Policy monitoring process and are reported through governance structures as part of the incident reporting. For SAE, the KPI is to complete the review by 60 days. Current performance is 80%.

- Adverse Event Casenote Reviews - NHS Lothian incident report process seeks to detect adverse events or safety incidents using voluntary reporting methods. It is, however, estimated that only 10 to 20% of incidents are reported this way; of these nine out of ten cause no harm. To enhance incident reporting NHS Lothian through the Scottish Patient Safety Programme undertakes monthly casenote reviews on the three acute hospital sites using a process refined by the Institute of Health Improvement called the Global Trigger Tool which proactively quantifies adverse events. The Global Trigger Tool helps teams rapidly review patient notes to identify ‘triggers’ that may signal harm from the patients’ point of view. The teams are then encouraged to improve care process and monitor changes over time. The national SPSP programme has a goal to reduce the adverse event rate by 30% by December 2012. NHS Lothian has sustained a significant reduction in adverse events from prevent harmful consequences resulting from SAEs.
baseline (2007) by 46%. The themes generated from the adverse casenote reviews mirror the main themes identified through Datix.

<table>
<thead>
<tr>
<th>10. Efficiency and Waste Reduction</th>
<th>Increase focus on waste reduction and the significant savings which can be made here. Develop process to demonstrate links between efficiency and quality improvement.</th>
<th>• The Quality Improvement Strategy has within it Quality Improvement Programmes that seek to link quality and efficiency. These include Lean in Lothian programme, Falls and Ulcer Prevention. This is an area requires further work to clearly demonstrate the link.</th>
<th>• Deliver the QUEST proposals that seek to deliver improvements in cost and quality.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Board Development</td>
<td>Review the purpose of Board development sessions to ensure these are taking account of the Scottish Government's focus on Quality and Safety. Include patient stories at future Board development sessions.</td>
<td>• NHS Lothian has a range of mechanisms to share learning and encourage spread of improvement programmes and programmes such as the Patient Safety Programme are regularly presented to the Board. These programmes examine the success and challenges implementing improvement work.</td>
<td>• Review the purpose of the Board development sessions including use of patient stories within the quality and safety agenda.</td>
</tr>
<tr>
<td>12. Sharing and Integration</td>
<td>Further development links between NHS boards to share learning and address challenges. Encourage staff to look at new ways to communicate and share successes both locally and nationally. Consider how to celebrate achievements of improvement work at Board meetings as well as addressing any concerns.</td>
<td>• NHS Lothian has a range of mechanisms to share and spread learning at service and Board level, including external opportunities. • The national Board on Board events provide ideal opportunities to share learning along with other national events through Scottish Government, Health Improvement Scotland, NHS Education for Scotland</td>
<td>• Encourage Board attendance of national events through SPSP, national conferences and learning sessions. • Examine use of new communication mediums such as blogs, Twitter, etc, to share success locally and nationally. • Review Celebrating Success awards.</td>
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HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to support the following activities, under the overall direction of the Director of Public Health and Health Policy, in delivering the agenda to reduce and manage Healthcare Associated Infection:

- Maintain enhanced weekly surveillance of Meticillin Resistant Staphylococcus aureus and Meticillin Sensitive Staphylococcus aureus Bacteraemia to target resources for a sustained reduction.
- Support the reduction of healthcare associated Clostridium difficile Infection by promoting compliance with the antimicrobial stewardship recommendations.
- Integration of the Meticillin Resistant Staphylococcus aureus screening programme into the core Infection Prevention and Control surveillance requirements.
- Support the development of an escalation process for failure to comply with hand hygiene policy and support progress for approval.
- Increased compliance with best practice, as recommended by the Antimicrobial Management Team.

3 Discussion of Key Issues

3.1 Staphylococcus aureus Bacteraemia: there were 18 episodes of Staphylococcus aureus Bacteraemia recorded in June 2012 (1 Meticillin Resistant Staphylococcus aureus, 17 Meticillin Sensitive Staphylococcus aureus), compared to 16 in May 2012 (3 Meticillin Resistant Staphylococcus aureus, 13 Meticillin Sensitive Staphylococcus aureus). There were 57 episodes of Staphylococcus aureus Bacteraemia recorded in Lothian for the first quarter of 2012, in comparison there were 380 cases in Scotland. NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013, with a current rate of 0.30 (updated to June 2012). In order to achieve the target, NHS Lothian has to average no more than 17 episodes per month for the twelve month period, with a current average of 19 episodes per month.
3.2 *Clostridium difficile* Infection: there were 34 episodes of *Clostridium difficile* Infection in patients aged 65 or over in June 2012, compared to 15 in May 2012. There were 60 episodes of *Clostridium difficile* Infection in patients aged 65 or over years recorded in Lothian for the first quarter of 2012, in comparison there were 334 episodes in Scotland. NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.39 cases or fewer per 1000 total occupied bed days by March 2013, with a current rate of 0.33 (updated to June 2012) compared to 0.30 in May 2012. In order to achieve the target, NHS Lothian has to average no more than 27 episodes per month for the twelve month period. The rise in reported *Clostridium difficile* Infection in June was distributed across the organisation, with an additional 6 cases in medicine for older people wards and specialised mental health services, an additional 3 cases across our community hospitals and an additional 8 people cared for in General Practice. Only one ward had two cases within the month. All episodes of *Clostridium difficile* Infection are investigated: patient care, ward environment and patient pathway are all examined, problems identified, improvements made in clinical practice and any environmental issues escalated. Investigations undertaken following this rise in reported cases are not yet complete but there is no evidence to indicate that this is a cluster. However, a Problem Assessment Group will be established to review the rise in cases and explore the requirement for further improvements in patient care, patient pathways and in the clinical environment.

3.3 Norovirus outbreaks: in NHS Lothian, the first norovirus outbreak for season 2012-2013 was recorded at the Western General Hospital during August 2011. To date there have been 135 incidents of gastro-enteritis investigated in NHS Lothian. Unlike previous seasons, clusters of norovirus have continued to occur into the summer in the community and in the hospital. Inevitably, this has an immediate impact on availability of beds but the scientific evidence is clear that isolating patients, rapid bay and ward closures and minimising unnecessary patient movement reduce harm to patients and outbreak duration. The Infection Prevention and Control, bed management and clinical teams are working closely to manage their impact.

3.4 The nineteenth bi-monthly national hand hygiene audit report, published in May 2012, indicated that NHS Lothian was achieving a hand hygiene compliance of 97%, which exceeded the national compliance rate of 96%. The table below (Table 1) shows a breakdown of staff groups comparing both national and local compliance.

<table>
<thead>
<tr>
<th></th>
<th>National Compliance (%)</th>
<th>NHS Lothian compliance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall compliance</td>
<td>96</td>
<td>97</td>
</tr>
<tr>
<td>Nurse</td>
<td>97</td>
<td>95</td>
</tr>
<tr>
<td>Medical</td>
<td>91</td>
<td>96</td>
</tr>
<tr>
<td>Ancillary/other</td>
<td>94</td>
<td>97</td>
</tr>
<tr>
<td>Allied Health Professional</td>
<td>97</td>
<td>98</td>
</tr>
</tbody>
</table>

Local monthly hand hygiene audits continue throughout all patient care areas, with delivery of hand hygiene education and training targeting areas of non-compliance. The standard operational procedure for escalation of non-compliance with hand hygiene has been approved in principal by the Local Negotiating Committee, awaiting confirmation of amendments required. New hand hygiene signage to raise
awareness amongst staff, patients and visitors is currently being installed throughout St John’s Hospital and the new Royal Victoria Hospital. Plans are progressing for signage to be installed in additional sites in NHS Lothian.

3.5  Mandatory Surgical Site Infection Surveillance: Monthly and quarterly reports are compiled and distributed to the clinical areas and any actions required discussed. These reports/figures are placed in the information display boards for staff, patients and visitors to peruse. For April 2012 347 procedures were performed with 3 Surgical Site Infections detected, a Surgical Site Infection rate of 0.9%. The table below (Table 2) includes Surgical Site Infections for abdominal hysterectomy (inpatient), caesarean section (inpatient and Post Discharge to day ten), hip arthroplasty (inpatient and readmission to day thirty) and repair of neck of femur (inpatient) procedures in NHS Lothian, April 2012.

Table 2: Surgical Site Infection Surveillance – April 2012

<table>
<thead>
<tr>
<th>Lothian Procedures</th>
<th>Number of Procedures</th>
<th>SSI's</th>
<th>SSI rate</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal hysterectomy</td>
<td>40</td>
<td>0</td>
<td>0.0</td>
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<tr>
<td>Caesarean Section</td>
<td>208</td>
<td>3</td>
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<td>Repair of Neck of Femur</td>
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3.6  The Healthcare Environment Inspectorate’s required Healthcare Associated Infection Self Assessment and associated evidence was returned to the Inspectorate on 1/6/12.

3.6.1  The Healthcare Environment Inspectorate has issued guidance on the introduction of applied timelines for future requirements and recommendations. These timelines are:

<table>
<thead>
<tr>
<th>Minor</th>
<th>No direct impact on patient safety or care</th>
<th>9 months</th>
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<tbody>
<tr>
<td>Low</td>
<td>Direct impact on patient safety or care</td>
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Further information can be found at:
http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_are/hei_policies_and_procedures/hei_prioritising_requirements.aspx

3.6.2  There are five outstanding actions from previous Healthcare Environment Inspectorate Inspections, outlined in Table 3. There was an unannounced visit to the Royal Hospital for Sick Children on 11/7/12; we await the Inspectorate’s report and recommendations.
Table 3: Outstanding actions

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<tr>
<th>Issue</th>
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<tr>
<td>Dress Code</td>
<td>To be resubmitted to Partnership</td>
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<tr>
<td>Escalation Protocol Hand Hygiene</td>
<td>Local Negotiating Committee approved on principal but required amendments. Meeting arranged to progress.</td>
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<tr>
<td>Infrequently Used Water Outlets</td>
<td>Policy ratification and publication awaited from Estates. Delayed as National Guidance anticipated in June 2012 not yet received.</td>
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<tr>
<td>Flushing Programme</td>
<td>Policy ratification and publication awaited from Estates. Delayed as National Guidance anticipated in June 2012 not yet received.</td>
</tr>
<tr>
<td>Education Strategy</td>
<td>Draft Strategy has been completed. Update on implementation awaited.</td>
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<tr>
<td>Antimicrobial Training</td>
<td>Training is ongoing, strategy depending on above education strategy implementation.</td>
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3.7 Incidents updates for June 2012: the Infection Prevention and Control Team have been involved in investigating several incidents, including:

- Legionella outbreak: there is ongoing investigation throughout Lothian.
- Norovirus outbreak at Liberton hospital: there is ongoing investigation.
- Cluster of patients with Pseudomonas and Klebsiella at Western General Hospital: there is ongoing investigation

3.8 Antimicrobial Management Team: Antibiotic Prescribing indicators: the target level for compliance with the guidelines and documentation of indication is 95%. In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is above the target level for the Western General Hospital and St John’s Hospital (with 100% compliance) and at target level for the Royal Infirmary Edinburgh (with 95% compliance). All the sites are above the target level for documentation of indication for antibiotic treatment (with 100% compliance). For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy has remained above target at 100% compliance in the last month; administration of single dose antibiotic prophylaxis has also remained above the target level at 100% compliance. The target level for both prescribing indicators is 95% compliance with Surgical Prophylaxis Guidelines and administration of a single dose of surgical prophylaxis.

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.
- Increased numbers of Healthcare Associated Infections leads to adverse patient harm as well as failure to comply with the Health Efficiency Access Treatment Target.
- There is the potential for Healthcare Environment Inspectorate inspectors to find adverse areas of cleanliness or standards of practice, which undermines
the organisation’s commitment to a healthier, safer healthcare environment and could lead to adverse publicity for NHS Lothian and loss of public/patient confidence.

- Infection Prevention and Control Team do not have sustainable resources to comply with Meticillin Resistant Staphylococcus aureus screening Key Performance Indicators set by HPS, which involves manual data entry into internet based system.

5 Risk Register

5.1 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.

6 Impact on Inequality, Including Health Inequalities

6.1 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.

7 Involving People

7.1 Patient public representatives are 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).

8 Resource Implications

8.1 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.

Fiona Cameron
Head of Service, Infection Prevention and Control
12/7/12
fiona.cameron@nhslothian.scot.nhs.uk

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
NHS Lothian

**SAB** There were 18 SAB recorded during June 2012 (1 MRSA & 17 MSSA). The lowest number recorded in the last 12 month period is 16 (May 2012).

**CDI** There were 45 CDI recorded in June 2012, 34 were in aged 65 & over. February 2012 recorded the lowest number in the last 12 month period with 20 cases.

**SAB HEAT Target** Currently, NHS Lothian is on trajectory to achieve the set target of 0.26 or less cases per 1000 AOBDS by March 2013. The challenge going forward is to reduce even further.

**CDI HEAT Target for Patients aged 65 and over** Currently, NHS Lothian is on trajectory to achieve the set target of 0.39 or less cases per 1000 OBDS. The challenge going forward is to maintain this or reduce even further.

This is the new Report Card Format introduced by Scottish Government July 2011

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**Royal Infirmary of Edinburgh**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 4 SAB recorded during June 2012.

**Clostridium difficile Infection (CDI)**
There were 7 CDI recorded during June 2012.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 3 SAB recorded during June 2012.

**Clostridium difficile Infection (CDI)**
There were 12 CDI recorded during June 2012.

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Staphylococcus aureus Bacteraemia (SAB)
There were no SAB recorded during June 2012.

Clostridium difficile Infection (CDI)
There were 2 CDI recorded during June 2012.

This is the new Report Card Format introduced by Scottish Government July 2011

Hand Hygiene Monitoring Compliance

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Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

Total Staphylococcus aureus Bacteraemia (SAB) Cases

MRSA Bacteraemia Cases

MSSA Bacteraemia Cases
**Liberton Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during June 2012.

**Clostridium difficile Infection (CDI)**
There were 2 CDI recorded during June 2012.

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**Hand Hygiene Monitoring Compliance**

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

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**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

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**MRSA Bacteraemia Cases**

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Royal Hospital for Sick Children

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during June 2012.

**Clostridium difficile Infection (CDI)**
There were no CDI recorded during June 2012.

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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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**MSSA Bacteraemia Cases**
**Royal Victoria Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during June 2012.

**Clostridium difficile Infection (CDI)**
There were 4 CDI recorded during June 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**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**

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**Community Hospitals**

**Staphylococcus aureus Bacteraemia (SAB)**
There were only 2 SAB recorded in the last 12 month period.

**Clostridium difficile Infection (CDI)**
There were 3 CDI recorded during June 2012.

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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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**This is the new Report Card Format introduced by Scottish Government July 2011.**
**Out of Hospital Infections**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 11 SAB recorded during June 2012 that were identified as Out of Hospital Infections.

**Clostridium difficile Infection (CDI)**
There were 15 CDI recorded during June 2012 that were identified as Out of Hospital Infections.

This is the new Report Card Format introduced by Scottish Government July 2011.
REFERENCE COMMITTEE CHAIR

1. Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the appointment of Peter Johnston as Chair of the Reference Committee, taking over immediately from Robin Burley.

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

2. Recommendations

2.1 The Board is recommended to agree the appointment of Peter Johnston as Chair of the Reference Committee with immediate effect.

3. Key Risks

3.1 There is a risk of a break in the operation of an effective governance arrangement if a Chair of the Reference Committee is not in place before the date of the next Reference Committee meeting.

4. Risk Register

4.1 There is no corresponding entry on the risk register - the appointment will address the issue.

5. Impact on Health Inequalities

5.1 This appointment reflects the application of the terms of a previously agreed Framework of Governance, and as such, no impact assessment has been performed.
6. **Impact on Inequalities**

6.1 This is an administrative matter and has no impact on Inequalities.

7. **Involving People**

7.1 This issue has been discussed with the Board member concerned.

8. **Resource Implications**

8.1 There are no resource implications arising from these recommendations.

Charles Winstanley  
Chairman  
13 July 2012  
charles.winstanley@nhslothian.scot.nhs.uk