NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 24 APRIL 2013

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.

AGENDA

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Lead Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Members of the Public and the Press</td>
<td></td>
</tr>
<tr>
<td>Apologies for Absence</td>
<td></td>
</tr>
<tr>
<td>1. Minutes of the Previous Meeting of Lothian NHS Board held on 27 March 2013</td>
<td>SA *</td>
</tr>
<tr>
<td>2. Matters Arising (9:35am - 9:50am)</td>
<td></td>
</tr>
<tr>
<td>2.1. Paediatric Services</td>
<td>DF v</td>
</tr>
<tr>
<td>3. Committee Minutes for Adoption (9:50am - 10:00am)</td>
<td></td>
</tr>
<tr>
<td>3.1. Healthcare Governance Committee - Minutes of the Meeting held on 2 April 2013</td>
<td>MB *</td>
</tr>
<tr>
<td>3.2. Staff Governance Committee - Minutes of the Meeting held on 20 March 2013</td>
<td>AJ *</td>
</tr>
<tr>
<td>3.3. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 28 February 2013</td>
<td>MA *</td>
</tr>
<tr>
<td>3.4. West Lothian Community Health &amp; Care Partnership Board - Minutes of the Meeting held on 22 January 2013</td>
<td>FT *</td>
</tr>
</tbody>
</table>

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

For further information please contact Peter Reith, ☏ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
4. Governance (10:00am - 10:35am)

4.1. Quality Report

4.2. Healthcare Associated Infection Update

4.3. Improving Care for Older People in Acute Hospitals (OPAH)
    Healthcare Improvement Scotland

5. Performance Management (10:35am - 11:45am)

5.1. Waiting Times Progress and Performance

5.2. Performance Management

5.3. Financial Position for the Year Ended 31 March 2013

5.4. Unscheduled Care Briefing for March 2013

5.5. Single Outcome Agreements

6. Policy & Strategy (11:45am - 12:00pm)

6.1. Corporate Objectives

7. Other Items (12:00pm - 12:30pm)

7.1. Shadow Health & Social Care Partnership Boards Memberships

7.2. Establishment of a Shadow Health and Social Care Partnership Board and Establishment of Post of Joint Accountable Officer in East Lothian

7.3. Communications Received

8. Date, Time and Venue of Next Meeting: Wednesday 22 May 2013 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

9. Resolution to take items in closed session

Dates of Meetings in 2013:

26 June 2013
24 July 2013
No August Meeting
25 September 2013
23 October 2013
27 November 2013
No December Meeting
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 27 March 2013 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Executive Directors: Mr T Davison (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) and Professor A K McCallum (Director of Public Health and Health Policy).

Non-Executive Directors: Dr C J Winstanley (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Ms K Blair; Dr M Bryce; Councillor D Grant; Councillor R Henderson; Mr P Johnston; Councillor C Johnstone; Mrs J McDowell; Ms A Mitchell; Councillor F Toner; Dr R Williams, Mr R Wilson and Mr G Walker.

In Attendance: Mr J Forrest (Director, West Lothian Community Health and Care Partnership); Mr P Gabbitas (Director of Health and Social Care, City of Edinburgh Council); Mr A Jackson (Associate Director of Planning for item 160); Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications and Public Affairs)

Apologies for absence were received from Mr J Brettell, Professor J Iredale, Mr A Joyce, Mrs A Meiklejohn, Mr D Small and Mr G Warner

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. Ms K Blair declared an interest as a Non Executive Director of NHS24 that might impact on a number of agenda items.

155. Welcome and Introductions

155.1 The Chairman welcomed members of the public and press to the meeting.

156. Minutes of the Previous meeting held on 27 February 2013

156.1 The minutes were approved as a correct record.
157. Matters Arising

157.1 Readmission Rates – The Medical Director advised he was planning to have random sets of medical notes looked at in detail to ascertain why the Lothian position was out of line with the rest of Scotland and this position would be looked at further by the Healthcare Governance Committee in June.

157.2 Paediatric Staffing – The Medical Director updated on positive progress with the recruitment of Consultant Paediatricians, specialist paediatric doctors, a neonatal fellowship and advanced practitioner posts.

157.3 It was reported that the on-call rota at St Johns Hospital was covered until July with work underway to seek to provide a sustainable position over the summer period subject to turnover rates in this speciality being stable.

157.4 The Medical Director advised that in the main the newly appointed staff would work at St Johns Hospital although they would be employed on Lothian Wide contracts. It was noted at this point because of the fragile UK wide position around the availability of trained doctors that the Medical Director did not feel it would be appropriate to downgrade the St Johns Hospital Risk Register in respect of paediatric services.

157.5 The Board noted that the public information campaign would focus on St Johns Hospital in particular and Lothian in General.

157.6 Mr Johnston thanked colleagues responsible for the success of the World Wide Recruitment Campaign and sought assurance that the current mix of staff at St Johns was sufficient to provide the necessary service requirement. The Medical Director confirmed this position advising that the service would make the best use of available staff. The Director of Human Resources and Organisational Development advised that he met with consultants from the paediatric unit at St Johns Hospital approximately every 2 weeks and would be happy to discuss issues with any staff group outwith this sequence. It was noted separate monthly meetings were also held with nursing staff.

157.7 The Director of Human Resources and Organisational Development and the Medical Director updated the Board on steps being taken to sustain the improved position and move forward on a longer term basis. It was noted that work was also underway in other service areas that were deemed to be at risk and previously reported to the Board. It was agreed that medium to longer term plans would be brought back to the Board in due course with the medium term focus being around 2017 which would lead up to the timeframe for the new Royal Hospital for Sick Children opening.

157.8 The Nurse Director updated the Board on national discussions underway in respect of advanced practitioner posts advising she would welcome a national approach to training to include other specialties other than just paediatrics. The Chief Executive advised he had met with the Scottish Government on this issue and they were publicly committed to the national programme but were dependant on higher education establishments as well as being cognisant of other operational issues. The Board were advised that the timeline between agreeing to run a course and it becoming a reality was between 12-18 months with there being little opportunity to circumvent the time to approval.
157.9 The Medical Director in response to a question about future engagement with NHS Education for Scotland (NES) around out of programme activity and other inputs around trainee numbers going forward advised trainees were entitled to participate in out of programme activity and this in itself was not a major area of concern with the most significant issue being around maternity leave. The Chief Executive commented currently it was difficult to identify an option other than using trainees at middle grade and across the country consultants were working down in to systems which was not the most cost effective use of their time. He advised at UK level there was a recognition around the difficulties in maintaining middle grade work and steps was underway to consider this in more detail. The Chief Executive reminded the Board that the position in respect of paediatrics remained fragile.

157.10 The Board noted the updated position.

158. Committee Minutes for Adoption

158.1 Audit and Risk Committee – Minutes of the Meeting held on 4 February 2013 – The Board adopted the minutes. It was noted that a workshop would be scheduled to develop the Boards risk appetite and tolerance.

158.2 Finance and Resources Committee – Minutes of the meeting held on 13 February 2013 – The Board adopted the minutes.

158.3 Mr Walker reported on a successful visit to the Royal Infirmary of Edinburgh which had been held as part of the meeting focussing on the area where new beds would be provided to increase capacity. He advised that this was an area that the Finance and Resources Committee were committed to and regarded as a priority. He advised that the property strategy would provide more detail around the master planning process at the Royal Edinburgh Hospital. The Board noted that the Finance and Resources Committee had approved the Business Case for the MRI scanner at St Johns Hospital.

158.4 The Director of Public Health and Health Policy advised in respect of minute 65.2 that it was not 3 General Dental Practitioners but 3 General Dental Practices that did not have plans in place to enable them to be compliant.

158.5 Healthcare Governance Committee – Minutes of the Meeting Held on 5 February 2013 – The Board adopted the minutes.

158.6 Dr Bryce commented that the Quality Report had featured on the agenda with it being felt that it met the granularity requirements and allowed the detail of indicators and trends to be discussed.

158.7 The point was made that there would be a need to look at how Board Committees linked to the Integrated Health and Social Care Partnership Boards particularly in respect of Risk Management and Governance issues. The Director of Finance undertook to arrange for a member of her staff to have early dialogue around this important relationship.
Dr Bryce advised that the Staff Governance Committee and the Healthcare Governance Committee had overlapping responsibilities and meetings were being held to identify any gaps and to enable an audit trail to be put in place to identify areas that needed to be addressed. She suggested there would be benefit in holding an early workshop once the legislative parameters around integration had been quantified.

Staff Governance Committee – Minutes of the Meeting Held on 30 January 2013 - The Board adopted the minutes.

East Lothian Community Health Partnership Subcommittee – Minutes of the Meeting Held on 20 December 2012 – The Board adopted the minutes noting that an update on the Gullane capital project had been provided.

Edinburgh Community Health Partnership Subcommittee – Minutes of the Meeting Held on 6 February 2013 – The Board adopted the minutes.

The Vice Chair advised that a robust capital programme was in place. It was noted that the Edinburgh Community Health Partnership (CHP) continued to meet quarterly to ensure legislative and governance issues were in place and to ensure appropriate linkages with the Shadow Partnership Board. The Chief Executive commented that this was appropriate as responsibility for Child Health Services was retained at CHP level as a consequence of not being included in the Partnership Board arrangements. It was noted that legislative direction specified and covered the formal membership of the Community Health and Care Partnership.

West Lothian Community Health and Care Partnership Subcommittee – Minutes of the Meeting Held on 31 January 2013 – The Board adopted the minutes.

NHS Lothian / City of Edinburgh Council Shadow Health and Social Care Partnership – Minutes of Meetings Held on 19 November 2012; 11 January 2013 (action note) and 15 February 2013 – The Board adopted the 3 sets of minutes. Councillor Henderson advised that significant work had been undertaken in the interim including around the draft partnership agreement. It was noted from April meetings would be held in public with each alternate meeting including a visit of a healthcare facility in order for members to obtain an understanding of the services they were responsible for. It was noted that membership of the NHS Lothian / City of Edinburgh Council Shadow Health and Social Care Partnership was now complete.

It was noted there had as yet been no formal decision about the requirements or otherwise for general practitioners to become members of the Partnership Board. The Chairman commented there was no impediment to Chairs co-opting people to attend and participate in meetings even if they were not formal members.

The Board noted that a major piece of work in respect of the development of partnership agreements was around the virement arrangements in order to ensure that potentially large issues were not discussed in isolation from the Board. The Director, Health and Social Care, City of Edinburgh Council advised in respect of the City of Edinburgh Council arrangements that he intended to bring the Partnership Agreement to the Board and the Council for full endorsement. The Director of Strategic Planning, Performance Reporting and Information updated on separate
discussions that were being held with the Scottish Government around this and related issues including multi agency engagement.

158.17 The Chief Executive assured the Board that he and senior colleagues were engaged in high level discussions with local authorities around the development of partnership agreements with there also being NHS participation at national level in discussions. He commented that a key aspect would be to ensure that partnership agreements and virement arrangements reflected an equitable risk share. It was noted that the issue about delegated responsibility for virement would need to be agreed and clearly understood. The Chief Executive commented that he would retain the overview for this work advising that he was looking for a core of consistency across the 4 partnerships which would also allow for local nuances at ground level to be accommodated. It was noted that once the Joint Director appointments had been made in East Lothian and Midlothian that further work would be undertaken in this area.

159. **Chairman’s Report**

159.1 The Board noted the Chairman’s report and in particular the establishment of the National Confidential Alert Line and the arrangements put in place to interview applicants for the Chair position of East Lothian and Midlothian Health and Social Care Partnerships.

159.2 The Director of Human Resources and Organisational Development commented in respect of the National Confidential Alert Line that he had been nominated as the NHS Lothian contact. He advised that NHS Lothian over the previous 3 years had a Freedom of Speech Policy in place which had required to be technically updated in October of last year. He commented that the work to refresh the policy had been undertaken in Partnership to the required timescale although it had been decided to defer its reissue until the opportunity had been taken to ensure it fully encapsulated the intentions of the National Confidential Alert Line. The Board noted that the intention would be any issue raised to the Scottish Government through the alert line would be passed to the local Health Board for action. It was noted that if an issue was reported that required other regulatory or police input then the appropriate steps would be taken.

159.3 The Chairman advised that the National Chair’s Group had received a presentation detailing a clear line of action in response to the Francis Report. The Chief Executive advised locally the intention was to use the Healthcare Governance Committee to capture views. The Medical and Nurse Directors would also be heavily involved in liaison with the Clinical Governance Committee in leading Lothian’s response. It was noted that a lot of the infrastructure needed to respond to the Francis Report recommendations was already in place.

159.4 The Medical Director advised that NHS Healthcare Improvement Scotland had produced a briefing on the Francis Report which outlined what was happening in Scotland and there would also be a need to take account of the Scottish Government response and position. The Nurse Director reported there was significant interest from clinical staff and the wider view would be brought back to the Board. It was noted that the Staff Governance Committee would also have an interest in the response to the report.
160. Quality Report

160.1 The Medical Director advised it was his intention to review the report over the next 2 months to include the dashboard component. The intention was to include Primary Care Interventions in order that the report provided a more balanced overview of the totality of NHS Lothian Services.

160.2 The Board received a detailed update from the Medical Director in respect of coronary heart disease (CHD) effectiveness measures noting in respect of premature deaths from coronary artery diseases that Lothian performed less well than the rest of Scotland and work was underway to understand the reasons for this. The Director of Public Health and Health Policy commented on the position in respect of different socio economic groups and the situation in relation to patients of South Asian origin. It was reported that work had been undertaken in respect of equity across the system and this evidence had been presented to the Public Audit Committee of the Scottish Parliament. In addition work around the Keep Well Project had focussed on harder to reach groups. The involvement of two local Lothian GPs in quantifying the socio-economic gradient in multiple morbidity was also highlighted.

160.3 The Medical Director commented in respect of readmission rates that previous data had suggested significant differences between Lothian and elsewhere. As reported under Matters Arising sets of notes were being looked at on a random basis to investigate further why the Lothian position was so different. The point was also made in respect of complaints information that the data was old and in future there was a need to populate the report with up to date information.

160.4 Dr Williams commented he welcomed the intention to provide Primary Care data in future reports and believed this would show that a generally high service was provided as well as demonstrating areas of improvement that the Board might give consideration to providing resource and support to address. The Chief Executive commented following attendance by himself and other senior colleagues at the GP Sub Committee a commitment had been given to undertake work on how to bring forward proposals in respect of making investments in Primary Care capacity.

160.5 The Medical Director in revamping the quality report undertook to give particular consideration to developing the dashboard indicator component as well as detailing what the challenge was around what was being reported.

160.6 The Board received the Quality Report and agreed its recommendations.

161. Healthcare Associated Infection Update

161.1 The Director of Public Health and Health Policy provided her regular update on Healthcare Associated Infection to the Board advising that the staphylococcus aureus bacteraemia target would not be met by March 2013. It was noted that there had been an increase in the proportion of cases where people who were ill were admitted into hospital with multiple morbidities with or at risk of staphylococcus aureus bacteraemia. The increase in respect of community incidents was part of a wider phenomenon and impacted on the ability to manage the position within a healthcare setting. The Board noted that this issue had been raised during a
meeting with members of the Healthcare Associated Infection team who had recognised the challenges around multiple morbidity and were content with the levels of scrutiny and diligence that was being undertaken.

161.2 The Board were advised that currently there were 2 outbreaks of norovirus in Liberton Hospital and the Royal Infirmary of Edinburgh. It was noted that daily meetings were being undertaken to address the position.

161.3 The Director of Public Health and Health Policy would look at the reasons why zero data was reported in respect of the Royal Victoria Hospital and building. She anticipated that this would be as a consequence of the date when data was validated although she also pointed out that there would be occasions where there were no cases to record.

161.4 It was noted in respect of key risks these required further mitigation particularly in respect of funding sources which were non recurrent. The Director of Public Health and Health Policy advised that Infection Prevention and Control was an invest to save service. She noted that work was being undertaken between herself and the Nurse Director to look at the position in respect of non recurrent investments from the Scottish Government with a view to looking at models for sustainable development. It was noted in respect of inspection findings that a process was in place to identify and remedy issues and that Chief Nurses had been corresponded with in respect of recent inspections in order to identify areas that needed addressed.

161.5 Mr Ash stressed in future there was a need to be clear about what actions were bring taken to mitigate risks identified.

161.6 The Board agreed the recommendations contained in the circulated paper.

162. Corporate Risk Register

162.1 The Medical Director advised the purpose of his report was to provide assurance of the management of risk at corporate level. It was noted there were 16 risks being managed on the NHS Lothian Risk Register, 10 of which had a risk level of high and 6 of medium level. It was reported that emerging risks were evident in respect of the medical workforce and the integration of health and social care and details were provided of steps being taken to mitigate these risks.

162.2 Discussion ensued around the detail of the Corporate Risk Register with it being suggested that each Board Committee should look at risk and reference their deliberations through the minutes of meetings considered at each Board meeting. It was agreed that whilst the organisation was working its way through new structures a quarterly risk report to the Board would be sufficient with the position being reviewed thereafter. It was agreed future Board papers in general needed to be more explicit about what the Board being asked to approve as many of the papers before the current meeting were for noting. In addition currently some risks were ‘bundled’ making it difficult to assess individual components. Reputational risk also needed to be addressed.
162.3 The Board commented it was not yet clear on the process for reaching an agreement about the rating of risks and who was responsible for allocating risk scores. The importance of ensuring separation in terms of people identifying and managing risk and scoring risk was discussed.

162.4 The Chief Executive commented the paper before the Board represented work in progress and acknowledged the point made about bundling risks. He reminded the Board that in the Corporate Objectives it had been agreed to de-bundle the team objective around patient quality and experience.

162.5 It was noted that the Audit and Risk Committee looked at the process of risk management and not the detail of material risk. In that respect it was felt to be appropriate for the Board to have a discussion on whether to refer back to the Audit and Risk Committee issues around how risks were bundled and prioritised in terms of process without getting involved in individual Board Committee responsibilities.

162.6 The Board agreed the recommendations in the circulated paper and noted it would receive quarterly reports until the end of the calendar year and thereafter review the frequency of reporting on the Risk Register.

163. Review of Information Received by the Board

163.1 The Chairman referred the Board to the satisfactory Internal Audit Report on the review of information received by the Board and reminded colleagues of the history of the exercise. The Board noted that the Internal Audit Report provided assurance that the information provided to the Board and that the committee structure were both suitable.

163.2 Dr Bryce commented that she had welcomed the process with had allowed her committee to better focus its agenda and articulate what its function was. Mr Walker concurred as Chair of the Finance and Resources Committee and advised that parallel work being undertaken by the finance department was also helpful in providing assurance.

163.3 The Chairman advised he regularly met with Committee Chairs to look at assurance gaps and it had been agreed to base future agendas on assurance needs.

163.4 The Board noted the report as work in progress.

164. National Person Centred Health and Care Programme

164.1 The Nurse Director advised that she felt that it was important the Board received early sight of the national programme and local work in taking it forward. She reminded colleagues that the programme was progressing along the lines of the Scottish Patient Safety Programme with events being held on how to develop this at national level.

164.2 The Board noted that a February workshop had been well attended and had included Non Executive Directors, NHS and Council staff as well as representatives from other local organisations. A number of volunteers had agreed to meet and do further
work around structure from an NHS Lothian perspective and a more substantial report would be brought to the Board in future.

164.3 The Director of Communications and Public Affairs reported that feedback to the public opinion website had been positive. The Chief Executive commented he would welcome examples of this feedback being considered by the Clinical Governance Committee and the Board as the contents of such feedback was often illuminating.

164.4 The Vice Chair commented the real benefit of the workshop event in Lothian had been that participants had worked together. There had also been important links made in respect of the Health and Social Care Partnership work. It was noted that the NHS Lothian workshop event had included adequate local authority input. The Board noted the need to consider what the process would mean for staff levels and work intensity moving forward.

164.5 The Board noted and supported the National Patient Centred Health and Care Programme.

165. Health and Social Care Integration in Midlothian – Establishment of Post of Joint Accountable Officer

165.1 The Director of Human Resources and Organisational Development provided the background to the technical paper in respect of the establishment of the post of Joint Accountable Officer for Health and Social Care Integration in Midlothian. It was noted that the use of Director in the title did not infer NHS Lothian Board membership. The Board noted that due to timing issues that the paper had been presented and the proposals agreed at the Midlothian Council meeting of 19 March 2013. A similar paper would be brought to the Board in respect of East Lothian arrangements.

165.2 The Board agreed the need to mitigate the key risk referred to in the paper as part of the review work previously referred to by the Director of Finance. The Chief Executive confirmed that the residual responsibilities of CHPs would be part of the ongoing risk mitigation process.

165.3 The Board approved the establishment of the post of Joint Accountable Officer of the Midlothian Health and Social Care Partnership.

166. Waiting Times Progress and Performance

166.1 The Medical Director advised that the purpose of his report was to update the Board on both waiting times performance and progress made in reducing the number of patients waiting longer than national targets and standards. It was noted that NHS Lothian continued to improve waiting times for patients and that the number of inpatients over 12 weeks continued to reduce. At the end of February 422 people had waited beyond this standard which was more than an 80% reduction from its peak in 2011. 123 of these patients were waiting for procedures excluded from the Waiting Times Guarantee. The Medical Director advised that reductions were expected to continue in coming months with those remaining being predominantly complex operations or exclusions.
The Board noted that the overall size of the inpatient list had reduced by over a third since its high point in 2011 with 7802 on the waiting list at the end of February. Of these 1041 were unavailable which represented a reduction of over 70% on its high point. The Board also noted that 96.7% of patients treated in February were seen within the Treatment Time Guarantee. 237 waited over this threshold in the month, of whom 181 had been admitted or no longer required treatment. Some patients had dates identified or were with external providers to find a suitable date.

The Board noted that the number of outpatients over 12 weeks had also improved to 2869 at the end of February. It was noted that further reductions were anticipated in March and would take Lothian to its best reported position since November 2011. It was noted that improvements were expected to continue thereafter.

It was reported that diagnostic endoscopy waiting times had improved in February with those over 6 weeks down to 690. Further reductions were expected in March with an increase anticipated in April due to reduced capacity at Easter.

The Board noted that the process for offering patients treatment outside NHS Lothian was in the early stages of redesign and proposals would be outlined in more detail at the next Board meeting.

Mrs McDowell sought further information on the data discrepancy referred to in the paper and when it had been discovered. Mr Jackson advised that the issue was in relation to reporting on adjusted and unadjusted waits. He advised in the preparation of the Board paper it had not been possible for the analyst to reconcile the figures normally produced by a colleague. Investigation had found that the wrong data field had been used. This had meant that the system was retrieving information on waits that took account of unavailability and clock re-sets rather than not. This effectively meant that the wrong data had been presented for several months. The Board noted that the positive side of this position was that the numbers waiting had reduced further than had been reported. The Scottish Government had been advised of the position.

The Director of Strategic Planning, Performance Reporting and Information advised that he proposed to link with existing work being undertaken within the system to ensure in terms of data quality that appropriate checks and balances were in place to improve on the system and to ensure that proper and accurate information was presented to the Board.

The Chief Executive hoped that the Board would recognise that as part of an open process it was important to report on this anomalous position which had arisen from bespoke analysis which he as Chief Executive had asked for as he had felt it would be of use to the Board.

The Chief Executive reported that the Director of Strategic Planning, Performance Report and Information’s role had been established in part to separate out data reporting from the Director responsible for delivery. He commented the fact this reporting anomaly had been identified locally represented a strength in the current arrangements.
The Board noted the positive progress being made in addressing the waiting times targets.

**Performance Management**

The Director of Strategic Planning, Performance Reporting and Information provided an update to the Board on the most recently available performance data as reported through local and national systems. He commented that new Health Improvement, Efficiency Access to Services and Treatment (HEAT) targets would be set in the new year and the report would therefore require to be refreshed for the April Board meeting. The Board noted the current focus in respect of the targets around substance misuse and drug and alcohol; carbon dioxide and energy consumption; stroke; cancer and delayed discharges.

The Director of Strategic Planning, Performance Reporting and Information advised that further reports had issued from Information Services Division (ISD) the previous day and he would arrange for these to be circulated to Board members.

The Nurse Director provided an update in respect of the position on Unscheduled Care advising that the February position was better than the January position with 91.1% being achieved against the 4 hour target with there having been only 8 12 hour beaches. She commented that there remained continued activity in respect of norovirus particularly at Liberton Hospital and the Royal Infirmary of Edinburgh which was making the March position challenging due to restrictions in the ability to move patients.

The Nurse Director highlighted work underway in respect of the improvement plans and made specific reference to capacity modelling being undertaken between health and social care; stepdown bed development; the emergency workforce plan; additional capacity at the Royal Infirmary of Edinburgh in wards 109 and 209 and assessment areas; the action plan for the day of care audit and the review of winter planning arrangements to be undertaken in April.

The Board noted in respect of stroke performance that detailed work was underway with the stroke teams.

The Director of Health and Social Care, City of Edinburgh Council provided the Board with an update in respect of the March census position for delayed discharges for Edinburgh advising that the position had improved from 90 to 80. It was noted that ISD had changed the counting methodology which impacted on the numbers reported. He commented that 10 people were waiting over 6 weeks and provided further information in respect of these. The Board noted that the City of Edinburgh Council were commissioning 60 stepdown beds, 10 challenging behaviour beds and 10 dementia beds.

The Board agreed the recommendations in the circulated paper and noted the positive performance.
168. **Financial Position to 28 February 2013**

168.1 The Director of Finance provided an overview of the financial position to the end of February 2013 and confirmed that NHS Lothian was reporting a £1.5m underspend to the end of February with the in month benefit relating to the fact the Scottish Medicines Consortium had rejected a number of drugs that NHS Lothian had expected to be approved.

168.2 The Director of Finance commented that at the year end it was likely that there would be a small underspend of between £2m and £2.5m and that this could be utilised to frontload payment of the £10m of waiting times brokerage leaving the remainder to be paid back over the next 2-3 years. The Director of Finance commented that it was likely that the Scottish Government would approve this approach.

168.3 The Board noted that the activity data reflected continuing private sector usage as well as an increase in planned admissions and a small increase in unplanned activity. It was noted that this would be an area of further focus for the Finance and Resources Committee.

168.4 The Director of Finance commented that it represented a huge challenge to manage a capital programme within a 1 year cash target. It was anticipated that the capital programme would breakeven.

168.5 The Director of Finance advised that the £12m of carry forward into the following year was reflected in the efficiency proposals for next year which would amount to around 3% with plans already in place for a substantial part of the programme.

168.6 The Board noted the positive financial position and the fact that the Director of Finance was predicting a small underspend at the year end.

169. **Complaints Performance**

169.1 The Director of Human Resources and Organisational Development provided the Board with a report giving a broad overview of the main trends and learning identified through complaints received by NHS Lothian. It was noted for future reports attempts would be made to obtain comparative data from other similar sized Health Boards in Scotland.

169.2 The Board were advised that training and development activity was being linked to areas where issues had been identified and had been brought forward. The Director of Human Resources and Organisational Development reported that complaints staff were working under considerable pressure in respect of the number and complexity of complaints. Staff development opportunities were focussing on process issues as well as adopting a different mindset with the outcome being around resolving the complaint for the patient. It was noted that qualitative patient feedback would be built into future reports which would come before the Board on a quarterly basis.

169.3 The Chair commented that complaints data should be part of the routine performance intelligence and should be used scientifically.
169.4 The Board debated the complaints paper and agreed it represented positive work in progress and welcomed the move to focussing on the patient experience by getting faster more responsive feedback. Dr Bryce offered to provide support in developing work moving forward. It was suggested that the outcomes of complaints should feature as shared learning experiences.

169.5 The Chairman reported on comments received by Mr Brettell in his absence which had been copied into the Director of Human Resources and Organisational Development which were generally supportive of the progress being made in terms of getting visibility of the issues at Board level.

169.6 The Director of Public Health and Health Policy welcomed the report advising she had discussed with the Director of Communications and Public Affairs about how best to intervene earlier in complex complaints and to look at the patient experience in a more rounded way. It was noted that there were detailed protocols in place for investigating complaints.

169.7 The Board agreed that the patient experience was critical and there was a need to develop a smart approach which continued to take complaints seriously and look at worrying areas at a strategic level.

169.8 The Vice Chair commented moving forward in respect of the integration agenda there would be a need to be careful to properly and pragmatically manage governance processes. Information would need to be available by discipline, by site and by specific area.

169.9 The Nurse Director advised that many issues were responded to in real time and that the report only dealt with formal complaints received. She cautioned there was a need to be clear about the cause of complaints before rushing to investigation and this was an area Quality Improvement Teams considered. It was noted fast frequent feedback was aligned to national work and was being piloted at the Royal Infirmary of Edinburgh. The Nurse Director agreed that patients stories were a rich way of understanding issues and were routinely considered by the Healthcare Governance Committee.

169.10 The Board agreed the recommendations in the circulated paper and welcomed the positive work in progress in this key area.

170. Local Delivery Plan 2013/14

170.1 The Director of Strategic Planning, Performance Reporting and Information reminded the Board they had considered the draft Local Delivery Plan (LDP) in the private session the previous month. The LDP had been submitted to the Scottish Government by the 15 March return deadline.

170.2 The Board noted that the LDP and HEAT targets were essentially the Boards contract with the Scottish Government and future work would link these back to the clinical strategy framework, the risk register, corporate objectives and the performance report.
170.3 Mr Walker commended the good work that had been undertaken and felt it was helpful linkages were being made with the corporate objectives. He noted in respect of workforce planning that the paper went into detail beyond paediatrics and questioned what was being done on the impact element and how less than full time working was being addressed recognising the need to work with other partners. He felt the paper detailed significant emerging issues in emergency medicine as well as obstetrics and gynaecology and sought assurance that the same level of detailed planning was being done in these areas as had been the case in paediatrics in order to deal with emerging pressures proactively.

170.4 The Director of Human Resources and Organisational Development assured the Board a very thorough process sat behind the paper and the issue was not just about identifying risks. He reported there was additional complexities in many specialties and the South East and Tayside Planning Group (SEAT) had devised a risk analysis which had been applied to all medical specialties across the whole region. The analysis would be completed later in the month. The Director of Human Resources and Organisational Development advised that the specialties referred to by Mr Walker would be areas of focus and consideration would be given to arrangements that needed to be put in place for these specialties in the same way as paediatrics to ensure any fragility was addressed in a professional manner. Fuller details would be provided to a future Board meeting.

170.5 The Chief Executive reminded the Board an additional 6 accident and emergency consultants had been appointed as well as expanding staffing at St Johns Hospital including GP input as well as an additional 28 nurses having been recruited. He felt this was a positive example of mitigating action being taken in these areas. He reported that generally medical staffing would be a risk as the profession became more female orientated. The Chief Executive felt in future there would be fragile arrangements around a number of specialties and in that regard there was a need to make Lothian jobs as attractive as possible.

170.6 The Chief Executive commented in respect of inputs that the previously planned reduction in trainee numbers had been paused and in some instances numbers had been raised. A national review was underway which was due to report in September which might mean a radical review of what was required. Mr Walker welcomed the assurances.

170.7 The Chairman advised that due to a prior engagement he required to leave the meeting at this point. He advised that the following Sunday marked the end of his second term as Chair and he was awaiting the Cabinet Secretary’s decision on whether or not he had been successful in his application to serve an additional term. The Chair commented that in the event he was not reappointed he wanted the take the opportunity to thank Board colleagues for their support and also in particular his office staff of Mr Weir, Mr Reith and Mrs Watters for all their help and support over his previous 2 terms.

170.8 The Vice Chair thanked the Chairman for his contribution over what had recently been a difficult time.

170.9 The Chairman left the meeting and the Vice Chair assumed the Chair for the remainder of the meeting.
171. **Financial Plan 2013/14 – 2017/18**

171.1 The Director of Finance advised that the plan was largely focussed on 2013/14 although it was set out to 2017/18. She advised as other strategies developed there would be a need to reflect these in a longer term financial plan.

171.2 The Board noted the draft financial plan had been considered twice by the Finance and Resources Committee as well as by the Board at its last meeting held in private session. The Finance and Resources Committee had been keen for more work to be undertaken in respect of supporting the move to Health and Social Care Integration.

171.3 The Director of Finance noted the good progress made in year on National Resource Allocation Committee allocations (NRAC) with further commitments having been given by the Scottish Government. It was noted however that NHS Lothian was still some way from parity. It was noted further work was needed around elective and unscheduled care capacity, auto enrolment and prescribing budgets.

171.4 The Board noted the risks set out in the paper and that these were being managed with the Director of Finance being confident with the robustness of the process moving forward. In respect of waiting times spend the Director of Finance was considering how to map this by sub-specialty in order to demonstrate the benefits from the capacity building undertaken over the course of the year. The Director of Finance acknowledged the need for continued use of the private sector in 2013/14 and beyond as the system continued to build internal capacity. It was noted however in future years there would not be the same level of backlog cases to be addressed.

171.5 The Chief Executive commented that the financial plan did not take account of demographic pressures over the next 3-5 years and reminded the Board that a lot of the waiting times pressures were in procedures of old age. He advised even with the £17m additional NRAC allocation that the system had received that NHS Lothian remained £50m adrift of parity. Whilst the financial plan did not predict capacity over the next 5 years taking account of demography the Scottish Government commitment in respect of NRAC was useful.

171.6 Mr Wilson questioned how realistic the productivity and efficiency target was given the fact the system had struggled to meet this fully in the previous years. He sought advise on what the contingency would be if targets were not met. The Director of Finance in response advised in the current year workstreams had been looked at as well as delivering redesign of services which took time to come to fruition. She commented management focus had also correctly been around addressing the waiting times position. Within finance a programme management infrastructure was now in place which would lead to a better balance between workstreams and local LRP. The Board were advised by the Director of Finance that the contingency position would be the availability of non recurring slippage.

171.7 The Board agreed the Financial Plan 2013/14 – 2017/18.
172. Property and Asset Management Investment Programme 2013/14 – 2017/18

172.1 The Director of Finance provided the Board with an overview of the 5 year property and asset management programme. It was noted that the timing of capital projects had not yet been fully approved and would require to be managed to ensure delivery of a balanced position in 2013/14 and there would therefore be a need to come back to the Board with further detail about what was committed expenditure and what was cost estimates.

172.2 The Director of Finance reported that the 2 main capital projects remained the Royal Hospital for Sick Children / Department of Clinical Neurosciences project and the first phase of the Royal Edinburgh Hospital project. She advised previously the Royal Victoria Hospital had been identified as a major disposal although this was being revisited as part of capacity planning and might therefore not be available in the short term. It was noted good progress was being maintained with Consort around delivering additional beds in wards 109 and 209 at the Royal Infirmary of Edinburgh in advance of the forthcoming winter. Work was also underway to look at creating additional assessment beds.

172.3 The Chief Executive reminded the Board that a development session had been arranged for 1 May 2013 which would look at the configuration of sites and this would provide an opportunity for further debate.

172.4 The Director of Finance undertook to discuss with Dr Williams the position in respect of Primary Care premises outwith the meeting.

172.5 The Board approved the Property and Asset Management Programme 2013/14 – 2017/18.

173. Equality Outcomes for 2013/17

173.1 The Director of Human Resources and Organisational Development advised that NHS Lothian's current equality scheme ran until April 2013. He commented a comprehensive set of equality outcomes had been developed to supersede the equality scheme and these were presented in the circulated paper and set out how NHS Lothian would continue to work towards equality, diversity and children and human rights aspects over the next 4 years until 2017.

173.2 The Board noted that involvement work to develop the outcomes had taken place over 8 months from June 2012 with the consultation for the new Equalities and Rights Outcomes running from 18 November 2012 to 11 February 2013.

173.3 The Vice Chair welcomed the fact that the equalities outcomes would be posted on the website and questioned how the Board would know how well it was performing. The Director of Human Resources and Organisational Development advised an ethnic coding taskforce had been established which confirmed positive rates of coding with additional fields being recorded. The Board noted Lothian was one of the few areas where the self identification of when they used services was undertaken by gypsy travellers.
173.4 The Director of Human Resources and Organisational Development also referred to the inclusion of equal pay indicators in the action plan and advised progress against this would be reflected in his annual report to the Board in November mapping progress against the Human Resources and Organisational Development Strategy.

173.5 The Board approved the equality and rights outcomes for 2013/17 along with the accompanying action plan, mainstreaming report and equal pay statement.

174. Shadow Health and Social Care Partnership Boards: Chairs and Memberships

174.1 The Board confirmed the appointments detailed in the circulated paper of Chairs and Members of the Shadow Health and Social Care Partnership Board for East Lothian and Midlothian and Partnership Members to the Edinburgh and West Lothian Shadow Health and Social Care Partnership Boards. The Board also authorised the Board Chairman to appoint to any outstanding vacancies subject to homologation at the next Board meeting.

174.2 The Board received a verbal update on proposals submitted, from the Director, Health and Social Care, City of Edinburgh for appointment to the Chair and Vice Chair positions on the Professional Advisory Committee. It was agreed discussions would be held off line about the required process with a paper coming forward with proposals to the next Board meeting.

175. Communications Received

175.1 The Board noted the list of communications received from the Scottish Government since the previous meeting.

176. Date and Time of Next Meeting

176.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 24 April 2013 in the Board Room Waverley Gate, 2-4 Waterloo Place Edinburgh.

177. Invoking Standing Order 15.2

177.1 The Vice Chair sought permission to invoke standing order 15.2 to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke standing order 15.2.
Minutes of the Meeting of the Healthcare Governance Committee held at 9.00am on Tuesday 2 April 2013 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present:
Dr M. Bryce (Chair); Mrs M. Anderson, Patient and Public Representative; Ms P. Eccles, Partnership Representative; Ms W. Fairgrieve, Partnership Representative; Ms C. Garrod, Patient and Public Representative; Mr A. Joyce, Non-Executive Board Member; Ms A. Meiklejohn, Non-Executive Board Member; Ms M. Scott Macfarlane, Patient and Public Representative; Cllr F. Toner, Non-Executive Board Member; Mr G. Warner, Non-Executive Board Member; Dr R. Williams, Non-Executive Board Member; Mr R. Wilson, Non-Executive Board Member.

In Attendance:
Ms S. Ballard-Smith, Divisional Nurse Director; Ms J. Bennett, Clinical Governance Manager; Ms P. Brooks Young, Senior Clinical Nurse Specialist (item 6.4); Dr D. Farquharson, Medical Director; Ms S. Fife, Nurse Consultant in Cancer and Palliative Care (item 6.4); Mr J. Forrest, West Lothian CHCP Manager; Miss T. Gillies, Associate Divisional Medical Director; Mr J. Glover, Head of Equality and Diversity; Dr A. McCallum, Director of Public Health; Mrs B. Pillath, Committee Administrator; Mr S. Young, Head of Spiritual Care and Bereavement (item 7.3).

Apologies for absence were received from: Mr C. Briggs, Edinburgh CHP Manager; Mrs M. Hornett, Nurse Director; and Mr D. Small, East and Midlothian CHP Manager.

Chair's Welcome and Introductions
Dr Bryce welcomed members to the meeting and members introduced themselves. Members were asked to declare any conflict of interest.

Patient Story
The patient story was circulated with the minutes. Ms Ballard-Smith commented that this story represented a good opportunity to consider the supervisor’s role in a different context.

1. Committee Cumulative Action Note and Minutes from the Previous Meeting (5 February 2013)

1.1 Dr Bryce noted that the action note for this committee had not been circulated as the format was being reviewed. Dr Bryce, Ms Bennett and Mrs Pillath would develop an improved version by the next meeting.

MB, JB, BP

1.2 Minutes of the previous meeting held on 5 February 2013 were approved.
2. Matters Arising

2.1 Francis Report

2.1.1 It was noted that the outcome of a meeting with the Scottish Government on the report was still awaited.

2.2 Information Services Division

2.2.1 Miss Gillies reported that more data on re-admissions had been requested from the information analyst. Mr Wilson suggested that if the validity of the data was being questioned, then this should be requested through the Chief Executive of National Services Scotland. Dr Bryce and Miss Gillies would agree a format for this request. MB, TG

3. Terms of Reference and Assurance Needs

3.1 A workshop would be held on 5 June 2013 for the discussion of assurance needs for the Committee, including the process of how the Committee met its requirements in the terms of reference by ensuring work in its remit was being carried out.

3.2 Revised terms of reference were tabled at the meeting and Committee members agreed to send any comments to Dr Bryce in order that the revised Terms of Reference could be submitted to the next Board meeting in May 2013 for approval. ALL, MB

4. Emerging Issues

4.1 Chair’s Update

4.1.1 Dr Bryce advised that a review of overlap and gaps between the Staff Governance and Healthcare Governance Committees was being discussed between committee chairs and would also be considered at the workshop in June.

4.2 Healthcare Governance Committee Annual Report

4.2.1 The annual report had been circulated to the committee. Dr Bryce noted that the report should reflect changes made and give assurance that the Committee had been effective over the previous year, and where it had not been effective, processes had been put in place for improvement.

4.2.2 Dr Williams requested that the note of his attendance at meetings in the annual report be checked for accuracy. MB

4.3 National Confidential Alert Line

4.3.1 Dr Farquharson advised that the National Confidential Alert Line was now in place. Dr Bryce agreed to ask Mr Boyter to update the Committee on how the Board would be kept up to date with developments. MB
5. **Person Centred Care**

5.1 **Patient Quality Indicator (PQI) Audit Update**

5.1.1 Ms Ballard-Smith advised that PQI audits had been being carried out for one year. Since the circulated paper was published, there had been an Older Persons Care (OPAC) inspection at the Royal Infirmary on 14 and 15 February 2013, and a Healthcare Environment Inspectorate (HEI) inspection at the Western General Hospital on 27 and 28 February 2013. The report from the OPAC inspection noted that progress had been made and fewer recommendations had been made than at previous inspections. The report from the HEI visit also noted improvements and there were four recommendations, one of which regarding the correct use of temporary closure on sharps bins was classed as ‘high’ priority. A revised sharps bins policy was due to be published by the EU in May 2013.

5.1.2 It was noted that PQI audit walk-rounds were unannounced to the ward but were undertaken according to a structured schedule which ensured that each ward was visited twice per year. Patient representatives were included in the audit group. The patient safety leadership walk-rounds were devised in conjunction with PQI audit schedules to ensure visits to each clinical area were spread out in time.

5.1.3 The Committee noted the findings and actions required set out in the report.

6. **Safe Care**

6.1 **Healthcare Associated Infection Update**

6.1.1 Dr McCallum reported that the government target for *Staphylococcus aureus* Bacteraemia (SAB) had not been met; however, there had been a large reduction in numbers since the improvement programme began. Each SAB was investigated with areas of improvement required being identified. There had been no clusters of cases. MRSA was found in patients in the community across the UK and in other countries.

6.1.2 Dr McCallum noted that the government target for *Clostridium difficile* (CDI) had been met.

6.1.3 Dr McCallum noted that there had been a number of norovirus outbreaks in various hospitals in NHS Lothian; this was similar to other Scottish Health Boards. Visitor restrictions had been put in place for a period in some areas of Liberton Hospital and the Royal Infirmary.

6.1.4 Dr McCallum noted that going forward Mrs Hornett would take over the executive lead for Healthcare Associated Infection.

6.1.5 Dr Williams noted an inconsistency between very good hand hygiene compliance results of above 95% in all staff groups, and poorer compliance with high level cleaning, completion of sign-off sheets, and dedicated patient equipment. Dr McCallum agreed to work with Ms Ballard-Smith and Mrs Hornett to establish the reasons for inconsistency between these two sources of data and ensure that audit systems were robust.

AMcC, SB-S, MH
6.2 Public Protection Update

6.2.1 Ms Ballard-Smith noted that money had been allocated for recruitment of child protection advisors. Dr Farquharson noted that a meeting would take place in the week beginning 8 April 2013 to consider the replacement of the designated child protection advisor, who was retiring.

6.3 Improving the Management and System Learning from Significant Adverse Events

6.3.1 Ms Bennett advised that she had undertaken the role of reviewing all adverse events and identifying any themes which could lead to actions for improvement. She referred the Committee to Appendix 2 of the report which set out the system themes that resulted from the review, and NHS Lothian’s response.

6.3.2 Dr Williams noted that medication errors were also on the agenda of the Area Drug and Therapeutics Committee.

6.3.3 Mr Glover noted that an impact assessment would be carried out on the Significant Adverse Events improvement paper to assess the impact on inequalities.

6.3.4 The Committee noted the actions completed and NHS Lothian’s response to system themes from the review of significant adverse events.

6.4 Liverpool Care Pathway Report

6.4.1 Mr Warner emphasised the importance of helping members of the public to reach a clear understanding of what the Liverpool Care Pathway Report (LCP) was, and commented that this understanding had not yet been reached. Dr McCallum noted that the research and evidence base for the LCP was clear, and it was important that this was available to the public. Ms Brooks Young noted that this was linked to the need for improvement of engagement with patients and relatives on the subject of death, dying and palliative care, and that Alexis Burnett, Communications Manager, had been asked to develop an end of life care communication strategy which was now in the first draft.

6.4.2 Ms Garrod noted that the public might associate the LCP with a saving of resources and suggested that communication about the pathway would help reassure the public. Ms Brooks Young noted that the phrase ‘best supportive care’ had previously been discussed and more accurately reflected how the LCP was used in practice.

6.4.3 Ms Brooks Young reported that a ‘Good Life, Good Death, Good Greif’ campaign was being launched as a forum for staff discussion of planning life and death. This would include events for staff at a number of locations including community sites.

6.4.4 Ms Scott Macfarlane noted the need to ensure that the patients, rather than the relatives, wishes were taken into account where there was a living will.

6.4.5 Ms Brooks Young noted that the result of the Scottish independent review was awaited.

6.4.6 The Committee agreed to support the recommendations of the LCP report and asked for an update in the Autumn.
6.5 Complaints Report

6.5.1 Mr Wilson requested that feedback was given when papers submitted to the Committee were also discussed at the Board.

6.5.2 Dr Bryce reported that the Board had decided that more information was needed on patient experience, trends, actions taken, and whether the complainant was satisfied, along with raw numbers of complaints. It was noted that reporting of figures gave assurance that there was a process in place to reduce numbers; as required by the Scottish Government.

6.5.3 Dr Williams requested clarity on paragraph 3.11 of the report as he was not aware that the GP Sub-Committee had agreed to send reports to the complaints team. Dr Bryce agreed to find out from Stuart Wilson.

6.6 Management of Deteriorating Patients

6.6.1 Ms Bennett noted that the Board had identified the need to improve the management of deteriorating patients and asked for each area of work to be discussed in more detail at the Healthcare Governance Committee. This included strategies to ensure that staff were equipped to identify deteriorating patients and that escalation protocols were robust, including for boarded patients. The first stage would be testing of existing systems to ensure they were reliable and effective.

6.6.2 If improvement had been made, figures should initially show an increase in medical emergencies due to improved recognition, and a decrease in actual cardiac arrests. It was noted that numbers always increased during the Winter.

6.6.3 Training of clinical staff was taking place using mentoring and 1 hour training within the clinical areas. This reduced staff pressure and time away from the clinical area.

6.6.4 Miss Gillies reported that further work was being done on cardiac arrests locally, and on the need to match end of life care with work on deteriorating patients.

6.7 Westcott Line Significant Adverse Event

6.7.1 The report set out a number of significant factors and issues identified during investigation of this incident, and improvements made. The Committee noted its support of the improvement plan.

7. Effective Care

7.1 Quality Report

7.1.1 Dr McCallum noted that the likelihood of premature death due to coronary heart disease had been found to have a five-fold difference between different socio-economic and ethnic groups. The most deprived parts of the population might have coronary heart disease along with a range of other problems such as smoking and diabetes. Further study would look at whether this was a distinct group of deaths which current measures did not seem to be covering.
7.1.2 Ms Ballard-Smith agreed to work with Mrs Hornett to develop a one-page description of the recognised national definitions for pressure ulcer categorisation and when these were considered avoidable or unavoidable. A similar patient information leaflet would also be considered.

SB-S, MH

7.1.3 It was suggested that further explanation of themes and areas affected should accompany the figures in this report for a greater understanding.

7.2 Business Continuity

7.2.1 Ms Bennett advised that work was being undertaken to link Business Continuity planning and training to incidents and scenarios which were relevant for staff.

7.2.2 Ms Ballard-Smith noted that work was also being done on how debriefing following incidents could ensure appropriate improvements were made.

7.3 Spiritual Care and Bereavement Update

7.3.1 Mr Young noted recent new guidance from the Scottish Government Healthcare Directorate in 2012 on disposal of pregnancy losses during the first trimester, and the plan for a new death certification process to commence in April 2014. NES would produce a package of resources for staff on the new death certification process.

7.3.2 Miss Gillies advised that she was part of the national advisory group on death certification and would be able to update the Committee in the future.

7.3.3 Mr Young explained that the majority of the chaplaincy team were ‘generic’ spiritual carers employed to care for all religious and non-religious groups. The Spiritual Care and Bereavement Team also worked with religious bodies who provided resources to look after their own members where this was required. These agreements might be voluntary or might involve a cost. An agreement was in place with the Roman Catholic Church, and discussions were currently ongoing with the Scottish Muslim Society. Dr Bryce agreed to report back with more detailed information on service level agreements to ensure that there was equity between different religious groups and denominations.

MB

7.3.4 A question was raised regarding services for ‘self-carers’ who were inpatients. Mr Young noted that care for these patients was offered by the spiritual care team, the patient information team, and voluntary services, and that the majority of cases referred to the spiritual care team were in this situation.

7.4 Risk Register

7.4.1 It was noted that the paper presented to this committee had been updated since circulation to the Board. The Board had acknowledged that the document was work in progress and had noted that there was no mention of NHS Lothian’s reputation or about the maintenance backlog in the report. It had also asked for more information about individual risks; and requested quarterly rather than six monthly reports.

7.4.2 It was noted that ‘patient experience’ and ‘patient safety’ had now been separated into two categories as processes for these were different. Mr Wilson suggested that definitions should be made clearer.
7.4.3 Dr Farquharson noted that each of the risks on the register was divided into the appropriate service, where they were managed. Dr Bryce noted that gaining information from services to assure the committee that relevant actions were being undertaken consistently throughout the organisation should be considered. Mr Wilson suggested that actions required and time frames for each risk should be added to the report. Ms Bennett noted that more information about the management of some risks could be found in other papers reported to the Committee.

7.4.4 Mr Wilson suggested that at future meetings the Committee should discuss specific risks in more detail. The Risk Management Steering Group met monthly and Dr Bryce agreed to attend the next meeting for information.

7.4.5 Ms Eccles requested details about how actions taken on risks were fed back to staff who initially submitted the risk. Ms Bennett agreed to report back on this.

8. **Other Minutes**

The Committee noted minutes from the following meetings:

8.1 Clinical Management Group, 8 January and 12 February 2013;
8.2 Health and Safety Committee, 29 January 2013;
8.3 Organ Donation Committee, 24 January 2013;
8.4 Area Drug and Therapeutics Committee, 1 February 2013. Item 1.7 was noted, highlighting the risk that practices using the EMIS system rather than the ‘Vision’ system which had the Lothian Joint Formulary included in it, might be less compliant with the Lothian Joint Formulary;
8.5 Lothian Infection Control Advisory Group, 26 November 2012;
8.6 Divisional Dental Executive, 20 December 2012.

9. **Exception Reports**

The Committee noted the following reports:

9.1 Final Equality Outcomes 2013-17 (post-consultation); Clinical Policy Annual Report
9.2 Local Supervising Authorities Report
9.3 Bowel Screening Annual Report.

10. **Date of Next Meeting**

10.1 The next meeting of the Healthcare Governance Committee would take place from 9.00am-11.30am on **Tuesday 4 June 2013 in Meeting Room 7, Waverley Gate**.

10.2 Further meetings in 2013 would take place on the following dates:
- Tuesday 6 August 2013
- Tuesday 1 October 2013
- Tuesday 3 December 2013
STAFF GOVERNANCE COMMITTEE

Minutes of the Staff Governance Committee held at 9.30am on Wednesday 20 March 2013 meeting room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr A Joyce (Chair); Mr A Boyter; Mrs J McDowell; Mrs A Meiklejohn; Mrs A Mitchell and Mr R Wilson.

In Attendance: Dr D Farquharson; Dr Kalman; Mrs R Kelly; Mrs B Pillath; Mr P Reith and Mr S Wilson.

Apologies for Absence: Councillor D Grant; Mr S McLauchlan; Mr G Warner; Dr C J Winstanley and Mrs M Hornett.

Declaration of Financial and Non Financial Interest

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

46. Minutes of the Previous Meeting

46.1 The minutes of the previous Staff Governance Committee meeting held on 30 January 2013 were approved as a correct record.

47. Matters Arising

47.1 Health and Social Care Integration – Mr Boyter advised the Committee that Joint Directors of Health and Social Care were in place in both Edinburgh and West Lothian Shadow Health and Social Care Partnerships. Work was also in progress to appoint Directors Designate for the East and Midlothian Shadow Health and Social Care Partnerships. The process in Midlothian was well underway and a decision was awaited. East Lothian would be deciding at the Council meeting in April. It was hoped to be able to report to the March Board meeting on the outcome of the Midlothian appointment and to the April Board meeting with the East Lothian appointment. NHS Lothian’s Human Resources & Organisational Development Directorate would be responsible for the process. The Committee agreed to endorse the process so far adopted.

47.1.1 The Committee noted that whilst NHS Boards had standard terms of service, local authorities each had different ones and work on resolving any difficulties arising from this was moving forward in the areas where joint appointments were not already in place. The Chair commented that the staff side had some concern that
terms of service might be established that did not comply with the forthcoming legislation. Mr Boyter advised that there was staff side representation on the group from NHS Lothian but not from the Local Authorities and that the Cabinet Secretary was keen that Boards press ahead with the Health and Social Care agenda.

47.1.2 Mr Wilson commented that there were risks associated with this approach and Mr Boyter advised the Committee that he was confident that these risks could be managed. The successful candidates in each post would be offered a choice of Local Authority or National Health Service Terms and Conditions of service. Mr Wilson commented on the lack of clarity in some major areas of the reorganisation and Mr Boyter advised that he expected that the Scottish Government would issue significant guidance but that this was still in the process of being drawn up.

47.1.3 Mr Wilson gave as an example of an area which had not yet been resolved, the issue of prescribing costs in Edinburgh where NHS Lothian paid for any overspend but any underspend would not revert to the Board. The Committee noted the position.

47.2 Updated Risk Register – Mr Boyter advised the Committee that work was ongoing and the Risk Register was in the process of being updated following discussions at the Joint Management Team and would be considered at the next Audit & Risk Committee. A presentation would also be given to the next Staff Governance Committee meeting by the Risk Manager, Jo Bennett.

47.2.1 Mr R Wilson expressed disappointment that there was no Risk Register available for the Staff Governance Committee yet and Mr Boyter advised that the Risk Management Steering Group had only just agreed what the division of risks between Committees should be. Mr Boyter undertook to circulate the current Risk Register to members of the Committee with the caveat that this was being updated.

47.3 NHS Lanarkshire Staff Governance Conference – The Chair advised the Committee that this event had been more a re-launch of the Staff Governance Standard and was not of any great relevance to NHS Lothian. He was, however, considering the idea of a half day event for a smaller group in Lothian and it was agreed that this possibility should be investigated further.

47.4 Auto Enrolment – Mrs Kelly advised the Committee that a letter would be sent out to the appropriate staff in April advising of the arrangements for auto enrolment. It was hoped that staff who wished to opt out of the Superannuation Scheme would be able to complete and return the necessary forms in time for most deductions from salary to be prevented. Mrs Kelly also advised that it was hoped to extend the window to allow contributions that had been deducted from those wishing to opt out to be repaid and NHS Lothian would endeavour to be as supportive of staff as possible. The lowest paid part time staff would be below the threshold for inclusion and might not be affected. The position of bank staff was different and they would not be auto enrolled if they already had a substantive contract. There would also be some staff who would not be eligible for the NHS Pension Scheme and arrangements were being made for them to be enrolled into the Government Sponsored National Employers Savings Trust. The overall cost to NHS Lothian
should be known by the summer. Mrs Kelly reminded the Committee that the auto enrolment process would happen again in 3 years time.

47.5 NHS Lothian Health and Safety Committee (Complex works at the Royal Infirmary of Edinburgh) – Mr R Wilson raised the issue of group responsibility for Capital Works at the Royal Infirmary of Edinburgh site. Mr Boyter advised that this came under the Director of Finance and the Finance & Resources Committee and that a project Health and Safety Advisor was being appointed. He advised that if it was considered necessary the Committee could seek further assurance on the arrangements from the Finance & Resources Committee.

47.5.1 Mr R Wilson commented that there appeared to be some confusion as to who was responsible for Health and Safety. Mr Boyter confirmed that the Board’s Health and Safety Committee was not responsible for health and safety on this project as health and safety responsibility was a line management issue. Line management responsibility would sit with the Director of Finance and Mr Boyter undertook to clarify the situation for the next meeting.

48. Protection of Vulnerable Groups / Progress Report

48.1 The Committee received a previously circulated report giving an update on the Protection of Vulnerable Groups Scheme and the progress with implementation of the retrospective checking within NHS Lothian.

48.2 Mrs Kelly reminded the Committee that the Protection of Vulnerable Groups legislation was introduced in February 2011 and replaced enhanced Disclosure Scotland checks for those deemed to be in regulated work with children and adults at risk with new types of disclosure records under the Protection of Vulnerable Groups Act. The cost of the initial scheme membership was £59 and this membership remained with the individual for the duration of their career. Within NHS Lothian there were approximately 20,000 staff who required Protection of Vulnerable Groups Scheme membership through retrospective checking and a service level agreement had been made with Disclosure Scotland that they would process around 700 checks per month for NHS Lothian during the period October 2012 to September 2015.

48.2 The Committee noted that whilst a period of retrospective checking had commenced on 29 October 2012, the first forms were not processed until January 2013. This allowed time for the necessary system to be put in place within NHS Lothian and also for additional administrative resources to be secured to undertake the additional work. 363 forms had been processed to date and 129 certificates had been returned from Disclosure Scotland. The first areas to be checked had been the Royal Edinburgh and Associated Hospitals and Medicine of the Elderly as these were areas where a significant number of retrospective checks would be required given the client group. Work had also commenced in the Woman’s and Children’s Directorate and more recently in radiology, cancer and head & neck.
Mrs Kelly advised that to date 14 forms had been returned from Disclosure Scotland with information for noting which would require to be considered. The policy on how undeclared convictions would be dealt with was being developed and it would shortly be known whether any of the 14 convictions so far notified had not been previously declared.

Mrs McDowell queried the level of applications processed to date and Mrs Kelly confirmed that this was not yet up to the target level although it was hoped that this would be achieved by May 2013. At Mrs McDowell suggestion it was agreed that a single table combining the number of requests submitted and the number of responses received and the different between the two would be used in future reports. In addition, each report would indicate how long it was anticipated that the overall process would take.

Mrs Kelly confirmed that work was ongoing with Disclosure Scotland to agree groups of staff for whom a Protection of Vulnerable Groups check was required and work was ongoing to improve the relationship between NHS Lothian and Disclosure Scotland.

The Committee agreed to note the current progress with Protection of Vulnerable Groups retrospective checking.

**Internal Communications Strategy**

The Committee received a previously circulated report outlining a proposed new internal communications strategy for NHS Lothian which sought to engage and inform all employees and ensure they were aware of what was going on and kept up to date with key issues.

Mr S Wilson introduced the report and commented that whilst it had many awards for communicating to the general public, NHS Lothian had not been particularly effective at communicating with its own staff. The original strategy had been approved in 2012 and had now been updated. Progress in its implementation was being constantly reviewed.

Mrs McDowell commented that the objectives seemed ambitious and Mr S Wilson advised that a number of these were based on responses received in the staff survey.

Mrs Kelly confirmed that the staff survey, undertaken nationally by the Information Services Division, would be carried out annually in 2013, 2014 and 2015. This would use a set number of questions and would be a closed questionnaire with no local questions, running from 27 May to 26 June. The final report on the survey was expected in October 2013. The questionnaire would be online but with paper versions available. Whilst there were no Board specific questions and no free format text, NHS Lothian would receive data relating to its staff.

The Chair commented that it would be good to see tailored team briefs and notice boards being kept up to date.
49.6 The Committee agreed to note and welcome the new Internal Communications Strategy for NHS Lothian which would ultimately form part of the overall communications strategy.

50. **Vexatious and Persistent Complaints – Support for Staff**

50.1 The Chair advised the Committee that there had been two major incidents recently involving vexatious and persistent complaints against staff. The Nurse Director was aware of both cases and the Committee noted that NHS Lothian had no policy for protecting staff in such circumstances although there was a brief mention in the Board’s policy on Dignity at Work.

51.2 Dr Kalman advised that Occupational Health was looking at providing counselling and support to staff in such circumstances but that no specific policy currently existed for dealing with this problem.

51.3 Mr Boyter advised that there might be a need to review the process of declaring a complaint vexatious and that the Central Legal Office would be consulted about the possibility of obtaining interdicts against vexatious and persistent complainants.

51.4 The Committee noted that the Nurse Directorate was checking with other NHS Boards to see if any of them had specific policies on this issue and Mr Boyter and Mrs Kelly would check with other UK University Hospitals to see if they had any similar policies in place.

51.5 The Committee agreed that Mr Boyter and the Chair should meet with the Nurse Director to work together to work on a draft policy on dealing with vexatious and persistent complaints.

52. **Future of Tic Talk Nursery**

52.1 Mr Boyter introduced a previously circulated report on a decision taken by the former Executive Management Team to close the Tic Talk Nursery based at St John’s Hospital in West Lothian.

52.2 The Committee noted that historically, NHS Lothian had provided subsidised nursery places for staff members’ children as a recruitment incentive. The Tic Talk Nursery at St John’s Hospital had been established when the hospital first opened as there was little nursery provision in the immediate area. The nursery offered flexible places for children to accommodate staff shifts and children tended to stay within the nursery until they reached school age.

52.3 Since that time there had been significant changes in the nursery provision in the area and 9 nurseries now operate in the vicinity of the hospital. With the advent of funded nursery school places for 3 - 5 year olds, the majority of children reduced their attendance at Tic Talk Nursery to move into pre-school education.
52.4 The Committee noted that the Tic Talk Nursery at St John’s Hospital was not self-funding and currently received a subsidy of approximately £70,000 a year from NHS Lothian and facilities estimated that maintenance, heating, cleaning and other costs for the building amounted to further £70,000 per annum.

52.5 Following a review of nursery provision across NHS Lothian undertaken in 2011, it was recommended that NHS Lothian withdraw from nursery provision over a timescale that was both reasonable and appropriate as hospital sites were re-provided. This recommendation was then endorsed by the Improving Care Investing in Change Committee, the Lothian Partnership Forum and the Executive Management Team at the start of 2012.

52.6 Following this review the decision was taken to discuss the timescales of the closure with staff and it was agreed that the nursery at St John’s Hospital would remain available to those children currently enlisted there until they were in a position to enter pre-school education. No new entrants were to be accepted by Tic Talk Nursery and the nursery was to close once all the children had naturally progressed into pre-school education.

52.7 The empty building vacated by Tic Talk Nursery would be used by NHS Lothian to provide clinical services as there was a pressing need for extra clinical space at St John’s Hospital.

52.8 This decision had subsequently prompted a number of representations to NHS Lothian from local and national elected members, members of staff and users of the nursery.

52.9 The Chair commented that this had been an ongoing issue for the past 2 years and that it was not NHS Lothian’s core business to provide nursery services. His view was that the nursery should close within the agreed timescale.

52.10 Mr Boyter commented that many of the users were not NHS staff and that the facility could be better used for clinical purposes.

52.11 The Committee noted that the proper procedures for consultation with staff on the closure of the facility had been implemented and it was supportive of the management decision. It would be helpful if the number of staff sending children to the Tic Talk Nursery could be provided.

52.14 Mr Boyter undertook to provide this information to Committee members.

53. Healthcare Improvement Scotland: Assessing Readiness for Medical Revalidation in NHS Lothian

53.1 The Committee received a previously circulated report from the Medical Director informing of the outcome of the review by Healthcare Improvement Scotland of NHS Lothian’s Readiness for Medical Revalidation, and the improvements which had been and continued to be made to address systems and processes where action was considered to be required.
53.2 Dr Farquharson spoke to the report and advised that the assessment had been based on an enhanced appraisal and he was relaxed that NHS Lothian would meet the appropriate standard. Good policies and appraisal mechanisms were in place and medical revalidation appraisals would link into the 360 degree appraisal system and be entered onto DATIX.

58.3 The Committee agreed to note the outcome of the Health Improvement Scotland Assessment of Readiness for Medical Revalidation for Lothian and for Scotland that an improvement plan was in place and had been updated to include action points for consideration.

59. **Equality Outcomes for 2013/17**

59.1 Mr Boyter introduced a previously circulated report on the Equality and Rights Outcomes for 2013/17 along with an accompanying action plan, main streaming report and equal pay statement.

59.2 Mr Boyter explained that as part of the Equality Act 2010, the Scottish Government had published a new set of specific duties which must be met by all public sector organisations in Scotland. Many of the new duties would come into force on 30 April 2013 and the new Equality and Rights Outcomes would ensure NHS Lothian was in the strongest possible position to meet these stringent new duties. Mr Boyter advised that a full report would be going to the March meeting of Lothian NHS Board. The Committee agreed to approved the Equality and Rights Outcomes 2013/17 paper along with the accompanying action plan, mainstreaming report and equal pay statement and recommend them to the Board.

60. **The Francis Report – Recommendations**

60.1 The Chair advised the Committee that the full Francis Report and its recommendations had now been received and sought the Committee’s views on where this should be discussed.

60.2 Mr Boyter advised that the Nurse Director and Medical Director would be taking a paper to the Board and emphasised that NHS Lothian’s actions would need to be in step with those of the Scottish Government.

60.3 Mr R Wilson suggested that the Francis Report should come to the Staff Governance Committee after it had been considered by the Board.

60.4 The Chair commented that the National Confidential Alert Line would come online in April 2013 and Mrs Kelly confirmed that a communication would be going out to all NHS Lothian staff notifying them of the national policy.

60.5 The Committee noted that a local whistle blowing policy was being developed and there would be a variety of marketing material available to ensure that staff were aware of the new National Alert Line.

60.6 The Committee noted the position.
61. **NHS Lothian Health and Safety Committee**

61.1 The Committee received for information the previously circulated minutes of the Health and Safety Committee meeting held on 29 January 2013.

61.2 Dr Kalman advised the Committee that NHS Lothian would be the first NHS Board to undertake a Corporate Organisation Audit. The Committee also noted that a formal review of Health and Safety Risks was undertaken at each meeting.

61.3 Mr R Wilson commented on the absence of completion dates in the action note and Dr Kalman advised that most of these items were actioned before the subsequent meeting.

62. **Date of Next Meeting**

62.1 It was noted that the next meeting of the Committee would be held on Wednesday 29 May 2013 in Meeting Room 7, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh.
Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday, 28th February 2013, in Council Chambers, Town House, Haddington

Present:  
Michael Ash (in the chair) (MA)  
David Small, General Manager (DAS)  
Donald Grant, Councillor, East Lothian Council (DG)  
Murray Leys, Head of Adult Social Care, East Lothian Council (ML)  
Ann McCarthy, PPF Representative (AMc)  
Gill Colston, PPF Representative (GC)  
Fiona Mitchell, (Director of Operations NHS Lothian) (FM)  
Sian Tucker, (Acting Clinical Director, LUCs) (ST)  

Apologies:  
Mandy MacKinnon, Health Promotion Manager (MMac)  
Moyra Burns, Health Promotion (MB)  
Lynne Hollis, Associate Director of Finance, NHS Lothian (LH)  
Alison MacDonald Chief Nurse (AXM)  
David Heaney, Strategy & Policy, East Lothian Council (DH)  
Thomas Miller, Partnership Representative EL&ML CHPs (TM)  
Robert Packham, AHP Manager, EL&ML CHPs (RP)  
Jon Turvill, Clinical Director, East Lothian CHP (JT)  
Sharon Saunders, Head of Children’s Services, East Lothian Council (SS)  
Rajvinder Singh, Carers of East Lothian (RS)  
Carol Lumsden, Integration & Transformation Manager ELML (CL)  

In Attendance:  
Wendy Michael (Minutes) (WM)  
Mike Porteous on behalf of Lynne Hollis (MP)  
Caroline Myles on behalf of Alison Macdonald (CM)  
Maureen McKenna, Team Leader, Adult Mental Health (MK)  
Dr Patricia Graham Head of Adult Mental Health, EL & ML Psychology (DrG)  
Peter Gilfoyle, Senior Project & Programme Manager, EL & ML CHPs (PG)  

1.0 Welcome and Apologies  

Apologies were noted it was again asked for representatives in the absence of members.  

1.1 Meeting Waiting Times: Midlothian Psychological Therapies Team  
Maureen McKenna (MM) & Dr Patricia Graham (DrG) gave a presentation on the above. MA thanked MM and DrG for their presentation and their success in redesigning the service.  

ML enquired about progress with reviewing mental health services following the November 2011 paper. It was agreed that DAS and ML would discuss outside the meeting. ACTION (DAS/ML)
AMc asked if this was just an adult service. MM confirmed that it was and that the children’s service is provided by CAMHS (Child and Adolescent Mental Health Services). AMc asked where the psychological therapies were provided. MM responded that the service is provided in Haddington, Musselburgh and Dunbar.

The East Lothian Sub Committee supported and formally noted the report.

1.2 Lanfine Unit Redesign Update

Ciara Byrne (CB) gave a presentation on the above.

The Lanfine Unit is based in a small ward in Liberton Hospital and the redevelopment for this unit was a recommendation as part of the Disability Strategy.

The redesign has completed Phase 1 Consultation, and Phase 2 Option Appraisal. Option 2 was the chosen preferred option. 10 beds, 5 multi disciplinary staff.

The redesign is now in Phase 3 Implementation which includes:

- moving from Liberton to the Astley Ainslie Hospital East Pavilion in April 2013.
- Reduce the beds from 18 to 10 by August 2013.
- Individual case review
- Delivering the new Lanfine Service Model.
- Best use of Breaks from Caring Resource.

MA confirmed that the presentation was a very useful briefing.

DG asked about the move of the service and if there would be a bus service. CB confirmed that there were many advantages of moving to AAH, especially the extra medical cover. CB reported that most patients tend to come in to stay either by taxi or by a family member not by bus service.

ML proposed that discussions on the respite element. East Lothian council are at the stage of producing a final Carer’s Strategy and it would be helpful to include this.

FM advised that it was a much needed service and commented on how helpful the report was. FM confirmed that this service runs at a 97% occupancy.

2.0 Minutes of Previous Meeting 20.12.12

Amendments were proposed by AMc to the Chief Nurse Report minute.

ML will bring back a joint report on Adult/Child Protection for future meetings. ML and AXM to liaise for future reports. ACTION

With the amendment above; minutes were agreed as a correct record.
3.0 Action Note Previous Meeting

Action log updated.

4.0 Items for Decision

4.1 East Lothian Joint Commissioning for Older People Strategy

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

The report is to inform and seek approval for the East Lothian Joint Strategic Commissioning Plan for Older People and the supporting self evaluation information which is required to be submitted to Scottish Government by 28th February 2013.

The sub committee is recommended to: Note the background to the requirement for, and the development of, the joint strategic commissioning plan; Note the significant progress in partnership working which has supported the development of the joint strategic commissioning plan; Note and approve the detail of the joint commissioning intentions within the plan and the supporting submissions

ML advised that the Joint Commissioning plan can also be seen as part of a pathway to the Integration of Health & Social Care. Scottish Government wants to ensure that at least 20% of funding is to be used to support carers. East Lothian has exceeded this figure.

<table>
<thead>
<tr>
<th>Carers</th>
<th>£ Projected spend in £</th>
<th>£ % of total 2013/14 Change Fund allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Fund investment on direct carer support</td>
<td>245,212</td>
<td>17%</td>
</tr>
<tr>
<td>Change Fund investment on indirect carer support</td>
<td>272,384</td>
<td>19%</td>
</tr>
<tr>
<td>Total Change Fund investment on all carer support</td>
<td>517,596</td>
<td>36%</td>
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5.0 Items for Discussion

5.1 Health & Social Care Integration Update

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

This report is to inform and update the sub committee on progress
towards the establishment of a Health and Social Care Partnership in East Lothian.

The Sub Committee was recommended to note the contents of this report and requested that a further report with detailed proposals to establish shadow partnership arrangements is brought forward to the sub committee for information after March 2013. These detailed proposals will also be submitted to East Lothian Council and to the NHS Board.

DG advised that a response has been received from Scottish Government which will help with deliberations for the future.

MA proposed that there is a need to have all party users, carers, professionals and public engaged together and to be ready to move forward.

5.2 Development of East Lothian Community Hospital

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

The purpose of this report is to update and brief members on the progress of the East Lothian Community Hospital (ELCH) project.

The Sub-Committee was invited to note the content of the report.

MA asked about timescales for this project. PG referred the group to the Scottish Capital Investment Manual for proposed timescales. The Initial agreement is currently being drafted with a view to it being presented to the East Lothian Sub Committee by September 2013.

PG was asked to amend the chart on Appendix 1 as the flow and descriptions were not clear to the committee.

6.0 Performance Reports

6.0 General Manager’s Report

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

The purpose of this report is to update and brief members on CHP Performance and developments.

Recommendations

The Sub-Committee was invited to note the content of the report.

Delayed Discharges

The total number was 24 in the January Census as at date of meeting the number was 20. No patients exceeded the six week target.

Capital Projects
Capital project for Gullane has started on site.

Tranent project still waiting for planning permission.

An extension Cockenzie health centre is the next priority.

DAS reported that proposals to transfer line management of Health Promotion Services to Public Health had been implemented.

Decisions

The report was noted.

6.1 Staff Governance Report

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

The purpose of this report is to recommend that the East Lothian Sub Committee be updated and advised on performance for the year to date across a range of Employee Relations/Staff Governance information pertaining to East Lothian CHP.

Sickness and Absence in East Lothian is still high and above the target at 5.75%. Partnership and Chief Nurse have been working along side managers to assist with processes and referrals in managing this.

Decisions

The report was noted.

Finance

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

The purpose of this report is to advise the East Lothian CHP Sub-Committee of the financial position to 31 December 2012.

The Sub-Committee is recommended to; note the overall financial position as presented and note the Prescribing budget out turn. MP confirmed that the CHP is on track to breakeven for 2012/13.

MA asked about NRAC Funds and the separate allocations which should also assist with funding for the CHP next year.

AMc asked when funding is received is it in the current year or into the next years budget. MP advised that funding would be put in to the relevant year’s budget. Budgets can be carried forward but only in specific situations.

Decisions

The report was noted.
Clinical Director’s Report

There was no report.

Chief Nurse Report

The Sub-Committee considered a report which had been circulated in advance of the meeting. Caroline Myles, Clinical Nurse Manager for Community Nursing, EL & ML CHP attended on behalf of Alison Macdonald, Chief Nurse.

The purpose of this report is to update and brief members on nursing within East Lothian CHP. The Sub Committee is invited to note the content of the report.

Community Nursing

District Nursing service – Anne Lyall, Team Lead has taken up post in East Lothian.

A Care Home Project continues providing Palliative Care support and education to all East Lothian Care Homes, supported by Change Fund and run by MacMillan Nurses until March 2014.

Ormiston Leg Club, pilot is running every Wednesday afternoon supported by District Nursing Services again options to identify funding to extend beyond the pilot phase are being looked into.

Public Health Nursing

Due to problems with recruiting into posts a review is being carried out across East Lothian and Midlothian.

HAI

GC asked for a further report for PQI Audits at this meeting at a later date confirming that any recommendations have been actioned.

Significant Case Reviews

Not to be included under the Chief Nurse report but a separate joint report given by EL Council and NHS Lothian. AXM and ML to liaise regarding this change.

Child Protection

No changes to report

Decisions

The report was noted.

AHP report

The Sub-Committee considered a report which had been circulated in advance of the meeting. In the absence of the AHP Manager or representative, DAS provided a verbal update.
The purpose of this report is to update and brief members on AHP Performance and developments.

A Fraility project report to be brought back to future meeting ACTION - DAS

Decisions

The report was noted.

Hosted services report

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

Lothian Unscheduled Care Service
The purpose of this report is to provide the Sub-Committee with an update from the LUCS Senior Management Team on service operations and planning.

This forthcoming weekend the LUCs service won’t be working from Roodlands, due to refurbishment, patients will be able to access other LUCs bases.

ML mentioned that the use of the East Lothian Council Website could be used for this type of communication to assist in circulating to the wider community.

Primary Care Contractors Organisation

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

Joint Health Improvement Partnership

Deferred. No report received and no verbal update.

7.0 Carers Forum
See point 9.0 around Committee Appointments.

No update at this meeting.

8.0 Public Partnership Forum

Public Partnership Forum visit to Lammerlaw Ward, Herdmanflat Hospital.

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

East Lothian Community Care Forum
A paper is being drafted in conjunction with the East Lothian Community Care Forum and will be brought back to a future meeting. ACTION GC.
9.0 Community Health Partnership Committee Appointments

The committee noted the appointment of Rajvinder Singh and also noted his apologies for today’s meeting.

10.0 AOCB

10.1 Representative at Future Meetings
MA will send out an email to the committee reminding them for representation of members and or a representative in their absence.

ACTION.

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<thead>
<tr>
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<th>Date of next meeting</th>
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<tbody>
<tr>
<td></td>
<td>It was agreed that the next meeting would take place on 25th April 2013 at 2.00 pm in the Council Chambers, ELC, Haddington</td>
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MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD held within THE STRATHBROCK PARTNERSHIP CENTRE, BROXBURN on TUESDAY 22 JANUARY 2013

Present – Frank Toner (Chair), Mike Boyle, Morag Bryce, Janet Campbell, Jane Houston, Anne McMillan

Apologies – John McGinty, Alison Mitchell

In Attendance – Jim Forrest (CHCP Director), Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), James McCallum (Clinical Director, NHS Lothian), Pamela Main (Senior Manager – Management and Support, West Lothian Council), Jill Derby (Service Development Officer, West Lothian Council), Chris Cunningham (Assistant Clinical Director, Salaried Primary Care Dental Service, NHS Lothian), Lorraine Gillies (Community Planning Development Manager, West Lothian Council); and John Richardson (PPF)

Apologies – Gill Cottrell (Chief Nurse), Lynne Hollis (Associate Director of Finance, NHS Lothian)

1. **DECLARATIONS OF INTEREST**

Frank Toner declared a non-financial interest as the council’s appointment to the Board of NHS Lothian as a Non Executive Director.

2. **MINUTE OF MEETING OF THE BOARD – 20 NOVEMBER 2012**

The Board approved the minute of its meeting on 20 November 2012 as a correct record.

3. **CHCP BOARD RUNNING ACTION NOTE**

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

**Decisions**

1. To note and agree the contents of the Running Action Note.

2. To agree that Items 2 to 8 (inclusive) were completed and should be delete.

3. To agree that Items 1 and 9 were not yet completed and should be carried forward.

4. To update and amend the Running Action Note accordingly

4. **MINUTE OF MEETING OF THE CHCP SUB-COMMITTEE HELD ON 18TH OCTOBER 2012**

The Board noted the Minute of the Meeting of the CHCP Sub-Committee held on 18th October 2012.

5. **MINUTE OF MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP HELD ON 8TH NOVEMBER 2012**

The Board noted the Minute of the Meeting of the Primary Care Joint
Management Group held on 8th November 2012.

6. **PREPARATION FOR THE IMPLEMENTATION OF THE SOCIAL CARE (SELF DIRECTED SUPPORT) (SCOTLAND) BILL**

The Board heard a presentation by Jill Derby, Service Development Officer for the council, informing it of the preparations being made by officers for the implementation in 2014 of the Social Care (Self-Directed Support) (Scotland) Act 2012. The presentation provided background information on the history of direct payment and self-directed support, the principles underpinning the new legislation, the four options to be made available to service users, and the statutory duties imposed on local authorities.

The Board also considered a report (which had been circulated) by the Head of Council Services about the new legislation and informing the Board of the local arrangements already made and to be made for implementation. It set out the additional funding from the Scottish Government to assist in implementation, and it was noted that the level of funding was below what had been estimated by COSLA as being required. A Service Development Officer had been appointed, and a Programme Board had been established with workstreams identified, and arrangements were being made for ongoing engagement with service users and key stakeholders and partners and for CHCP colleagues to join the Board.

**Decisions**

1. To note the presentation and the history, background and future of direct payments and self-directed support.

2. To note that the Scottish Parliament passed the Social Care (Self-Directed Support) (Scotland) Bill on 28th November 2012.

3. To note the appointment of a Service Development Officer for Self-Directed Support implementation.

4. To note the intention to establish a Self-Directed Support Programme Board.

7. **NATIONAL DENTAL INSPECTION PROGRAMME FOR SCOTLAND 2012 PRIMARY 1**

The Board considered a report (which had been circulated) by the Head of Health Services informing the Board of the recently published national report into the dental health of Primary 1 children in Scotland which showed that Lothian has sustained the large improvement from 2010, and continued to exceed the national target for the dental health of this age group of children. The target was that 60% of primary one children should have no obvious dental decay by 2010. At the time of the 2012 survey, 70.1% of P1 children had no obvious dental decay. 66% of P1 children in West Lothian had no obvious decay compared to 74% in Edinburgh. As well as a continued overall improvement of children’s oral health in Lothian, the aim of the programme was to see the inequality gap close.

The report provided background information on the origin and the operation of the scheme, nationally and locally, and detailed information and statistics on the progress made since the programme’s inception.

**Decisions**
1. To note the contents of the report "National Dental Inspection Programme" (NDIP) for Scotland 2012.

2. To continue its support for the Childsmile Programme in schools and nurseries.

8. **STRATEGIC ASSESSMENT UPDATE AND DEVELOPMENT OF SINGLE OUTCOME AGREEMENT**

The Board considered a report (which had been circulated) by the CHCP Director updating the Board on the Community Planning Partnership (CPP) Strategic Assessment and plans for developing the new Single Outcome Agreement (SOA). The purpose of the Strategic Assessment was to help identify, assess and prioritise what is important for West Lothian’s communities, and enable the setting of achievable and demonstrable outcomes for the next Single Outcome Agreement and the Community Plan refresh. Representatives from across the CPP had been involved in the process from data collection and analysis to priority-setting.

The priorities and over-arching themes identified were:

- "Tackling Inequality" was the core theme for the Community Planning Partnership (CPP).

- A scenario-planning exercise was to take place during Summer 2013 to primarily focus on the impact of projected demographic change and welfare reform in West Lothian. This will also allow the CPP to look at the opportunities these changes could bring.

- Horizon scanning would be put as a regular agenda item on the Community Planning steering group in order to look at local and national developments and manage the impact and opportunities presented by them.

- That the principles of the CPP were around Sustainability and Economic Development, Preventative intervention, Working with Families and Early years.

- That sustainability and eco-issues were considered in conjunction with each thematic area and embedded within the work of the Community Planning Partnership (CPP).

The report went on to list the areas of work which would be the CPP’s focus, under the headings of Healthier, Smarter, Greener, Safer and Stronger, and Wealthier and Fairer. It concluded by advising that the Strategic Assessment priorities would inform the development of a new SOA, with a SOA development day scheduled for 4 February 2013 to involve partners in agreeing a new SOA. Further work and activity would then be needed to agreed indicators and measures between February and April 2013.

**Decisions**

1. To note the completion of the Community Planning Partnership Strategic Assessment.

2. To note the process for developing a new Single Outcome Agreement and its
potential impact on the Board activity.

3. To note that the draft new Single Outcome Agreement would be brought to the Board at its meeting in March 2013.

9. LAUNCH OF LIVING IN SAFE ACCOMMODATION (LISA)

The Board considered a report (which had been circulated) by the Head of Council Services informing the Board on the new service “Living in Safe Accommodation” (LISA) for women and children experiencing domestic abuse. The report explained the background to the council’s approach to tackling domestic violence through the West Lothian Domestic and Sexual Assault Team (DASAT) (formerly known as the Domestic Abuse Service (DAS)) which, working together with key partners in the Community Planning Partnership, West Lothian Domestic and Sexual Assault Team (DASAT), provided a host of critical services for children and adults.

The report explained that in January 2012, the council had been successful in its application to the Scottish Government Violence against Women Fund for a 3 year grant of £81,350 (per year) supporting an innovative system re-design, now named LISA (Living in Safe Accommodation) and reflecting an innovative move from a model focused on crisis intervention, emergency accommodation, refuge and the displacement of women and children, to a model prioritising early intervention, reducing trauma, preventing homelessness, and enabling economic independence. It went on to set out the project’s overarching priorities and the key components of the model and concluded by describing the steps taken and events held to launch the new service.

Decision

To note local developments and progress on early intervention and prevention work around violence against women and children in West Lothian.

10. DELIVERING INTEGRATED DEMENTIA CARE - THE 8 PILLARS MODEL OF COMMUNITY SUPPORT

The Board considered a report (which had been circulated) by the Head of Council Services highlighting and putting into context the publication and contents of a report by Alzheimer Scotland entitled “Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support”. The report explained the Scottish Government’s launch of the first National Dementia Strategy in 2010, which had made considerable progress in the delivery of the associated priority areas, namely acute hospital care and post diagnostic support, and which was scheduled for review in 2013. In relation to that review, Alzheimer Scotland had proposed that a new eight pillar model should be adopted by the Scottish Government, local authorities and NHS Boards, with the intention of enabling health and social care interventions to be brought together in a coordinated way, so as to use available resources to best possible effect in meeting the needs of the person with dementia living at home, within their own community along with their families and friends for as long as they choose.

The eight pillars were identified as:-

- A Dementia Practice Co-ordinator, a named practitioner working at an enhanced level who would ensure access to all pillars of support and would coordinate all practitioners delivering treatment and care.
• Therapeutic interventions to tackle symptoms of the illness in order to address cognitive impairments, functional limitations and behavioural problems.

• General health and care treatment to maintain general wellbeing and physical health.

• Mental health care and treatment – psychiatry being seen as having an essential role is assessing, diagnosing and providing appropriate treatment; also seen as having a crucial role is assisting carers to cope and respond to problem behaviour.

• Personalised support that supported and facilitated independence, citizenship and the right to participate in society.

• Support for carers of people with dementia

• Environment – with consideration being given to housing issues being seen as an essential component in supporting people to remain living in the community.

• Community connections – assisting both the person with dementia and their carer to maintain and build on existing social networks and identify opportunities for peer support.

The report had yet to be accepted or agreed that it would be incorporated by the Scottish Government into the next National Dementia Strategy but its timely release sought to promote the preferred model identified by Alzheimer Scotland with a recommendation that it should be incorporated within the revised National Dementia Strategy in 2013.

The report concluded that whilst the proposal was not at odds with the council's approach locally, until the National Strategy was revised and agreed it was not possible to confirm whether this would be accepted either in part or in its entirety by the Scottish Government and thus deemed to be a strategic priority and approach which Local Authorities and NHS Board would be required to deliver.

Decisions

1. To support the strategic direction which is broadly consistent with the aspirations outlined in the report and in particular the emphasis on upstream preventative interventions, including personal and community capacity building in keeping with the principles underpinning the life stages approach to planning for key priority groups.

2. To note that there is good progress being made towards compliance with the aspirations outlined in this recent publication.

11. DEVELOPMENT OF THE WEST LOTHIAN CARERS STRATEGY 2012-15

The Board considered a report (which had been circulated) by the Head of Council Services advising the Board of the development of the West Lothian Carers Strategy, which was contained in the appendix to the report. The report explained the way the strategy had been developed, and the consultation process and partnership working approach employed. The strategy had a
number of locally identified priorities that mirrored those within the National Carers Strategy. To support the effective delivery an action plan that would enable delivery of both local and national targets has been developed.

The outcomes set out in the draft Carers’ Strategy were:-

- Carers are identified and staff were ‘carer aware’.
- Carers were recognised as partners and experts in care in their caring role
- Carers had access to support which is personalised and assisted carers to maintain their caring role
- Carers had access to quality information are signposted to sources of information and support across West Lothian
- Young carers were recognised, protected from inappropriate caring and had the support they needed to be successful learners, confident individuals, effective contributors and responsible citizens.

The report advised that a period of wider consultation required to be undertaken, involving Carers of West Lothian, Adult Social Care, Children & Families, NHS Lothian and the independent sector. Consultation was also to be held with carers’ support groups facilitated by the Carers Centre.

Decisions

1. To note the terms of the draft Carers’ Strategy and the draft Young Carers’ Strategy contained in the appendices to the report.

2. To note and support the proposal to go out to wider consultation.

3. To note that the draft strategies and information on the results of the consultation process would be brought back to the Board.

4. To note that the intention was to ensure implementation of the strategies through an implementation group and plan, and designated responsible officers.

12. CLINICAL GOVERNANCE - SINGLE HANDED PRACTICES

The Board considered a report (which had been circulated) by the Clinical Director highlighting the vulnerable position of single handed practices (SHP), and some others, in the provision of medical cover during periods of unexpected and/or prolonged absence of the GP; the vulnerable position of single handed practices (SHP), and some others, in the provision of medical cover for planned retirement of the GP; and the challenge for the CHCP to support the practice in those eventualities. The report advised that there were 10 practices in Lothian at clear risk (excluding challenging behaviour practice). To date business continuity arrangements had relied on the goodwill of neighbouring practices often supported by CHCP (GP clinical leads and enhanced nursing). However, the unplanned nature of the arrangements made them unsatisfactory which was compounded by lack of capacity and absence of process. There was a resultant risk to patients’ clinical care including urgent clinical need and planned long term condition management with a consequent increased risk of admission and emergency department attendance.
The report set out the options available for tackling these risks, and advised that CHCPs were now actively considering plans. Lothian Local Medical Committee was to review the situation at its next meeting.

Decisions

1. To note the vulnerable position of single handed practices (SHP), and some others, in the provision of medical cover during periods of unexpected and/or prolonged absence of the GP.

2. To note the vulnerable position of single handed practices (SHP), and some others, in the provision of medical cover for planned retirement of the GP.

3. To note the challenge for the CHCP to support the practice in those eventualities.

4. To agree that vulnerable practices should be placed on the CHCP risk register.

5. To agree that the practices’ contractual obligations should be highlighted to them.

6. To agree that clear collaborative plans should be developed to ensure medical cover.

13. CARE GOVERNANCE - STRATHBROCK BUNGALOW - SHORT BREAK CARE AND MANAGEMENT SERVICES FOR CHILDREN AND YOUNG ADULTS

The Board considered a report (which had been circulated) by the Head of Council Services updating the Board on the progress made in the delivery of Short Break Care and Management Services for Children and Young Adults at Strathbrock Bungalow. In response to the National Strategy on short breaks, the council had explored a range of options for the local delivery of a service providing short breaks from caring for the families of children and young people with complex needs. The opportunity had arisen to use the council owned bungalow adjacent to the Strathbrock Family Unit for this purpose. It had been decided to seek the partnership of an experienced external agency to operate the service on behalf of the council. The council contract for the delivery of this key service was awarded to Barnardo’s and the service became operational on 6th January 2012. The report went on to describe the services offered and the level of usage of the services.

The report concluded by advising that the establishment of this local resource providing short breaks from caring for families of children and young people with complex needs was a major achievement for the council in providing an early intervention service to children and young people with complex needs, in such a way as to prevent the need for more extensive service provision in the future.

Decisions

1. To note the success and use being made of the Strathbrock Bungalow in providing a service for children and young people.

2. To note the benefits this resource provides to children and young people with
complex needs and their families.

3. To note the positive progress being made by this early intervention service to prevent the need for more extensive service provision in the future.

14. STAFF GOVERNANCE

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

The report provided information in relation to Local Quality Improvement Plans, compliance with the Public Records (Scotland) Act (PRSA), the NHS Lothian Risk Management Steering Group, and accreditation achieved to the Public Service Improvement Framework.

Decisions

1. To note the development of local quality improvement plans.

2. To note the successful compliance with the Public Records (Scotland) Act.

3. To note the establishment of and the arrangements for the NHS Lothian Risk Management Steering Group.

4. To note the arrangements in hand for securing accreditation for CHCP services through the Public Service Improvement Framework.

15. 2012/13 REVENUE BUDGET MONITORING REPORT AS AT 30 NOVEMBER 2012

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services containing a joint report on financial performance in respect of CHCP figures for the period to 30 November 2012.

The report advised that the anticipated draft out-turn for the CHCP as a whole was for an under-spend of £1,560,000. In relation to the CHCP council services, the forecast was for an underspend of £1,560,000. In relation to the share of the CHCP budget for NHS Lothian, the forecast was for breakeven.

The report outlined the reasons for the forecast positions and the pressure areas for the council and NHS Lothian elements of the budget.

Decisions

1. To note the anticipated budgetary figures provided for Council and Health Services, and the CHCP as a whole.

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

3. To congratulate all CHCP services staff on securing the current budget and financial position.
16. **DIRECTOR’S REPORT**

The Board considered a report (which had been circulated) by the CHCP Director setting out key areas of work in which the partnership had been involved since the last meeting of the Board.

The Board was provided with information in relation to:-

- Redesigning the community justice system – A Consultation on Scottish Government Proposals.

- A visit by the Cabinet Secretary for Health and Wellbeing on 24 January to see how integration arrangements between health and social care worked in West Lothian.

- The business of the CHCP Sub-Committee.

**Decisions**

1. To note the consultation exercise taking place regarding the redesign of the community justice system in Scotland.

2. To note the visit to West Lothian by the Cabinet Secretary for Health and Wellbeing.

3. To note the business of the December CHCP Sub-Committee.
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for March 2013.

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

2 Recommendations

The Board is asked to:

2.1 Review the quality measures.

3 Discussion of Key Issues

3.1 The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland’s quality ambitions and across levels 1 to 3.

3.2 Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 3. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures only. The May report will include Mental Health clinical effectiveness measures.

3.3 The Quality Report is intended to link with NHS Lothian’s Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.
3.4 The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

3.5 Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

3.6 The Scottish Government commenced production of a Hospital Scorecard in 2012. There is significant overlap between this and the dashboard. The Hospital Scorecard measures not captured in the dashboard and not reported elsewhere, (e.g. A&E waiting times), have therefore been added to the front sheet. These are not currently accompanied by background trend charts.

3.7 As stated in a previous report, inpatient feedback through a patient questionnaire has been developed and will be initially introduced at the Royal Infirmary of Edinburgh (RIE) and then rolled out across the main acute sites throughout 2013. This data will be reported through the Quality Report once the process has been fully implemented at the RIE. At ward level through the ward scorecard, patient experience will be integrated with a range of other data, including complaints and incidents.

3.8 Exception Reporting – Quality Dashboard

3.8.1 The 3-day and 20-day complaints response rate remains a challenge (see graphs 1 and 3). This data reflects the complaints report submitted to the Board in March 2013.

3.8.2 Compliance with Incident Management Key Performance Indicators (see graph 7) of completing Significant Adverse Events investigation within 60 working days of being reported continues to reduce. This is reflective of a new Lothian-wide process being put into place to strengthen accountability for management and approval of these events through line management structures from service to Executive Management. This will take a few months to reliably embed. A monthly monitoring of compliance with this KPI for all services has been developed to support system-wide monitoring of this process. A number of the outstanding incidents relate to the completing of suicide investigations and below sets of the actions being taken to address this situation.

3.8.2.1 It has been highlighted that the NHS Lothian processes for notification, investigating and learning from suicides/potential suicides requires improvement through an internal review and a recent approach from the Healthcare Improvement Scotland (HIS) Suicide Reporting System team. In response to the internal review and in partnership with HIS, the following actions have taken place and been agreed by NHS Lothian’s Mental Health Quality Improvement Team (MHQI Team) in March 2013 to improve the current approach:-
A small group will meet to develop and monitor implementation of an improvement plan for reporting (including notification to HIS), investigating and learning from suicides/potential suicides in NHS Lothian. This will be multi-disciplinary, pan Lothian membership would include representation from amongst:

- Medical management, e.g. ADMD REAS, CD/nominated lead WLCH(C)P
- General management representation e.g. Director of Operations (REAS) General Manager East & Midlothian CHPs, Edinburgh
- Chief nurse representative
- Clinical governance support team – Quality & Safety Assurance lead, CE facilitator for Mental health

A report with recommendations will be brought back to the May meeting of the MH QI team.

- The Quality & Safety Assurance Lead/CE facilitator for Mental Health will meet with each of the areas (REAS/ECHP/WLCH(C)P/East and Midlothian CHPs) to review current operational processes for notifying and investigating suicide with relevant staff and develop robust standard operating procedures. This will be done in advance of the larger meeting.

- The current audit of suicides will be completed and continue on an ongoing basis to ensure reliability of process from notification to investigation and improvement planning in partnership with HIS. This will include provision of a monthly report to HIS of all relevant suicides reported or closed on Datix.

- The Lothian Mental Health Quality Improvement Team (Lothian MHQIT) have in place a Suicide Overview Group to examine all investigation reports pertaining to suicides in Lothian, in order to identify trends and collate learning points. The Suicide Overview Group is still in development phase and will need to clarify their remit, frequency of meetings and reporting dates. Publicity of this information could help in encouraging staff to follow the recommended process.

3.8.3 The number of cardiac arrest calls in October, November and December 2012 has stabilised (Graph 15). As previously stated, the October figures are due to increases in cardiac arrest calls at St. John’s Hospital and the Western General Hospital. The November increase is predominantly due to calls from the Royal Infirmary of Edinburgh. There is normally an increase in calls at this time of year which is also reflected in an increase in HSMR between October to December. The HSMR and Harm Reduction Plan, presented to the Board in January 2013, aims to put a range of interventions in place to reduce cardiac/respiratory arrest and improve the management of the deteriorating patient. A paper on the management of deteriorating patients across NHS Lothian was presented to the April 2013 Healthcare Governance Committee. This work is in the initial stages of implementation and a proposal for additional funding to accelerate this work is being considered against QUEST funding.
3.8.4 Meeting the HEAT target for Staph. Aureus Bacteraemias remains a challenge (see graph 13) and is described in more detail in the Healthcare Associated Infections paper.

3.8.5 Compliance with the three stroke standards also remains a challenge (see graphs 22 – 24).

3.8.6 The Board is asked to note that since commencing the Pressure Ulcers project and Care Rounding rollout, it has been identified that there has been under-reporting of pressure ulcers on Datix. It is anticipated that the total number of pressure ulcers reported will first increase, then there should be reduction in severity of harm before the total number of avoidable pressure ulcers reduces (see graph 20).

3.9 Francis Report

3.9.1 The Board is expecting a paper on the Francis Report (February 2013), which includes Lothian’s response at the June 2013 Board. The Francis recommendations are summarised below:-

- Emphasis on and commitment to common values throughout the system by all within it based on person-centred care and active clinical engagement
- Reliable delivery of fundamental care standards and means of assuring compliance
- No tolerance of non-compliance and the rigorous policing of fundamental standards
- Openness, transparency and candour in all the system’s business
- Strong leadership in nursing and other professional values
- Strong support for leadership roles and governance at all levels
- A level playing field for accountability
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.

3.9.2 In order to develop a system-wide approach which seeks to further improve NHS Lothian’s commitment to person-centred, outcome-based care, and to guard against the above a range of workstreams are being brought together. These include corporate objectives, the clinical framework, the values & culture programme and measurement framework for assurance and improvement which will include a review of this quality report. This will be supported by an engagement/communication plan.
Quality Dashboard - March 2013 (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. The trend arrow shows the change from the previous month’s/quarter’s data.\(^1\) Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focussing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.

### Quality Ambition: Person-centred

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-day Complaints Response Rate *</td>
<td>Number of complaints *</td>
</tr>
<tr>
<td>3-day Complaints Response Rate *</td>
<td></td>
</tr>
</tbody>
</table>

### Quality Ambition: Safe

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Management Key Performance Indicator *</td>
<td>Hospital Standardised Mortality Ratios for RIE, WGH &amp; St. John’s *</td>
</tr>
<tr>
<td>Hand Hygiene Compliance *</td>
<td>Incidents with harm *</td>
</tr>
<tr>
<td>Peripheral Vascular Catheter Compliance *</td>
<td>Adverse Event Rate *</td>
</tr>
<tr>
<td>Early Warning Score Compliance *</td>
<td>C. Difficile Rate *</td>
</tr>
<tr>
<td>Medicine Reconciliation Compliance *</td>
<td>Staph. Aureus Bacteraemia Rate *</td>
</tr>
</tbody>
</table>

### Quality Ambition: Effective

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls Prevention Compliance *</td>
<td>Inpatient Falls with Harm *</td>
</tr>
<tr>
<td>Pressure Ulcer Compliance *</td>
<td>Inpatient Pressure Ulcers Grade 2 or above *</td>
</tr>
<tr>
<td>Admission to stroke unit on day or day after admission*</td>
<td>Nursing Medication Administration Incidents *</td>
</tr>
<tr>
<td>Stroke Treatment Measure: CT Scan *</td>
<td></td>
</tr>
<tr>
<td>Stroke Treatment Measure: Swallow Screen *</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Quality Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate (Per 1000 admissions)</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>21.76</td>
<td>20.23</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>42.77</td>
<td>38.83</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>50.42</td>
<td>45.18</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>111.57</td>
<td>101.56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>0.90</td>
<td>1.00</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

\(^1\) Note that these arrows have not been assigned following a formal set of rules; they are more of a general indication of the last period’s data. For example HSMR is shown to be remaining stable across Lothian, although the actual ratios for the last quarter may show slight reductions or slight increases.
Quality Ambition: Person-Centred
“Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.”

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Number of complaints responses within 20 days</td>
<td><strong>Numerator:</strong> Total number of complaints</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Number of all complaints responses</td>
<td><strong>Goal:</strong> Reduction in number of complaints</td>
</tr>
<tr>
<td><strong>Goal:</strong> 85% of complaints responded to within 20 days</td>
<td><strong>Data Source:</strong> Datix</td>
</tr>
<tr>
<td><strong>Goal:</strong> 100% formal acknowledgement within 3 working days</td>
<td><strong>Data Source:</strong> Datix</td>
</tr>
</tbody>
</table>

**Process Measure**

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Outcome Measure</th>
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</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Number of complaints responses within 20 days</td>
<td><strong>Numerator:</strong> Total number of complaints</td>
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<tr>
<td><strong>Denominator:</strong> Number of all complaints responses</td>
<td><strong>Goal:</strong> Reduction in number of complaints</td>
</tr>
<tr>
<td><strong>Goal:</strong> 100% formal acknowledgement within 3 working days</td>
<td><strong>Data Source:</strong> Datix</td>
</tr>
</tbody>
</table>

**Outcome Measure**

**Data Source:** Datix
Quality Ambition: Safe

“There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.” Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, adverse event rate, key performance indicators for incident management and HAI indicators.

**Safe: Reduction in mortality**

<table>
<thead>
<tr>
<th>Title</th>
<th>Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Total number of in-hospital deaths and deaths within 30 days of discharge from hospital</td>
</tr>
<tr>
<td>Denominator</td>
<td>Predicted total number of deaths</td>
</tr>
<tr>
<td>Goal</td>
<td>National goal 20% reduction against 2006/07 baseline by 2015.</td>
</tr>
</tbody>
</table>

**Outcome Measure**

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – Sept 2012  (Graph 4)

[Graph 4]

Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – Sept 2012  (Graph 6)

[Graph 6]

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – Sept 2012  (Graph 5)

[Graph 5]

**Data Source:** ISD (Quarterly)
### Safe: Reduction in Incidents with Harm and improved Incident Management

<table>
<thead>
<tr>
<th>Title: Incident Management Key Performance Indicators (KPIs)</th>
<th>Title: Incidents with harm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Incidents with major harm or death and/or graded as very high or high risk, fully closed within 60 working days of being reported.</td>
<td><strong>Numerator:</strong> Number of incidents associated with serious harm reported per month in NHS Lothian (Mar 2011 - Jan 2013)</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Number of incidents with major harm or death and/or graded as very high/high.</td>
<td><strong>Goal:</strong> There are specific goals for reductions in Falls, Pressure Ulcers &amp; Medication Incidents. See separate graphs for progress against these.</td>
</tr>
<tr>
<td><strong>Goal:</strong> Compliance target – 100%</td>
<td></td>
</tr>
</tbody>
</table>

#### Process Measure

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-11</td>
<td>0%</td>
</tr>
<tr>
<td>May-11</td>
<td>20%</td>
</tr>
<tr>
<td>Jun-11</td>
<td>40%</td>
</tr>
<tr>
<td>Jul-11</td>
<td>60%</td>
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<td>Aug-11</td>
<td>80%</td>
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<td>Sep-11</td>
<td>100%</td>
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<td>Oct-11</td>
<td>80%</td>
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<td>Nov-11</td>
<td>60%</td>
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<td>Dec-11</td>
<td>40%</td>
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<td>Jan-12</td>
<td>20%</td>
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<tr>
<td>Feb-12</td>
<td>0%</td>
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<tr>
<td>Mar-12</td>
<td>0%</td>
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<tr>
<td>Apr-12</td>
<td>0%</td>
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<tr>
<td>May-12</td>
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<td>Jun-12</td>
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<td>Nov-12</td>
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<td>Dec-12</td>
<td>40%</td>
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<tr>
<td>Jan-13</td>
<td>20%</td>
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Data Source: Datix

#### Outcome Measure

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Reported Incidents</th>
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<tbody>
<tr>
<td>Mar-11</td>
<td>0</td>
</tr>
<tr>
<td>Apr-11</td>
<td>20</td>
</tr>
<tr>
<td>May-11</td>
<td>40</td>
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<td>Jun-11</td>
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<td>Jul-11</td>
<td>80</td>
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<tr>
<td>Nov-12</td>
<td>60</td>
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<tr>
<td>Dec-12</td>
<td>40</td>
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<tr>
<td>Jan-13</td>
<td>20</td>
</tr>
</tbody>
</table>

Data Source: Datix

### Adverse Event Rate (NHS Lothian Acute Hospitals)

<table>
<thead>
<tr>
<th>Title: Adverse Event Rate (NHS Lothian Acute Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> The number of adverse events (AE) in a monthly random sample of closed case notes (deaths and live discharges)</td>
</tr>
<tr>
<td><strong>Denominator:</strong> The total number of patient days (PD) in the month for the randomly drawn patients in the sample</td>
</tr>
<tr>
<td><strong>Goal:</strong> 30% reduction in Adverse Events from a 2007 baseline by 2012</td>
</tr>
</tbody>
</table>

#### Outcome Measure

<table>
<thead>
<tr>
<th>Rate of Adverse Events per 1000 patient days. Nov 2008 to May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Median = 52</td>
</tr>
</tbody>
</table>

Data Source: Case Note Reviews
**Safe: Reduction in Healthcare Associated Infections**

**Title:** Percent compliance with hand hygiene (NHS Lothian Acute Hospitals)  
(Graph 10)

**Numerator:** The total number of opportunities in the sample where appropriate hand hygiene was conducted

**Denominator:** The total number of opportunities in the sample. **N=6,600 per month**

**Goal:** 95% Compliance

---

**Title:** C. difficile associated disease rate against HEAT Target 2011-12  
(Graph 11)

**Numerator:** Total number of patients over 65 with C.Difficile toxin positive stool sample (CDI)

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards’ rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less. **Rate at Mar 2013 – 0.33**

---

**Process Measure**

**Outcome Measure**

**Progress against HEAT Target for C.difficile Infection (CDI)**

**Data Source:** Local Audits (QIDS)

**Data Source:** Infection Control Team
### Safe: Compliance with Peripheral Vascular Bundles

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent compliance with PVC Bundle (NHS Lothian Acute Hospitals) (Graph 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Total number of patients who have all elements of the PVC bundle in place</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of patients reviewed per month. (n=1000)</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
</tr>
</tbody>
</table>

**Source Data:** Local Audits (QIDS)

### Title: Staph. aureus bacteraemias (SABs) rate against HEAT Target 2011-12 (Graph 13)

| Numerator: | The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections) |
| Goal:      | Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less. Rate at Mar 2013 – 0.32 |

**Source Data:** Infection Control Team
Safe: Improved management of the deteriorating patient. Compliance with Early Warning Score Bundle

Title: Percent compliance with the EWS Bundle (NHS Lothian Acute Hospitals) (Graph 14)

Numerator: The total number of SEWS observations completed correctly

Denominator: The total number of observations reviewed per month. n=11,265

Goal: 95% Compliance

Cardiac/Respiratory Arrests

Title: Number of Cardiac & Respiratory Arrest Calls

Numerator: Arrest – Number of 2222 calls which were for a cardiac or respiratory arrest. Call relating to staff, visitors, False Alarms, Cancelled Calls and Out of Hospital Arrests are excluded.

Goal: 30% reduction in Cardiac/Respiratory Arrest calls from February 2012 baseline within 2 years from baseline

Source Data: Local Audits (QIDS)

Source Data: Local Audits (Resuscitation Officer Database)
**Safe: Improvement in Medicines Reconciliation**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent of patients with medication reconciliation performed (NHS Lothian Acute Hospitals) (Pilot Site=One Ward) (Graph 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Total number of patients with medication reconciliation performed</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of patients reviewed. n=15 per month</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
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</tbody>
</table>

**Process Measure**

Source Data: Local Audits (QIDS)

**Outcome Measure**

OUTCOME MEASURE TO BE DETERMINED
Quality Ambition: Effective

“The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.” Progress on this ambition is measured through clinical quality indicators, stroke care, medicine reconciliation and cost effective prescribing in primary care.

<table>
<thead>
<tr>
<th>Effective: Reduction in in-patient Falls - Delivering Better Care</th>
<th>Title: Patient Falls with Harm (Graph 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: No. of patients fully compliant</td>
<td>Numerator: Number of falls reported with harm, moderate, major/death</td>
</tr>
<tr>
<td>Denominator: Total no. of patients reviewed per month n=964</td>
<td>Goal: 20% reduction in inpatients falls and associated harm by March 2013.</td>
</tr>
<tr>
<td>Goal: 95% Compliance</td>
<td></td>
</tr>
</tbody>
</table>

Process Measure

Outcome Measure

Patients’ falls reported with harm – data for NHS Lothian inpatient sites

Data Source: QiDS

Data Source: Datix
Effective: Reduction in Pressure Ulcers in patients

Title: Percent compliance with the Pressure Ulcer Prevention CQI (NHS Lothian Acute Hospitals) (Graph 19)

Numerator: No. of patients fully compliant CQI
Denominator: Total no. of patients reviewed at risk of pressure ulcers per month n=546
Goal: 95% Compliance

Data Source: QiDS

Number of Pressure Ulcers per month across NHS Lothian (Graph 20)

Title: Number of Grade 2 or above pressure ulcers
Numerator: Number of Grade 2 or above pressure ulcers
Goal: To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2014 (from one a day to none a day)

Data Source: Datix
Effective: Delivering Better Care - Reduction in Nursing Medication Administration Incidents

Title: Number of Nursing Medication incidents per month (Graph 21)

Numerator: Number of all medication incidents

Goal: 10% reduction in all nursing and midwifery medication errors by March 2013

Outcome Measure

Number of Nursing Administration of Medication Incidents:
All Incidents

Data Source: Datix
**Effective: Admission to Stroke Unit & Stroke Treatment Measures**

<table>
<thead>
<tr>
<th>Title: Admission to Stroke Unit within 1 day of admission (Graph 22)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board</td>
</tr>
<tr>
<td><strong>Goal:</strong> By March 2013 90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission</td>
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</tbody>
</table>

**Process Measure**

Data Source: ISD

**Title:** Stroke Treatment Measures (Graph 23)

<table>
<thead>
<tr>
<th>Numerator: Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> Number of patients admitted with initial diagnosis of stroke</td>
</tr>
<tr>
<td><strong>Goal:</strong> 100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission</td>
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</table>

**Process Measure**

Data Source: ISD

**Title:** Stroke Treatment Measures (Graph 24)

<table>
<thead>
<tr>
<th>Numerator: Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> Number of patients admitted with initial diagnosis of stroke</td>
</tr>
<tr>
<td><strong>Goal:</strong> 80% of patients with initial diagnosis of stroke should receive a brain scan on day of admission</td>
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**Process Measure**

Data Source: ISD
4 **Key Risks**

4.1 Achieving the national 3-day and 20-day response rate target for complaints, achieving the HAI SABs Infection HEAT target and meeting stroke target and standards.

4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.

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). Access to Acute Stroke Unit is on the University Hospital Division Risk Register – Medicine and Associated Services (Risk 2444).

6 **Impact on Inequality, Including 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.

6.2 This paper combines elements of 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) and the Scottish Patient Safety Programme (assessed in May 2009).

7 **Involving People**

7.1 Not applicable.

8 **Resource Implications**

8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.
List of Appendices

Appendix 1: Supporting Technical Appendix
Appendix 1

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. For Patient Safety Measures, please refer to measurement plan on the NHS Lothian Intranet - http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGovernanceinNHSLothian/SPSP/Workstreams/Documents/SPSP%20Measurement%20Plan.pdf

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.

Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011. This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days
As for 7 day readmissions.

Medical Re-admissions Within 7 Days
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty. The data are presented for calendar year 2011. This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions Within 28 Days
As for 7 day readmissions.
**Average Length of Surgical Stay (Adjusted)**
Ratio of 'observed' length of stay over 'expected' length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

**Average Length of Medical Stay (Adjusted)**
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations. [http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs](http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs)
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.
- Support the ongoing work with Meticillin Resistant *Staphylococcus aureus* screening programme by promoting compliance with Clinical Risk Assessment and swabbing.
- Recognise the need for ongoing work to maintain standards in anticipation of announced and unannounced Healthcare Environment Inspectorate visits.
- Increased compliance with best practice, as recommended by the Antimicrobial Management Team.
- Agree that the Executive Lead for Healthcare Associated Infection should pass to the Nurse Director to align with her responsibilities for Unscheduled Care and that the Director of Public Health and Health Policy should lead the development of a programme of specific interventions designed to further reduce the burden of avoidable ill health from Healthcare Associated Infection across the Lothian population.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 23 episodes of *Staphylococcus aureus* Bacteraemia in March 2013 (5 Meticillin Resistant *Staphylococcus aureus*, 18 Meticillin Sensitive *Staphylococcus aureus*), compared to 27 in February 2013 (5 Meticillin Resistant *Staphylococcus aureus*, 22 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian’s Health Efficiency Access Treatment Target was to achieve a rate of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013, with a current rate of 0.32. NHS Lothian has not achieved the set Health Efficiency Access Treatment target. NHS Lothian’s new Health Efficiency Access Treatment target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days by March 2015.
3.2 **Clostridium difficile** Infection: there were 20 episodes of *Clostridium difficile* Infection in patients aged 65 or over in March 2013, compared to 17 in February 2013. NHS Lothian’s Health Efficiency Access Treatment Target was 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. NHS Lothian has achieved the set Health Efficiency Access Treatment Target target. NHS Lothian’s new Health Efficiency Access Treatment Target target is to achieve a rate of 0.25 cases or fewer per 1000 total occupied bed days by March 2015 (patients 15 years and over).

3.3 **Norovirus outbreaks**: within NHS Lothian the first case of norovirus outbreak for season 2012-2013 was recorded at the Royal Infirmary Edinburgh during August 2012. Since 1/1/2013 there have been 321 patients identified as norovirus positive in all acute sites. Incident management teams are in place to manage prolonged outbreaks at the Royal Infirmary Edinburgh and Liberton Hospital.

3.4 The 24th bi-monthly national hand hygiene audit report was published by Health Protection Scotland 27/3/2013. This reported NHS Lothian achieved a hand hygiene compliance of 97%, exceeding the national compliance of 95%. The escalation policy for non-compliance with hand hygiene has been communicated to appropriate forums and is currently being implemented throughout all patient care areas.

3.5 The Meticillin Resistant *Staphylococcus aureus* Key Performance Indicators have been agreed and the compliance levels have been set at a minimum of 90% for Clinical Risk Assessment and the swabbing. For the period January to March 2013 NHS Lothian achieved a Clinical Risk Assessment compliance of 53% and swabbing compliance of 75%. The compliance levels vary across the organisation and work is ongoing to ensure the required levels are met on a consistent basis. Discussions are being undertaken with the TRAK team to develop a process where staff will be reminded to carry out universal Clinical Risk Assessment when admitting patients. Compliance data will be reported to Health Protection Scotland from 1/4/2013.

3.6 **Mandatory Surgical Site Infection Surveillance**: For the period 1/1/2013-31/1/2013, within NHS Lothian there were 350 procedures performed and three Surgical Site Infections detected, with a rate of 0.9%. The voluntary surveillance for abdominal hysterectomies will be discontinued from 1/4/2013. The surgical site infection rate for this procedure has reduced from 1.28% in 2010 to 0.23% in 2012. Following discussions with Health Protection Scotland it is anticipated that NHS Lothian will commence reporting on selected colorectal procedures later this year and work is ongoing to establish an agreed programme of surveillance.

3.7 **Antimicrobial Management Team:**

3.7.1 The Alert Antibiotic Policy has been implemented at the Royal Infirmary Edinburgh, Western General Hospital and St John’s Hospital. The range of antibiotics subject to the restrictions detailed in the Alert Antibiotic Policy have been increased since the Policy was implemented last year and it is planned that this list will be increased further over the next few months.

3.7.2 Antibiotic Prescribing Indicators: the target level for compliance within the Acute Services Antimicrobial Prescribing Guidelines and documentation of antibiotic indication is 95%. In-scope clinical areas within the Western General Hospital and the Royal Infirmary Edinburgh are currently achieving 100% compliance for both
Prescribing Indicators and documentation compliance. Unfortunately, no data was gathered for St John’s Hospital last month. For surgical prophylaxis, the data collection focuses on colorectal surgery. Compliance remains at 100% for areas being measured.

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.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Funding for Meticillin Resistant *Staphylococcus aureus* screening and monitoring of Key Performance Indicators set by Health Protection Scotland is non-recurring.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register is currently graded medium. The risk register covers norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on 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 Infection Prevention and Control is an invest to save service. 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 Infection Prevention and Control Services
12/4/2013
fiona.cameron@nhslothian.scot.nhs.uk

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
### SAB
There were 23 SAB recorded during March 2013 (5 MRSA & 18 MSSA). The lowest number recorded in the last 12 month period is 15 (August 2012).

### CDI
There were 27 CDI recorded in March 2013, 20 were in aged 65 & over. May 2012 recored the lowest number in the last 12 month period with 22 cases.

### SAB HEAT Target
NHS Lothian has not achieved the set target of 0.26 or less cases per 1000 AOBDS by March 2013.

### CDI HEAT Target for Patients aged 65 and over
NHS Lothian has achieved the set target of 0.39 or less cases per 1000 OBDS.

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

<table>
<thead>
<tr>
<th></th>
<th>A-12</th>
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<th>J-12</th>
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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
**Royal Infirmary of Edinburgh**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 6 SAB recorded during March 2013.

**Clostridium difficile Infection (CDI)**
There were 11 CDI recorded during March 2013.

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**
**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 5 SAB recorded during March 2013.

**Clostridium difficile Infection (CDI)**
There were 7 CDI recorded during March 2013.

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

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### Hand Hygiene Monitoring Compliance

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

### MRSA Bacteraemia Cases

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### Total Staphylococcus aureus Bacteraemia (SAB) Cases

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

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**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during March 2013.

**Clostridium difficile Infection (CDI)**
There were 2 CDI recorded during March 2013.

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

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

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Liberton Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during March 2013.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during March 2013.

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**
Staphylococcus aureus Bacteraemia (SAB)
There were 2 SAB recorded during March 2013.

Clostridium difficile Infection (CDI)
There was 1 CDI recorded during March 2013.

For the purpose of this report we include all NHS Lothian Patients aged 15 and over who have tested positive for CDI.

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

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

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Total Staphylococcus aureus Bacteraemia (SAB) Cases

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MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during March 2013.

**Clostridium difficile Infection (CDI)**
There were no CDI recorded during March 2013.

This is the new Report Card Format introduced by Scottish Government July 2011.
**Community Hospitals**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during March 2013.

**Clostridium difficile Infection (CDI)**
There were 3 CDI recorded during March 2013.

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

**Staphylococcus aureus Bacteraemia (SAB)**
Patients who are identified with a SAB within 48 hours of admission to Hospital are included in this report card. During March 2013 there were 9 SAB recorded.

**Clostridium difficile Infection (CDI)**
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice’s. During March 2013 there were 2 CDI recorded.

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

1.1 The purpose of this paper is to report on the outcome of the unannounced follow-up inspection by Healthcare Improvement Scotland (HIS) on 14th -15th February at the Royal Infirmary and to note other developments related to the inspection process.

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

2 Recommendations

The Board is recommended to:

2.1 Note the feedback from HIS and support the actions to address areas for improvement. The full report was published on the 11th April, see Appendix 1.

2.2 Support the action plan developed as a result of this inspection (see Appendix 2) and reaffirm support for and note the progress of the overarching Vulnerable Peoples Quality Improvement Framework and the OPAH mock inspections.

3 Discussion of Key Issues

3.1 Previous meetings have been informed of the pilot inspection at Liberton, the formal visit to the Western General Hospital in April and the unannounced visit to the Royal Infirmary in August and the local mock inspections conducted across all sites examining care for Older People in Acute Hospitals (OPAH) as part of the Patient Quality Improvement (PQI) process.

3.2 The main focus of the HIS visits to date have been on patient care, staff attitude and behaviour, interaction between staff and patients with a specific emphasis on patients with a cognitive impairment. On this visit the team also focussed on nutrition, hydration and pressure ulcer risk assessment and management. The team reviewed 33 sets of health records, spoke with 25 patients and received completed questionnaires from 79 patients/carers/relatives.
3.3 The visit on the 14 & 15 February was a follow up to consider what progress had been made on the RIE site.

3.4 The inspection team visited a variety of clinical areas including the Emergency Department (ED).

3.4.1 The HIS Inspectors following the visit noted that this had been a positive experience and that they were aware that progress was being made. They noted that despite the wards being busy, the wards were calm and organised and that patient’s buzzers were being answered promptly, they noted that staff were motivated and engaged with developments taking place. They noted that staff within the ED were working well towards the needs of older people and in particular those with a cognitive impairment.

3.4.2 The report noted 6 areas of strength and identified 10 areas for improvement and 2 areas for continued improvement.

3.4.3 Specific comments were made around the following:

**Treating older people with compassion, dignity and respect**
- That the majority of patients were being cared for in a compassionate, dignified and professional manner
- Patients appeared well cared for
- Patients were being addressed appropriately
- The peg system in place on bedside curtains to indicate that care delivery is ongoing
- That Care Rounding had been implemented and staff were empowered to develop this further
- They had received from ward staff and patients positive feedback

Areas for improvement - required within this aspect were in relation to the use of gowns, instead of pyjamas and that some bedside curtains were shorter than required but the inspection team noted that plans were in place to resolve this.

**Dementia and cognitive impairment:**
- Staff knew how to access the Elderly Care Assessment Team (ECAT), psychiatric liaison and also specific Alzheimer support
- Progress in the implementation of the Vulnerable People’s Quality Improvement Framework
- Good practice with cognitive screening within the Emergency Department and Ward 204
- They noted however, that screening of patients over 65 was not yet consistent throughout the hospital

Areas for improvement - the use of “This is me document”. Appropriate use of Power of Attorney and documentation of the same.
Nutrition and care hydration

- Protected mealtimes were in place
- Mealtimes were well managed with the majority of patients who required support were being given appropriate assistance

Areas of improvement – completion of food and fluid balance charts and completion of MUST assessment.

Preventing and managing pressure ulcers:

- They noted the implementation of the “One-to-none ” pressure ulcer project, the goals and future completion dates
- Positive process was noted within gynaecology, in particular in relation to pre-assessment and the advance ordering of appropriate pressure relieving equipment
- Changing of patients’ positions included as part of the Care Rounding checklist

Areas of improvement – timely completion of appropriate documentation re assessment and pressure ulcer management.

3.5 The action plan has been updated (Appendix 2) and made available to all areas. Each clinical area must now consider this information and progress those activities that relate directly to their specialties/areas of responsibility.

3.6 HIS in November published their scrutiny priorities for 2013-15. In this document HIS explained that they were reviewing their methodology for OPAH visits, in particular how these visits would link with other National work e.g. Person-Centred Health and Care Programme and the parameters of the review and how the subsequent outcomes will be communicated to each Board.

3.6.1 HIS will continue to focus on treating patients with compassion, dignity and respect and will specifically look at assessment and implementation of appropriate care plans in relation to dementia and cognitive impairment, falls prevention and management, nutritional care and hydration and the prevention and management of pressure ulcers. In addition to this however, HIS will seek awareness around staff knowledge of key policies and procedures and their implementation in practice and specifically these may be in relation to confidentiality, consent, chaperoning, protected mealtimes, falls management, discharge planning and management of patients with a cognitive impairment.

3.7 Audit Scotland in February 2013 set out their proposals for an audit of reshaping care for older people. The aim of this audit is to seek answers to the question in relation to, “how much progress have public sector organisations made in reshaping care for older people”. This will specifically look at how public bodies have shifted the balance of care for older people from acute to community settings, what impact the change fund has made on making sustainable improvements to care and services for older people and to identify what the main challenges facing older people’s services are and how effectively public bodies are addressing these. It is anticipated that this work would take place between February and April 2013 and final reports published in September 2013.
3.8 The work of The Vulnerable People’s Steering Group, (Vulnerable People’s Quality Improvement Framework) was launched in August 2012 and combines numerous strands of work following the Board approval of the recommendations from the 2010/11 5x5x5 on Improving Care for Vulnerable People in Hospital.

3.8.1 Specific work streams have now significantly progressed since the implementation of the steering group and these are as follows:

- Agreement on the use of 4AT as the initial screening tool for cognition on patients over 65. This work commenced in the Medical Assessment Unit but is now being progressively rolled out as part of an education and awareness programme.
- Policy and procedure on the management of patients with a cognitive behaviour has been updated and was agreed at the Clinical Policy meeting in March 2013.
- The roll out of the Vulnerable People’s Resource Pack has commenced with the majority of areas on the RIE complete with the WGH/RVB and SJH sites anticipated to have packs in place by the end of April 2013.

4 Key Risks

4.1 Vulnerable patients do not receive the care they require. Mitigation of this risk as in the work described above.

4.2 Internal audit were asked to consider NHS Lothian’s preparedness for inspections and this report published in December identified that whilst the infrastructure and framework for awareness, guidance and audit was robust that there was a need to see improvement in the follow-up of actions/areas for improvement identified as part of the inspection/local assessment process and that this should be progressed via the Clinical Management Teams with reports now being provided on activity for the Chief Nurse for Quality & Professional Standards, this process commenced in March 2013.

4.3 Public confidence in NHS Lothian services and older peoples trust in our care can be put at risk by inspection reports and subsequent media articles.

5 Risk Register

5.1 The risk of harm to patients is already noted in the NHS Lothian Corporate Risk Register. An additional element has now been added to the Corporate Risk Register relating essential care delivery.

6 Impact on Inequality, Including Health Inequalities

6.1 The Vulnerable Peoples Quality Improvement Framework has been impact assessed and updated in response to the findings.
7 Involving People

7.1 Within each HIS inspectorate team there are Lay members. In NHS Lothian on the core PQI team there are lay representatives and every effort is made to have a lay representative on the local site visits, however this is not always feasible.

8 Resource Implications

Work of the Delivering Better Care programme, specifically the support of the Hub, the Vulnerable People’s Project and the One-to-one Tissue Viability Project is funded by non-recurring monies. To embed and sustain this work recurring funding for continued facilitation will be required in 2014/15 and work is in progress to address this.

Melanie Hornett
Nurse Director

Carol Crowther
Chief Nurse Quality & Professional Standards
April 2013
carol.crowther@luht.scot.nhs.uk

Appendices
Appendix 1: RIE Unannounced Inspection Report April
Appendix 2: RIE Unannounced Inspection Action Plan April
Unannounced Inspection Report – care for older people in acute hospitals

Royal Infirmary of Edinburgh | NHS Lothian
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
## Contents

1. **About this report** | 4

2. **Summary of inspection** | 5

3. **Our findings** | 7

   - Appendix 1 – Areas for improvement | 14
   - Appendix 2 – Details of inspection | 16
   - Appendix 3 – List of national guidance | 17
   - Appendix 4 – Inspection process flow chart | 18
   - Appendix 5 – Glossary of abbreviations | 19
1 About this report

In June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. These inspections are to provide assurance that the care of older people in acute hospitals is of a high standard. We will measure NHS boards against a range of standards, best practice statements and other national documents relevant to the care of older people in acute hospitals, including the Clinical Standards Board for Scotland (CSBS) Clinical Standards for Older People in Acute Care (October 2002).

Our inspections focus on the three national quality ambitions for NHSScotland, which ensure that the care provided to patients is person-centred, safe and effective. The inspections will ensure that older people are being treated with compassion, dignity and respect while they are in an acute hospital. We will also look at one or more of the following areas on each inspection:

- dementia and cognitive impairment
- falls prevention and management
- nutritional care and hydration, and
- preventing and managing pressure ulcers.

This report sets out the findings from our unannounced inspection to the Royal Infirmary of Edinburgh, NHS Lothian from Thursday 14 February to Friday 15 February 2013.

This report gives a summary of our inspection findings on page 5. Detailed findings from our inspection can be found on page 7.

The inspection team was made up of five inspectors, with support from a project officer. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. Although we try hard to involve members of the public as public partners on our inspections, none were available for this inspection. Membership of the inspection team visiting Royal Infirmary of Edinburgh can be found in Appendix 2.

The report highlights areas of strength, areas for improvement and areas for continuing improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 14. Wherever possible, the areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. A list of relevant national standards, guidance and best practice can be found in Appendix 3.

More information about Healthcare Improvement Scotland, our inspections, methodology and inspection tools can be found at http://www.healthcareimprovementscotland.org/OPAH.aspx
2 Summary of inspection

The Royal Infirmary of Edinburgh serves the Lothian region. It contains 1,158 staffed beds and has a full range of medical and surgical services, and specialist services for people from the south east of Scotland and beyond. The hospital has a 24-hour accident and emergency department.

We previously inspected the Royal Infirmary of Edinburgh in August 2012. That inspection resulted in four areas of strength and 23 areas for improvement. The inspection report is available on the Healthcare Improvement Scotland website http://www.healthcareimprovementscotland.org/OPAH.aspx.

We carried out an unannounced inspection to the Royal Infirmary of Edinburgh from Thursday 14 February to Friday 15 February 2013.

We inspected the following areas:

- accident and emergency department
- acute medical unit
- ward 106 (general surgery)
- ward 108 (orthopaedics trauma)
- ward 201 (medicine of the elderly)
- ward 203 (medicine of the elderly)
- ward 204 (respiratory)
- ward 207 (acute medicine)
- ward 208 (orthopaedics elective), and
- ward 210 (gynaecology).

Before the inspection, we reviewed NHS Lothian’s self-assessment and gathered information about the Royal Infirmary of Edinburgh from other sources. This included Scotland’s Patient Experience Programme, and other data that relate to the care of older people. Based on our review of this information, we focused the inspection on the care of people with dementia and cognitive impairment, nutritional care and hydration, and preventing and managing pressure ulcers.

On the inspection, we spoke with staff and used additional tools to gather more information. In some wards, we used a formal observation tool. We carried out five periods of observation during the inspection. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.

We also carried out patient interviews and used patient and carer questionnaires. We spoke with 25 patients during the inspection. We received completed questionnaires from 79 patients.

As part of the inspection, we reviewed 33 patient health records to check the care planned and delivered was as described in the care plans. For this inspection, we reviewed 33 patient health records for dementia and cognitive impairment. We also reviewed 30 of them for nutritional care and hydration and 33 for preventing and managing pressure ulcers.
Areas of strength
We noted areas where NHS Lothian was performing well in relation to the care provided to older people in acute hospitals.

We saw staff treating patients with dignity and respect in all our observations. We also noted that accident and emergency is working well to adapt to and meet the needs of older people and those who are cognitively impaired. A range of specialist services are available to support the care of older people. Dementia Champions from a range of disciplines are also being trained and used throughout the hospital.

Areas for improvement
We found that further improvement is required in the following areas.

Since the previous inspection, there has been progress on assessment and screening. However, assessment and screening of patients for dementia and cognitive impairment, nutrition and hydration and pressure ulcer care is still not taking place in the majority of cases. We also found there was limited personalised care planning.

This inspection resulted in six areas of strength, 10 areas for improvement and two areas for continuing improvement. A full list of the areas for improvement can be found in Appendix 1 on page 14.

We expect NHS Lothian to address all the areas for improvement. Those areas where improvement is required to meet a recognised standard must be prioritised.

The NHS board has developed an improvement action plan, which is available to view on the Healthcare Improvement Scotland website http://www.healthcareimprovementscotland.org/OPAH.aspx.

We would like to thank NHS Lothian and in particular all staff at the Royal Infirmary of Edinburgh for their assistance during the inspection.
3 Our findings

Treating older people with compassion, dignity and respect

Although wards were busy during our unannounced inspection, we noted that wards were managed in a calm and organised manner. This contributed to patients’ care being carried out in a way that maintained patient dignity and that was compassionate and respectful. Staff addressed patients by their preferred name and when they were unsure, asked the patient how they would like to be known.

The majority of the wards inspected were mixed sex wards with patients accommodated in either single sex bays or single rooms. Designated male and female toilets and shower facilities were available in all the wards. In the acute medical unit, we found patients were still being accommodated in mixed sex bays. Since the August 2012 inspection, the unit has worked to reduce the number of patients accommodated in mixed sex bays, caring for patients in single sex bays as far as possible.

While the majority of patients were out of bed and dressed in their own clothes, we found patients were also sometimes dressed in hospital gowns that did not maintain their dignity. In one ward, this issue had been addressed by dressing a patient in two gowns, with the one on the top worn back to front to cover any gaps at the back. We did not see sufficient nightwear provided by the hospital available to ward staff. When we spoke to nursing staff about this, they told us they were unable to get nightwear from the laundry and only received gowns. When we raised this with senior staff in the hospital on the first day of inspection, we were told that this had been addressed and nightwear would be provided in future. On the second day of inspection, staff told us that nightwear was available.

All the wards inspected had a nurse call system in use. We saw that the nurse call handsets were not always placed near the patients to make them accessible. For example, the nurse call handset was on the patient locker on the other side of the bed from where the patient sat. When patients were able to use the nurse call system, we noted that responses were quick.

During the August 2012 inspection, we noted that curtains around beds were used to maintain the privacy and dignity of patients. However, on some wards the curtains were too short to provide privacy. During this inspection, we saw short curtains still in use in some areas. When we spoke with staff on wards, we were told that this was due to on-going Norovirus outbreak and a lack of supply of the long curtains from the laundry. Senior staff in the hospital provided evidence to show that a significant investment had been made to purchase longer curtains in order to address the issue. We were assured that these curtains would be in place soon. A peg system had also been introduced for bed curtains. A peg was attached to curtains when patients were receiving treatment to both hold the curtains closed and to stop people entering while treatment was taking place.

Staff continued to keep personal care information above patient beds to a minimum. Personal items such as glasses, walking aids and patients’ water jugs were within reach of patients.

Care rounding has been introduced in some of the areas inspected. This system prompts nursing staff to approach patients at assessed intervals (every 1 to 6 hours) to identify if they have any additional care needs, for example pain relief or needing the toilet. NHS Lothian intend to complete implementation of care rounding by December 2013. We also noted that ward rounds were carried out discreetly.
Patient comments
Through our patient surveys and patient interviews, patients had the opportunity to give us their opinion of the care they received. Overall, patients were positive about the care and help they received. Of the 74 people who completed our questionnaire, 81% stated that they had been given clear information about their condition and treatment. 89% said the quality of care they received was good.

- 'The care and attention that I have received has been excellent. Some people stand out more than others and they are what I would call dedicated professionals. I have all intentions of writing to the executive to make my views known and name people who deserve a 'pat on the back' and a written reference.'
- 'I could not have asked for better help. Everyone has been so kind. All grades of staff.'
- 'After 6 weeks of the most excellent care and attention, I can't really put it all into words, but I can say I couldn't pay for it. Everyone from top to bottom are so caring and they do it all with a smile. What an experience!!'
- 'Regular visitor to the ward where I receive excellent care from all staff. Very well looked after physically and mentally,'
- 'From the time I arrived to out patients and then to the ward, I received courtesy and respect from all members of the team. I was informed clearly what the procedures were.'

Some patients told us of some concerns and worries they had.

- 'Why give patients a buzzer to ring and then completely ignore the buzzer when attention is required? Why do nursing staff have to answer telephone when they should be caring for patients? If after 20 rings phone should be diverted to main switchboard. There is a notice above my bed assistance with meals, when first admitted some days I had no lunch - couldn't get packs of sandwiches open! Other days food required to be cut up. One nurse said 'surely you can do it!' I could go on and on, the nurses don't have enough time to help patients.'
- 'I'd like my views to be taken more seriously. I dislike being called "darling" in an artificial, caring voice. Plain speaking will be fine, thank you.'

Patient and staff interactions
We used a formal observation tool in four of the wards inspected to observe interactions between staff and patients. The majority of interactions were warm, caring and friendly between patients and all staff disciplines, including nurses, medical staff and physiotherapists. We found that staff were encouraging, supportive and compassionate, and talked to patients in a quiet, gentle and respectful manner. On one ward, a nurse carrying out a medication round took time with a patient with a tracheostomy (a tube inserted in to the windpipe to help with breathing). They took time to listen to the patient and find ways to communicate with them. We also observed a doctor speaking quietly to a patient but ensured they understood what was being said.

Patient confidentiality
On five of the wards inspected, we observed six occasions when patient health records were left open and unattended in ward areas. In some cases, computer screens displaying patient health records were left unlocked. In others, files containing patient health records were left out and open on top of nurses’ station, facing the corridor.
## Area of strength
- We saw staff treating patients with dignity and respect in all observations.

## Areas for improvement
1. NHS Lothian should ensure nurse call handsets are available and accessible to patients at all times.
2. NHS Lothian should ensure that patient confidentiality is respected and maintained at all times by ensuring that patient health records are handled appropriately.

## Area of continuing improvement
- NHS Lothian should continue with the implementation of care rounding in the Royal Infirmary of Edinburgh.

## Dementia and cognitive impairment

### Screening and assessment of people with dementia and cognitive impairment
NHS Lothian’s self-assessment states that older people are screened for cognitive impairment on admission to the hospital. When screening takes place, an assessment tool is used that asks four basic questions and a score of three or below suggests a cognitive impairment.

During the August 2012 inspection, we found that there was no routine screening for cognitive impairment taking place when patients were admitted to hospital. During this inspection, we found that screening for cognitive impairment was inconsistent in the areas inspected. Screening had taken place at admission in 11 of the 33 patient health records reviewed, although two had not been carried out due to clinical reasons. A further five patient health records showed that screening had been carried out following admission. On one ward, we were told that patients are only screened for cognitive impairment if an impairment is suspected.

Improvements to documentation of assessments for cognitive impairment on admission are being made in the acute medical unit and the accident and emergency department. We were told that these are being received well by ward staff, although implementation of the new documentation is in the early stages in the accident and emergency department.

### Record-keeping and care planning for people with dementia and cognitive impairment
The self-assessment states that NHS Lothian uses the ‘This is Me’ document to request and record key personal information about patients. This document allows patients and their carers to highlight personal information to staff such as habits, background, likes and dislikes and things that are important to them. It also allows carers to identify how involved they wish to be during the patient’s stay in hospital.

During the August 2012 inspection, we found that this document was used inconsistently in the wards and departments inspected. The NHS Lothian action plan following the August 2012 inspection, states that the ‘This is Me’ document is in use in some areas. During this
inspection, we did not find any of the documents in use in any of the 33 patient health records we reviewed for dementia and cognitive impairment. However, we acknowledge that NHS Lothian is still in the process of implementing new documentation following the last inspection.

**Adults with Incapacity (Scotland) Act 2000 and welfare powers of attorney**

During the inspection, we found four Adults with Incapacity forms in patient health records. These forms provide the authority to treat patients who are unable to consent to treatment themselves. In both of these instances, appropriate discussions had been held to establish who, if anyone, held welfare power of attorney for the patients.

In other patient health records we reviewed for dementia and cognitive impairment, it was difficult to find evidence of any discussions regarding welfare power of attorney. There was no clear place in the patient health records to record if a patient had a welfare power of attorney. There was also no evidence that staff had asked if there was one. When asked where the information would be recorded, staff gave varying answers. There appears to be no clear system to record this information.

**Specialist services for older people**

NHS Lothian provides a range of specialist services for older people. These include the elderly care assessment team, psychiatric liaison and Alzheimer’s support. These services provide support from occupational therapists, physiotherapists and a specialist doctor. Patients should be referred to these services if a need is identified following assessment.

**Education and training for staff caring for patients with dementia and cognitive impairment**

Staff from a variety of disciplines have been identified and trained as Dementia Champions. Staff told us that they have had a positive effect on knowledge, attitudes and behaviour on the ward. Many staff in the areas inspected have completed or are undertaking the NHS Education for Scotland online dementia learning resource.

**Environment for people with dementia and cognitive impairment**

People with dementia or a cognitive impairment can benefit from environments that are adapted to limit potential confusion or distress. In the wards inspected, few changes had been made to improve the environment and, as a result, the wards are not suitable for people with dementia. We also saw no evidence that best practice on the use of colour contrast was in use. This is helpful to people with dementia and cognitive impairment to identify specific areas, such as handrails or toilets. However, we saw some appropriate signage on toilet and shower doors, and day/night clocks on some wards.

During the August 2012 inspection, it was noted that lighting on some wards was poor and that older people need additional light to be able to see well. During this inspection, only one main ward corridor was dimly lit.

During the August 2012 inspection, a lack of stimulation and activity for patients was noted. This was also observed during this inspection. There appeared to be limited stimulation or activity for patients other than individual TV equipment and interactions with staff and visitors.
Areas of strength

- Accident and emergency is working well to adapt to and meet the needs of elderly patients and those who are cognitively impaired.
- A range of specialist services are available to support the care of older people.
- Dementia Champions from a range of disciplines are being trained and used throughout the hospital.

Areas for improvement

3. NHS Lothian must ensure that all older people who are admitted to hospital are screened and assessed for cognitive impairment.
4. NHS Lothian must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information should be used to inform a plan of care and be shared with all staff in direct contact with the patient.
5. NHS Lothian must carry out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment.
6. NHS Lothian must ensure that patients have access to a range of activities and stimuli to help keep them active and maintain their current level of functioning.

Area of continuing improvement

b. NHS Lothian should continue with the implementation of the NHS Education for Scotland online dementia learning resource.

Nutritional care and hydration

Nutritional assessment and personalised care plans

NHS Lothian’s self-assessment states that, as part of the hospital admission process, patients have a nutritional risk assessment carried out using the validated Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. This includes information on a patient’s height and weight, body mass index (BMI), any unplanned weight loss and whether the patient is acutely ill or has not eaten for more than 5 days. The tool also states that reassessment will take place regularly while the patient remains in hospital.

During the August 2012 inspection, we found completion of the MUST tool within 24 hours was poor. During this inspection, completion of the MUST tool was variable. Of the 30 patient health records reviewed, 17 were completed within 24 hours of admission, although two had not been carried out due to clinical reasons. Where MUST assessments were completed, it was not always clear if the patient had been weighed or if the weight was estimated. However, where MUST assessments had been completed, there was evidence of reassessment during some patients’ stay.

Information about patients’ likes and dislikes was very limited and not always recorded in patient health records.
**Food intake and fluid balance charts**

Food intake and fluid balance charts are used to record how much patients are eating and drinking where there are concerns about their intake. These were not completed consistently in the areas inspected.

As part of the ongoing assessment of a patient’s needs, where a need for a food intake or fluid balance chart was identified during a patient’s stay, one was introduced. We observed the case of a patient who had not eaten their sandwiches from lunchtime. A clinical support worker assured us they had eaten soup at lunch and wanted to keep the sandwiches for later. Staff documented this in the patient health record, although the patient was not on a food intake chart at the time. When we returned the following day, staff had noted that the patient had lost their appetite over a 24-hour period and had introduced a food intake chart.

**Provision and assistance of nutrition and hydration**

Protected mealtimes have been introduced across the hospital. These are intended to reduce non-essential interruptions during mealtimes to make sure that patients can focus on eating and drinking without unnecessary distractions. During the August 2012 inspection, mealtimes were not always protected.

During this inspection, we found that protected mealtimes were in place, well managed and generally working well. The majority of patients who required assistance were given appropriate assistance. We noted that there were still some interruptions to mealtimes but, where these were necessary, they were handled well. We saw two instances of porters coming to take patients for X-ray during mealtimes. One porter was told that it was lunchtime so there should be no interruption. The other porter had to take the patient at that time, but staff assured the patient that another meal would be ordered for their return. Since the last inspection, the acute medical unit has made significant progress to manage protected mealtimes despite the challenging nature of this unit.

The menu system in the hospital had also been adapted recently to include information on the patient’s diet, such as pureed or solids, as well as their meal choice. This prompted staff to consider what support may be required for the patient. The choice on the menu was varied and meals appeared to be nutritious.

**Areas of strength**

- Protected mealtimes are in place, well managed and generally working well.
- There was a consistent and caring approach to the support given to patients during mealtimes.
- Patients were provided with a choice of meals.

**Areas for improvement**

7. NHS Lothian must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital.

8. NHS Lothian must ensure that patients’ intake of food and fluid is accurately recorded in consistent manner.
Preventing and managing pressure ulcers

Pressure area and ulcer assessment and care planning

NHS Lothian uses a recognised pressure ulcer risk assessment to assess a patient’s risk of developing a pressure ulcer. National guidance states that this assessment should be done within 6 hours of admission. During the August 2012 inspection, we found only six patient health records of the 32 we reviewed had an assessment carried out in the 6-hour timescale. Although more of these assessments were being completed within the 6-hour timescale during this unannounced inspection, we still found the majority were not. Of the 33 patient health records we reviewed for pressure ulcer management and prevention, 15 had a pressure ulcer risk assessment carried out within 6 hours of admission. Some assessments were carried out after the 6-hour timescale, which may have been appropriate in some cases.

Patients who were identified as at being at an increased risk of developing a pressure ulcer were provided with specialist pressure relieving equipment. In ward 210, patients who were in for planned surgery were risk assessed before they were admitted. If they were at risk of developing pressure ulcers, arrangements were made to ensure specialist pressure relieving equipment was in place for the patient’s admission.

In wards where care rounding had been implemented, it was clear that care was in place to minimise the risk to patients. This included moving patients who could not do so themselves to relieve pressure and prevent pressure ulcers. Where care rounding was not in place, the documentation and the care plan did not always make it clear what care was planned and had taken place.

Areas for improvement

9. NHS Lothian must ensure that all patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks.

10. NHS Lothian must ensure that personalised care plans are in place and followed for patients identified as at risk of developing pressure ulcers. The care plan should clearly document the interventions required to reduce pressure ulcers.
Appendix 1 – Areas for improvement

Areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. The list of national standards, guidance and best practice can be found in Appendix 3.  

### Treating older people with compassion, dignity and respect

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### Dementia and cognitive impairment

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| 3                        | must ensure that all older people who are admitted to hospital are screened and assessed for cognitive impairment (see page 11).  
This is to comply with Clinical Standards for Older People in Acute Care, Standard 2. |
| 4                        | must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information should be used to inform a plan of care and be shared with all staff in direct contact with the patient (see page 11).  
This is to comply with Standards of Care for Dementia in Scotland, page 26. |
| 5                        | must carry out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment (see page 11).  
This is to comply with Standards of Care for Dementia in Scotland, page 26. |
| 6                        | must ensure that patients have access to a range of activities and stimuli to help keep them active and maintain their current level of functioning (see page 11).  
This is to comply with Standards of Care for Dementia in Scotland, page 26. |
Nutritional care and hydration

NHS Lothian:

7  must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital (see page 12).

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Standard 2.

8  must ensure that patients’ intake of food and fluid is accurately recorded in consistent manner (see page 12).

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.6.

Preventing and managing pressure ulcers

NHS Lothian:

9  must ensure that all patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks (see page 13).

   This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers, section 2.

10 must ensure that personalised care plans are in place and followed for patients identified as at risk of developing pressure ulcers. The care plan should clearly document the interventions required to reduce pressure ulcers (see page 13).

   This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers, section 4.

Areas for continuing improvement are improvements that the NHS board has already identified and started to address. We acknowledge the work carried out by the NHS board at the time of inspection and encourage progress in these areas.

Areas for continuing improvement

NHS Lothian:

a  should continue with the implementation of care rounding in the Royal Infirmary of Edinburgh (see page 9).

b  should continue with the implementation of the NHS Education for Scotland online dementia learning resource (see page 11).
Appendix 2 – Details of inspection

The inspection to Royal Infirmary of Edinburgh, NHS Lothian was conducted from Thursday 14 February to Friday 15 February 2013.

The inspection team consisted of the following members:

**Ian Smith**
Regional Inspector

**Joanne Odgers**
Associate Inspector (Locum)

**Gail Pennington**
Associate Inspector (Clinical Advisor)

**Irene Robertson**
Associate Inspector

**Jane Walker**
Associate Inspector

Supported by:

**Sara Jones**
Project Officer
Appendix 3 – List of national guidance

The following national standards, guidance and best practice are relevant to the inspection of the care provided to older people in acute care.

- **Best Practice Statement for Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)
- **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals** (NHS Quality Improvement Scotland, September 2003)
- **Clinical Standards for Older People in Acute Care** (Clinical Standards Board for Scotland, October 2002)
- **Dementia: decisions for dignity** (Mental Welfare Commission, March 2011)
- **National Standards for Clinical Governance and Risk Management** (NHS Quality Improvement Scotland, October 2005)
- **Scottish Intercollegiate Guideline Network (SIGN) Guideline 86 – Management of Patients with Dementia** (SIGN, February 2006)
- **SIGN Guideline 111 – Management of Hip Fracture in Older People** (SIGN, June 2009)
- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)
Appendix 4 – Inspection process flow chart

This process is the same for both announced and unannounced inspections.

Before inspection:
- Self-assessment framework finalised and issued
- NHS board undertakes self-assessment exercise and submits outcomes to Healthcare Improvement Scotland
- Healthcare Improvement Scotland reviews self-assessment submission to inform and prepare on-site inspections

During inspection:
- Arrive at hospital
- Inspections of selected wards and departments
- Individual discussions with senior staff or operational staff, or both, and patients
- Group discussions with NHS board and senior hospital staff
- Feedback with NHS board and senior hospital staff
- Further inspection of hospital if areas of significant concern identified

After inspection:
- Report and improvement action plan published
- Follow-up activity to ensure improvement actions are completed
# Appendix 5 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>HDL</td>
<td>Health Department Letter</td>
</tr>
<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
</tbody>
</table>
How to contact us

You can contact us by letter, telephone or email to:

- find out more about our inspections, and
- raise any concerns you have about care for older people in an acute hospital or NHS board.

**Edinburgh Office** | Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB

**Telephone** 0131 623 4300

**Email** [hcis.chiefinspector@nhs.net](mailto:hcis.chiefinspector@nhs.net)

www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.
Improvement Action Plan

NHS Lothian

Royal Infirmary of Edinburgh

Care for older people in acute hospitals inspection

Inspection Date: 14 & 15 February 2013

Improvement Action Plan Declaration

It is essential that the NHS board’s improvement action plan submission is signed off by the NHS board Chair and NHS board Chief Executive. It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that a representative from Patient/Public Involvement within the NHS board has been involved in developing the improvement action plan. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above.

NHS board Chair

Signature: [Signature]

Full Name: Alex Macleod

Date: 8th April 2013.

NHS board Chief Executive

Signature: [Signature]

Full Name: Timothy Davison

Date: 8th April 2013
## Improvement Action Plan

**NHS Lothian**

**Royal Infirmary of Edinburgh**

**Care for older people in acute hospitals inspection**

**Inspection Date: 14 & 15 February 2013**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Action Planned</th>
<th>Timescale to meet action</th>
<th>Responsibility for taking action</th>
<th>Progress</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NHS Lothian should ensure nurse call handsets are available and accessible to patients at all times.</td>
<td>Immediate</td>
<td>Chief Nurses and all Charge Nurses</td>
<td>This message will be reinforced through ward safety briefs, ward meetings, Chief Nurse and CNM walk rounds delivering better care events, Patient Quality Indicators (PQI) and mini OPAH internal inspections. This is part of the Care Rounding checklist. Being rolled out within NHSL Lothian – anticipated completion for acute in-patients December 2013.</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
# Improvement Action Plan

**NHS Lothian**

**Royal Infirmary of Edinburgh**

Care for older people in acute hospitals inspection

**Inspection Date: 14 & 15 February 2013**

<table>
<thead>
<tr>
<th></th>
<th>NHS Lothian should ensure that patient confidentiality is respected and maintained at all times by ensuring that patient health records are handled appropriately.</th>
<th>Immediate</th>
<th>Divisional Medical and Nurse Director / AHP lead</th>
<th>Discussed at Clinical Management Group (CMG) with Chief Nurses and Associate Divisional Medical Directors. (ADMD) Internal communications and ward safety briefs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2</strong></td>
<td>NHS Lothian must ensure that all older people who are admitted to hospital are screened and assessed for cognitive impairment.</td>
<td>Immediate and ongoing</td>
<td>Divisional Medical and Nurse Director</td>
<td>Roll out in progress.</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>NHS Lothian must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information should be used to inform a plan of care and be shared with all staff in CMG April 2013 meeting &amp; ongoing</td>
<td>Divisional Medical and Nurse Director / Chief Nurses/ ADMD</td>
<td>Implement the Vulnerable Peoples Action Plan which includes the ongoing roll out of the use of the 4 AT assessment tool. Discuss and emphasis at CMG and re-emphasis via</td>
<td></td>
</tr>
</tbody>
</table>

## Dementia and cognitive impairment

4 NHS Lothian must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information should be used to inform a plan of care and be shared with all staff in CMG April 2013 meeting & ongoing.
### Improvement Action Plan

**NHS Lothian**

**Royal Infirmary of Edinburgh**

**Care for older people in acute hospitals inspection**

**Inspection Date: 14 & 15 February 2013**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NHS Lothian must ensure direct contact with the patient.</td>
<td>Line management and professional meetings.</td>
</tr>
<tr>
<td>2</td>
<td>NHS Lothian must ensure that patients have access to a range of activities and stimuli to help keep them active and engaged.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>3</td>
<td>NHS Lothian must ensure that care staff are trained in dementia care.</td>
<td>Chief Nurse Quality &amp; Standards and AHP</td>
</tr>
<tr>
<td>4</td>
<td>NHS Lothian must ensure that care staff are trained in dementia care.</td>
<td>Chief Nurse Quality &amp; Standards and AHP</td>
</tr>
<tr>
<td>5</td>
<td>NHS Lothian must carry out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment.</td>
<td>Commence summer 2013 and ongoing</td>
</tr>
<tr>
<td></td>
<td>Director of Facilities</td>
<td>Scope and cost works to improve the ward environments for patients with cognitive impairment and dementia e.g. replacement toilet seats.</td>
</tr>
<tr>
<td></td>
<td>Chief Nurse Quality &amp; Standards</td>
<td>NB as a PFI build there are additional limiting factors to implementing such schemes</td>
</tr>
<tr>
<td>6</td>
<td>NHS Lothian must ensure that patients have access to a range of activities and stimuli to help keep them active and engaged.</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Chief Nurse Quality &amp; Standards and AHP</td>
<td>Continue to improve patient flow to prevent delayed discharge</td>
</tr>
</tbody>
</table>

NHS Lothian must ensure that care staff are trained in dementia care. This includes ensuring that staff are adequately informed about the specific needs of patients with dementia, as well as receiving any necessary additional training or support. This will help to ensure that patients receive the best possible care and support. Additionally, it is important to provide patients with a range of activities and stimuli to help keep them active and engaged, as this can have a positive impact on their overall well-being.

NHS Lothian must ensure that patients have access to a range of activities and stimuli to help keep them active and engaged. This includes providing opportunities for patients to participate in group activities, social events, and other forms of entertainment. By doing so, patients can remain active and engaged, which can help to improve their overall health and well-being.

NHS Lothian must ensure that care staff are trained in dementia care. This includes ensuring that staff are adequately informed about the specific needs of patients with dementia, as well as receiving any necessary additional training or support. This will help to ensure that patients receive the best possible care and support. Additionally, it is important to provide patients with a range of activities and stimuli to help keep them active and engaged, as this can have a positive impact on their overall well-being.
Improvement Action Plan

NHS Lothian

Royal Infirmary of Edinburgh

Care for older people in acute hospitals inspection

Inspection Date: 14 & 15 February 2013

| Maintain their current level of functioning. | Director | Discharge. Continue the review of the activities of volunteers. Continue with the implementation of the Vulnerable Peoples Action Plan. |

Nutritional care and hydration

| 7 | NHS Lothian must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of under-nutrition, within 24 hours of admission to hospital. | Immediate / April Chief Nurse meeting | AHP Director and Divisional Nurse Director | Nursing staff reminded via Chief Nurses and managerial line to ensure that the MUST tool is completed. CNM walk rounds will include checking compliance. Nutrition action plan continues to be implemented. |
## NHS Lothian

### Royal Infirmary of Edinburgh

#### Care for older people in acute hospitals inspection

**Inspection Date:** 14 & 15 February 2013

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>NHS Lothian must ensure that patients’ intake of food and fluid is accurately recorded in consistent manner.</td>
<td>Immediate / April Chief Nurse meeting</td>
<td>Divisional Nurse Director</td>
</tr>
</tbody>
</table>

### Preventing and managing pressure ulcers

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>NHS Lothian must ensure that all patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks.</td>
<td>Immediate / April Chief Nurse meeting / ongoing</td>
<td>Divisional Nurse Director and Chief Nurse Quality &amp; Standards</td>
</tr>
</tbody>
</table>
### Areas for continue improvement

<table>
<thead>
<tr>
<th></th>
<th>NHS Lothian should continue with the implementation of care rounding in the Royal Infirmary of Edinburgh.</th>
<th>Ongoing</th>
<th>Clinical Effectiveness Team</th>
<th>Implementation across in-patient acute wards, pan NHSL, be the end of December 2013. The Emergency Department at the RIE also currently implementing care rounding.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Ongoing</td>
<td></td>
<td>Chief nurse for Quality &amp; Standards</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>NHS Lothian should continue with the implementation of the NHS Education for Scotland online dementia learning resource</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**WAITING TIMES PROGRESS AND PERFORMANCE**

1 **Purpose of the Report**

1.1 The purpose of this report is to update the Board on both waiting times performance and progress made in reducing the number of patients waiting longer than national targets and standards.

1.2 Any member wishing additional information should refer to the background paper or contact the Executive Lead in advance of the meeting.

2 **Recommendations**

The Board is recommended to:

2.1 Note the Board’s current position in relation to waiting times, including continued trend of reductions in the numbers of people waiting longer than target timescales for inpatient, outpatient and diagnostic appointments.

3 **Current Position**

3.1 NHS Lothian is continuing to improve waiting times for patients, undertaking the most significant waiting time recovery operation ever faced by a Health Board in Scotland.

3.2 The number of inpatients over 12 weeks continues to reduce - dropping by two-thirds on the level it was six months ago and over 1900 less than at its peak in 2011. 97 of those waiting over 12 weeks are for procedures excluded from the treatment time guarantee. The remaining 233 are predominately waiting for complex operations.

3.3 This gradual downward trend is set to continue with a rise anticipated in April underlining the importance of continuing to strengthen arrangements for the sustainable delivery of elective capacity;

3.4 The overall size of the inpatient list and unavailability level remain significantly lower than in the past. 7,843 were on the waiting list at the end of March, of whom 1062 are unavailable - one third and two-thirds lower than their respective peaks;

3.5 96.2% of patients treated in March were seen within the treatment time guarantee. 173 patients waited over this threshold in the month, of whom 125 have been admitted or no longer require treatment and 39 have dates identified or are with external providers to find a suitable date.
3.6 As anticipated at the last meeting, the number of outpatients over 12 weeks has improved to its best figure since November 2011. 2426 were waiting over 12 weeks at the end of March and further improvement expected in the coming quarter.

3.7 Diagnostic endoscopy waiting times improved in March with those over 6 weeks down to 374 - a reduction of 74% in three months. Additional capacity has been able to overcome the anticipated rise at the end of April and further reduction is expected.

3.8 As reported last month, recruitment to the first round of posts designed to deliver sustainable capacity is largely complete with some additional posts to be re-advertised. The detail of subsequent rounds continues to be worked on.

3.9 A follow up to March’s board seminar on waiting times is occurred after this month’s board meeting. It is anticipated this will provide further opportunity for the Board’s policy of offering patients treatment outside NHS Lothian to be reflected on before coming to next month’s board meeting.

3.10 The Board’s Audit & Risk Committee received an update on progress against the Management Actions at its meeting earlier this month. A letter of assurance is being sent by the Committee Chair to the Scottish Government on this matter.

Andrew Jackson
Associate Director, Strategic Planning
22 April 2013
Andrew.C.Jackson@nhslothian.scot.nhs.uk

The Waiting Time Progress and Performance Background Paper is available online - click on the button below:
PERFORMANCE MANAGEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board on the most recently available information on NHS Lothian performance against HEAT targets and standards. The data as reported is through both 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 To note that this Performance paper has been revised following the NHS Lothian March Board, where it was agreed that from the 1st April only the 16 HEAT targets plus the standards on delayed discharge and cancer waiting times and stroke performance would be included. Other waiting times and performance information on waiting times and unscheduled care will be addressed under separate reports.

2.2 Receive this update on the current performance against all of the current 2013/14 HEAT targets, and relevant standards. Note that whilst this version of the paper includes both nationally published and locally sourced data, we will continue to review the best sources of providing robust and timely data.

2.3 To note that work is continuing on the development of this Performance paper as part of a wider programme of Data Quality and Governance. A Data Quality Forum has been established to drive forward this work, and will meet monthly, chaired by Prof Alex McMahon. The first meeting took place on 17 April. This group will focus on a range of data quality and governance actions which will form part of our continuous quality improvement and Board Assurance work.

3 Discussion of Key Issues

3.1 Of the 23 items monitored within Appendix 1, the most recent data indicates NHS Lothian is off trajectory / does not meet the overall target on 13 occasions.

4 Key Risks

The following performance measures in the report are exceptions where NHS Lothian is currently off trajectory or items requiring to be highlighted to the JMT.
4.1 Heat Targets

4.1.1 A&E Attendances(T10) (Responsible Director: Nurse Director and Joint Director, Edinburgh)

This target is being reviewed by the Scottish Government. We will keep Board members informed of any change this review brings, but the focus will be shaped through the national collaborative being established to support admissions into and discharges from hospital.

4.1.2 Child Fluoride Varnishing (Responsible Director: Director of Public Health and Health Policy)

Data for the period from 1 October 2011 to 30 September 2012 shows NHS Lothian provided two fluoride varnishing applications to 31% of three year old and 38% of four year olds in the most deprived SIMD quintile (quintile 1). Performance overall is reported on the lowest performing quintile, which was Quintile 5 (least deprived) at 8.06%. Figures for all mainland Boards are below 10%. The Scottish Government is planning national work with general dental practitioners (GDPs) to promote routine application of fluoride varnish when a child visits the dentist. The Director of Public Health and Health Policy will provide further information if required.

4.1.3 Staphylococcus Aureus Bacteraemia (Responsible Director: Director of Public Health and Health Policy)

NHS Lothian is currently not on target to achieve the HEAT target. This is covered more fully in the Director of Public Health and Health Policy’s report on HAI Compliance.

4.1.4 Faster Access to CAMHS (Responsible Director: Director Health & Social Care West Lothian)

This target now focuses upon 18 weeks referral to treatment, and is to be delivered by December 2014. A team has been established to review progress in this area and take necessary actions.

4.1.5 Faster Access to Psychological Therapies (PT’s) (Responsible Director: Director Health & Social Care West Lothian)

This target focuses upon 18 weeks referral to treatment. The newly recruited “Lothian Meets A12” team will increase service capacity to implement the agreed processes and data model.

4.1.6 4-hour Emergency Access (Responsible Director: Nurse Director)

For March performance was 88.04% against a target of 98%. The Nurse Director will provide further details under her report on Unscheduled Care.
4.1.7 **IVF Treatment** (Responsible Director: Medical Director)

This is a new target for 2013/14. As yet, no trajectory has been agreed by the Scottish Government. Plans are being developed for Lothian and other Boards to work collectively towards this target, by working out correct capacity across these Boards that deliver this service.

4.1.8 **Dementia diagnosis** (Responsible Director: Director Health & Social Care West Lothian)

This is a new target. Plans are being developed to work towards ensuring that the dementia strategy (to be tabled on 2nd June) and the updated standards as well as this specific target have a clear plan of action. The Board will receive a paper on this in due course.

4.2 **HEAT Standards**

4.2.1 **Cancer Waiting Times** (Responsible Director: Medical Director)

Performance data for Quarter 4 (Oct – Dec) 2012 was published by ISD Scotland on the 26th of March 2013.

Overall, for the quarter, cancer waiting times in NHS Lothian were:

- 62 days – 97.0% (All Scotland 95.8%)
- 31 days – 98.6% (All Scotland 98.1%)

This is in line with local forecasts drawn from analysis of weekly and monthly management information scrutinised over the last quarter of 2012, and reported to JMT.

Monthly management information on cancer waiting times shows that performance in February 2013 for 62-days was 92.4%, and 31-days at 99.3%.

4.2.2 **Delayed Discharges** (Responsible Director: Director of Strategic Planning, Performance Reporting and Information)

The table gives a summary of headline figures from the March 2013 census

<table>
<thead>
<tr>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Total Delays (Excel. x-codes)</th>
<th>Complex Codes</th>
<th>6 Weeks+ (National standard - 0)</th>
<th>4 Weeks+ (National standard due April 2013- 0)</th>
<th>Short Stay (Target - 0)</th>
<th>Average length of stay as a delayed discharge (non- x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>180 ↓</td>
<td>120 ↑</td>
<td>60 ↓</td>
<td>10 ↓</td>
<td>24 ↓</td>
<td>6 ↓</td>
</tr>
</tbody>
</table>

↑↓ Indicates an increase or decrease from the previous month

- 120 delays after X codes removed (112 Feb, 135 Jan, 78 Dec)
- 180 overall including X codes ( 191 Feb,177 Jan, 139 Dec)
- 10 Patients delayed >6wks (11 Feb,8 Jan,16 Dec)
- 18 days is the average length of stay ( 22 Feb,18 Jan, 29 Dec)
- Zero Non-Lothian delays ( 0 Feb,1 Jan, 2 Dec)
- 60 X codes (79 Feb, 42 Jan,61 Dec)
- 367 Overall number of patients held on the delayed discharge database on census day (398 Feb, 365 Jan, 328 Dec)
- Edinburgh has 80 delays which is down 10 from Feb. They have 24 over four weeks
- East have 29 which is double their ‘norm’ but zero over six and only 2 over four weeks.
- Midlothian have 11 delays with zero over 6 weeks and 1 over 4 weeks
- West Lothian have zero delays

April 2013 will see the introduction of the revised National Standard on the maximum length of time a patient should wait for his/her future care arrangements to be put in place and be discharged from hospital.

The new standard is 4 weeks and this will be further revised for April 2015, when no patient should wait longer than 2 weeks.

The table below sets out the delay code by council area, for March

<table>
<thead>
<tr>
<th>Council of</th>
<th>Code of</th>
<th>&lt;2 wks</th>
<th>3-4 wks</th>
<th>&gt;6 wks</th>
<th>&gt;3 months</th>
<th>&gt;9 months</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Edinburgh</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Asley Ainslie Hospital</td>
<td></td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Grampian Hospital</td>
<td></td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Eilidh Glen House</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>2</td>
</tr>
<tr>
<td>Linlithgow Hospital</td>
<td></td>
<td>9</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
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<td>Royal Edinburgh Hospital</td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Royal Infirmary of Edinburgh at Little France</td>
<td></td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
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<td>12</td>
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<td>St John’s Hospital</td>
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<tr>
<td>Western General Hospital</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>City of Edinburgh Total</td>
<td></td>
<td>45</td>
<td>13</td>
<td>11</td>
<td>8</td>
<td>1</td>
<td>10</td>
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<tr>
<td>East Lothian</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Asley Ainslie Hospital</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>Grampian Hospital</td>
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<td>5</td>
<td>4</td>
<td>2</td>
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<td>Linlithgow Hospital</td>
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<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
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<tr>
<td>Royal Edinburgh Hospital</td>
<td></td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Royal Infirmary of Edinburgh at Little France</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Royal Victoria Hospital</td>
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<td>Western General Hospital</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>East Lothian Total</td>
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<td>51</td>
<td>14</td>
<td>14</td>
<td>8</td>
<td>1</td>
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<tr>
<td>Midlothian</td>
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<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Asley Ainslie Hospital</td>
<td></td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Linlithgow Hospital</td>
<td></td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Royal Edinburgh Hospital</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Royal Infirmary of Edinburgh at Little France</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Midlothian Total</td>
<td></td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>102</td>
<td>24</td>
<td>14</td>
<td>8</td>
<td>1</td>
<td>120</td>
</tr>
</tbody>
</table>

4.2.3 Stroke (Responsible Director: Nurse Director)

Stroke is now a HEAT standard, however, we will continue to report progress in this area to keep the Board updated. A new MoE consultant has been appointed at RIE and will be starting in post in July. The job plan is being negotiated to allow time to support stroke enhancements on the RIE site. The Nurse Director has funded a three month pilot at RIE for a band 6 nurse to focus on stroke outreach with an emphasis on improving access to the unit to meet the HEAT standard.

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 i.e. delayed discharges.
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.

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. Financial implications are reported as appropriately to the Board, CMT and other committees.

Moray Paterson Alex McMahon
Business Manager Director of Strategic Planning
11th April 2013 11th April 2013
moray.paterson@nhslothian.scot.nhs.uk alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: Performance Management Scorecard
<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>Lothian Milestones - Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Out</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Health Weight - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (add, requirement that at least 40% of child healthy weight interventions are delivered to children/families in the two most deprived SIMD quintiles by local SIMD datazone to be reported annually)</td>
<td>Mar-14</td>
<td>3,208</td>
<td>Apr-11 - Mar-12 683</td>
<td>Apr-12 - Dec-12 467</td>
<td>265</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Reduction - % of suicides per yr per 100,000 population</td>
<td>2013</td>
<td>20%</td>
<td>2008-10 14.1%</td>
<td>2009-11 13.7%</td>
<td>30%</td>
<td>↓</td>
<td>AVK</td>
<td>This target is currently being reviewed by the Scottish Government. Consultation closes in June 2013.</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation - to deliver universal smoking cessation services to achieve at least 11,066 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within Lothian SIMD areas over the period 2011/12 to 2013/14</td>
<td>Mar-14</td>
<td>11,686</td>
<td>Oct-12 7,830</td>
<td>Jan-13 9,221</td>
<td>7,175</td>
<td>↑</td>
<td>JF</td>
<td>This includes 5,643 in the 40% most-deprived within-board SIMD</td>
<td></td>
</tr>
<tr>
<td>Child Fluoride Varnishing Aged 3 - achieve at least 60 per cent of 3 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>31/03/2012 2012 Quintile 1 11.65%</td>
<td>30/09/2012 2012 Quintile 2 17.76%</td>
<td>87.36%</td>
<td>↑</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Child Fluoride Varnishing Aged 4 - achieve at least 60 per cent of 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>31/03/2012 2012 Quintile 1 11.65%</td>
<td>30/09/2012 2012 Quintile 2 17.76%</td>
<td>87.36%</td>
<td>↑</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 20% are to be diagnosed while in the first stage of the disease</td>
<td>Mar-15</td>
<td>25%</td>
<td>90.60%</td>
<td>80%</td>
<td>85.77%</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Access to Antenatal Care - at least 60% 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>Dec-12 77%</td>
<td>Feb-13 61%</td>
<td>60%</td>
<td>↑</td>
<td>AVK</td>
<td>Local trajectories still to be agreed with the Scottish Government. Bowel screening campaign has just run across Scotland as the second of three campaigns.</td>
<td></td>
</tr>
<tr>
<td>Efficiencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Carbon Emissions - % reduction year-on-year (Tonnes of CO2)</td>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qt 2, 12/13 0.24</td>
<td>Qt 3, 12/13 0.32</td>
<td>0.94%</td>
<td>↑</td>
<td>AB</td>
<td>Current data shows Feb 2013 performance against 18 week target. However, this target only came into effect from 1 April 2013. Previous reports covered a target of 50% of patients to be seen within 26 weeks March 2013. This was the first stage of delivery.</td>
<td></td>
</tr>
<tr>
<td>Reduce Energy Consumption - % reduction year-on-year (Energy GJ)</td>
<td>Mar-15</td>
<td>-2.07%</td>
<td>Qt 2, 12/13 0.24</td>
<td>Qt 3, 12/13 0.32</td>
<td>0.94%</td>
<td>↑</td>
<td>AB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster access to C-AIMH - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td>0</td>
<td>Jan-13 77%</td>
<td>Feb-13 61%</td>
<td>80%</td>
<td>↑</td>
<td>MI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td>0</td>
<td>Jan-13 77%</td>
<td>Feb-13 61%</td>
<td>80%</td>
<td>↑</td>
<td>MI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Appropriate for Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Attendances - rate of A&amp;E attendances per 100,000 population</td>
<td>Mar-14</td>
<td>1,911</td>
<td>Dec-12 2,085</td>
<td>Jan-13 1,937</td>
<td>1,946</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSKA / MSKA Reductions - achieve a reduction in the infection rate of MRSA/MSKA</td>
<td>Mar-15</td>
<td>0.24</td>
<td>Feb-13 0.32</td>
<td>Mar-13 0.32</td>
<td>0.26</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAIF Infections - achieve a reduction in the rate of Clostridium difficile infections in patients aged 19 and over to 0.25 cases per 1,000 acute occupied bed days</td>
<td>Mar-15</td>
<td>0.25</td>
<td>Feb-13 0.33</td>
<td>Mar-13 0.33</td>
<td>0.39</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in emergency bed day rates for patients aged 75+</td>
<td>Mar-15</td>
<td>8.1%</td>
<td>Sep-12 11%</td>
<td>Oct-12 12%</td>
<td>10%</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed Discharges - no patients to wait more than 14 days to be discharged from hospital into a more appropriate care setting</td>
<td>Apr-15</td>
<td>0</td>
<td>Feb-13 62</td>
<td>Mar-13 46</td>
<td>0</td>
<td>↓</td>
<td>AVK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MF - Eligible patients will commence IV treatment within 12 months by 31 March 2015</td>
<td>Mar-15</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Where Target includes breakdown by quintiles, Trend uses bottom cell to calculate analysis.
Dementia Diagnosis – all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of person-centred support plan

| Apr-15 | 0 | | | | | |

4-hour A&E - 95% of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&E treatment as a minimum and NHS Boards should pursue further sustainable improvement towards the 95% 4 hour A&E standard

| Apr-14 | 95% | Feb-13 | | RIE - 86.1% | Mar-13 | RIE - 80.2% | | WGH - 91.1% | 95% |

<table>
<thead>
<tr>
<th>HEAT Standards &amp; Other Measures</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<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>Standard</td>
<td>90%</td>
<td>Q3 12/13</td>
<td>86.00%</td>
<td>Feb-13</td>
<td>93.10%</td>
<td>90.00%</td>
<td>↑</td>
<td>AM-M</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>95%</td>
<td>Jan-13</td>
<td>100.00%</td>
<td>Feb-13</td>
<td>95%</td>
<td>↓</td>
<td>DF</td>
<td></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>95%</td>
<td>Jan-13</td>
<td>100.00%</td>
<td>Feb-13</td>
<td>95%</td>
<td>↑</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Stroke Unit - 95% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Ongoing</td>
<td>95%</td>
<td>Jan-13</td>
<td>75%</td>
<td>Feb-13</td>
<td>87%</td>
<td>90%</td>
<td>↓</td>
<td>MH</td>
</tr>
</tbody>
</table>

Local recovery trajectory agreed at: February 60%, March 60%, April 70%, May 75%, June 80%, July 90%.
FINANCIAL POSITION FOR THE YEAR ENDED 31 MARCH 2013

1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the financial position of NHS Lothian for the year ended 31 March 2013.

1.2 Any member wishing additional information on the detail of this paper should be raised with the Executive Lead prior to the meeting.

2 Recommendation

2.1 Members of the Board are asked to note the:

- achievement of financial targets for the year 2012/13, subject to external audit review.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting delivery of the Revenue Resource Limit target for 2012/13; subject to external audit review.

3.2 An under spend of £0.447m has been achieved for the year ended 31 March 2013, compared with the forecast break even position reported since mid year review. This position encompasses a baseline under spend of £4.164m offset by unachieved efficiency savings of £3.717m.

3.3 A total of £33.82m of efficiency savings, also known as Local Reinvestment Plans (LRP), have been delivered operationally, in year, across the organisation, against an original target of £37.54m. The balance has been offset from strategic reserves and other under spends. Of this £27.9m has been delivered recurrently.

3.4 Overall capital programme expenditure of £47.17m is reported for the year, including £7.254m of capital grants to third parties, £3.176m of revenue maintenance expenditure and £36.741m of ‘direct’ capital expenditure. This represents a break even position against the Capital Resource Limit (CRL) for the year.

3.5 The outturn revenue position is summarised in Table 1 below, showing the additional costs and benefits emerging through the year. A detailed analysis by expenditure type is attached as Appendix 1 and by operational unit in Appendix 2.
Table 1 – Financial Position to 31 March 2013

<table>
<thead>
<tr>
<th>Year to date</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>(675)</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff</td>
<td>3,855</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>(2,072)</td>
</tr>
<tr>
<td>Allied Healthcare Professional</td>
<td>1,618</td>
</tr>
<tr>
<td>Other Pays</td>
<td>2,489</td>
</tr>
<tr>
<td>Drugs</td>
<td>6,167</td>
</tr>
<tr>
<td>Clinical Supplies, Equipment &amp; Hotel Costs</td>
<td>(7,748)</td>
</tr>
<tr>
<td>All Other Non Pays</td>
<td>(8,204)</td>
</tr>
</tbody>
</table>

**Baseline position** (4,985)

Outstanding efficiency savings (3,717)

**Operational position** (8,701)

Waitting Times (4,865)

Release of provisions and reserves | 16,211 |

**Under/(over) spend** 2,645

Reduction in SGHD brokerage (2,200)

**Total under/(over) spend** 445

3.6 The key financial issues underpinning the position to the end of March are consistent with those reported throughout the financial year. Appendix 1 provides a subjective analysis of the position, showing that overall pay budgets are under spent by £5.9m; whilst there are a number of specific overspends in non pay areas such as clinical supplies, equipment costs and property related costs.

**Efficiency & Productivity**

3.7 As highlighted in Table 2, savings of £33.1m have been achieved during the year. This represents 88% of the original annual target of £37.5m for 2012/3.
### Table 2 – Efficiency & Productivity Programme 2012/13

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target £k</th>
<th>Slippage to March £k</th>
<th>Actual carry forward £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Interventions Low Clinical Value</td>
<td>537</td>
<td>(537)</td>
<td>(537)</td>
</tr>
<tr>
<td>Primary &amp; Community Care Bed Reduction</td>
<td>650</td>
<td>(459)</td>
<td>459</td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity Management</td>
<td>3,233</td>
<td>(708)</td>
<td>(794)</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>(1,618)</td>
<td>(1,894)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>11,411</td>
<td>(327)</td>
<td>0</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>(1,867)</td>
<td>(606)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>(698)</td>
<td>(1,521)</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td>1,945</td>
<td>0</td>
<td>(946)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,779</td>
<td>(820)</td>
<td>(651)</td>
</tr>
<tr>
<td>Primary &amp; Community Care Care</td>
<td>5,171</td>
<td>486</td>
<td>(1,203)</td>
</tr>
<tr>
<td>UHD Local</td>
<td>3,893</td>
<td>2,153</td>
<td>(1,759)</td>
</tr>
<tr>
<td>LAMS</td>
<td>2,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Planned Savings</strong></td>
<td><strong>37,902</strong></td>
<td><strong>(4,395)</strong></td>
<td><strong>(9,452)</strong></td>
</tr>
<tr>
<td>Residual Gap</td>
<td>(362)</td>
<td>678</td>
<td>(2,866)</td>
</tr>
<tr>
<td>Strategic Contribution</td>
<td></td>
<td>3,717</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37,540</strong></td>
<td>0</td>
<td><strong>(12,318)</strong></td>
</tr>
</tbody>
</table>

3.15 A contribution of £3.7m was provided from strategic reserves to ensure delivery of the full savings target.

**Waiting Times**

3.16 The total cost of delivering additional elective capacity to meet waiting times to the end of March is £27m. In addition to the cost of reducing the backlog, expenditure includes recurring investment in core capacity. Expenditure by category is summarised in figure 3, below:
### Table 3 – Waiting Times Expenditure 2012/13

<table>
<thead>
<tr>
<th>Forecast</th>
<th>2012/13 Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
</tr>
<tr>
<td>Internal</td>
<td>6,642</td>
</tr>
<tr>
<td>Golden Jubilee National Hospital</td>
<td>2,844</td>
</tr>
<tr>
<td>Other NHS</td>
<td>331</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>12,275</td>
</tr>
<tr>
<td>Other Contractors</td>
<td>4,670</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td><strong>26,762</strong></td>
</tr>
<tr>
<td>AVAILABLE RESOURCES</td>
<td>21,882</td>
</tr>
<tr>
<td>Surplus/(Deficit) against plan</td>
<td>(4,880)</td>
</tr>
</tbody>
</table>

3.17 The position remains broadly in line with the mid year review forecast of £26.8m. Included within the final outturn position are estimated charges in relation to independent sector activity not yet invoiced.

### Capital

3.18 Total capital expenditure, net of disposal and donation income of £2.9m, was £44.3m. This reflects progress with the re-provision programme and ongoing investment in statutory standards, backlog maintenance, eHealth and replacement medical equipment; it also includes £7.25m of capital grants to third parties. Major areas of investment include:

- Wester Hailes - NHS component only (£4.2m);
- RIE lifecycle costs (£4.5m);
- Royal Victoria Hospital (£2.2m);
- Radiotherapy (£2.7m);
- GDP Dental Premises (£1.3m);
- RVH Relocations (£1.2m)

The detail relating to individual schemes is included in Appendix 3.

### 4 Key Risks

4.1 The underlying risks associated with the financial position have been highlighted throughout the year. Whilst actions have been put in place to manage these through the financial planning process, it is likely that some aspects will continue throughout 2013/14 and beyond.

### 5 Risk Register

5.1 There is nothing to add to the Risk Register at this stage.
6 Impact on Health 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 Impact on Inequalities

7.1 Refer to 6.1 above.

8 Involving People

8.1 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.

9 Resource Implications

9.1 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
19 April 2013
Susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Income & Expenditure Summary March 2013
Appendix 2: NHS Lothian Summary by Operational Unit March 2013
Appendix 3: NHS Lothian Capital Expenditure Programme March 2013
## NHS Lothian Income & Expenditure Summary to March 2013

### APPENDIX 1

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget</th>
<th>YTD Budget</th>
<th>YTD Actuals</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td><strong>NHS LOTHIAN CORE POSITION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
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<tr>
<td>Sub Total Income</td>
<td>(257,043)</td>
<td>(257,043)</td>
<td>(256,369)</td>
<td>(674)</td>
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<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,307,296)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Total Income</strong></td>
<td>(1,564,339)</td>
<td>(257,043)</td>
<td>(256,369)</td>
<td>(674)</td>
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<tr>
<td><strong>EXPENDITURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medical &amp; Dental Staff</td>
<td>206,896</td>
<td>206,896</td>
<td>203,042</td>
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<tr>
<td>Nursing Staff</td>
<td>332,985</td>
<td>332,985</td>
<td>335,057</td>
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<td>Allied Healthcare Prof</td>
<td>60,466</td>
<td>60,466</td>
<td>58,848</td>
<td>1,618</td>
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<tr>
<td>Ancillary/Estates/Other</td>
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<td>46,219</td>
<td>46,439</td>
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<td>Professional/Technical</td>
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<td>38,532</td>
<td>37,617</td>
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<td>Pharmacy/Psychology</td>
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<td>20,367</td>
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<td>GMS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Management/Admin Staff</td>
<td>86,050</td>
<td>86,050</td>
<td>84,996</td>
<td>1,054</td>
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<td><strong>Total Pay</strong></td>
<td>792,255</td>
<td>792,255</td>
<td>786,366</td>
<td>5,889</td>
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<td>Non-Pay</td>
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<td>Drugs</td>
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<td>95,865</td>
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<td>Clinical Supplies</td>
<td>70,657</td>
<td>70,657</td>
<td>75,221</td>
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<td>Equipment</td>
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<td>23,653</td>
<td>26,758</td>
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<td>Hotel Costs</td>
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<td>19,766</td>
<td>19,844</td>
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<tr>
<td>Other Non Pays</td>
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<td>183,145</td>
<td>172,746</td>
<td>10,399</td>
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<td>GMS</td>
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<td>120,408</td>
<td>120,377</td>
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<td>Prescribing</td>
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<td>125,719</td>
<td>125,433</td>
<td>286</td>
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<td>Primary Care</td>
<td>8,145</td>
<td>8,145</td>
<td>9,044</td>
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<tr>
<td>Property/Transport</td>
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<td>45,084</td>
<td>52,283</td>
<td>(7,199)</td>
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<td>Staff/Admin Expenses</td>
<td>17,906</td>
<td>17,906</td>
<td>20,071</td>
<td>(2,165)</td>
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<td>Depreciation</td>
<td>(1)</td>
<td>(1)</td>
<td>(78)</td>
<td>77</td>
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<td><strong>Total Non-Pay</strong></td>
<td>712,961</td>
<td>710,348</td>
<td>711,399</td>
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<td><strong>Total Expenditure</strong></td>
<td>1,505,216</td>
<td>1,502,603</td>
<td>1,497,765</td>
<td>4,838</td>
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<td><strong>SUB TOTAL CORE BASELINE POSITION</strong></td>
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<td>1,245,560</td>
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<td><strong>LRP</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LRP</td>
<td>(3,717)</td>
<td>(3,717)</td>
<td>0</td>
<td>(3,717)</td>
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<tr>
<td><strong>SUB TOTAL CORE POSITION</strong></td>
<td>(62,840)</td>
<td>1,241,843</td>
<td>1,241,396</td>
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<td><strong>NHS LOTHIAN NON CORE POSITION</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Depreciation &amp; Capital Grants</td>
<td>40,506</td>
<td>40,506</td>
<td>40,274</td>
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<tr>
<td>Revenue Funded Capital Schemes</td>
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<td>5,901</td>
<td>6,133</td>
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<tr>
<td>Impairments, Provisions &amp; Donated Depreciation</td>
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<td>16,433</td>
<td>16,433</td>
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<td><strong>TOTAL NHS LOTHIAN CORE/NON CORE POSITION</strong></td>
<td>(62,840)</td>
<td>1,304,683</td>
<td>1,304,236</td>
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### NHS Lothian Summary by Operational Unit to March 2013

#### UNIVERSITY HOSPITALS DIVISION

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<tr>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
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<tr>
<td><strong>Medical &amp; Associated Services</strong></td>
<td>127,036</td>
<td>(2,114)</td>
<td>(1,349)</td>
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<tr>
<td><strong>MoE</strong></td>
<td>27,966</td>
<td>(333)</td>
<td>(290)</td>
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<td><strong>Surgical Directorate</strong></td>
<td>89,421</td>
<td>(172)</td>
<td>720</td>
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<td><strong>Labs, A&amp;T, Critical Care &amp; HSDU</strong></td>
<td>124,597</td>
<td>(41)</td>
<td>(1,172)</td>
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<tr>
<td><strong>Women, Children &amp; Neuroscience</strong></td>
<td>91,980</td>
<td>(634)</td>
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<td><strong>Radiology, Cancer, Head &amp; Neck</strong></td>
<td>105,628</td>
<td>478</td>
<td>433</td>
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<tr>
<td><strong>Corporate</strong></td>
<td>(19,831)</td>
<td>9,322</td>
<td>8,844</td>
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<td><strong>Total</strong></td>
<td>546,797</td>
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#### CHPs/CHCP/PCCO

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<th>Baseline</th>
<th>LRP</th>
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<td><strong>East Lothian CHP</strong></td>
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<tr>
<td><strong>Edinburgh CHP</strong></td>
<td>286,700</td>
<td>387</td>
<td>387</td>
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<td><strong>Midlothian CHP</strong></td>
<td>70,803</td>
<td>96</td>
<td>96</td>
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<tr>
<td><strong>West Lothian CHCP</strong></td>
<td>0</td>
<td>(0)</td>
<td>(0)</td>
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<td><strong>Primary Care Contractor Organisation</strong></td>
<td>8,426</td>
<td>67</td>
<td>67</td>
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<td><strong>REAS</strong></td>
<td>99,950</td>
<td>75</td>
<td>73</td>
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<td><strong>Corporate</strong></td>
<td>(16,047)</td>
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<td>(3)</td>
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<tr>
<td><strong>Total</strong></td>
<td>521,359</td>
<td>621</td>
<td>620</td>
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#### CORPORATE BUDGETS

<table>
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<th>Budget</th>
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<th>LRP</th>
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<tbody>
<tr>
<td><strong>Chief Executive</strong></td>
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<td>7</td>
<td>7</td>
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<tr>
<td><strong>Consort</strong></td>
<td>45,703</td>
<td>615</td>
<td>615</td>
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<td><strong>Communications</strong></td>
<td>1,160</td>
<td>195</td>
<td>195</td>
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<td><strong>Ehealth</strong></td>
<td>27,328</td>
<td>(78)</td>
<td>(78)</td>
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<tr>
<td><strong>Facilities Management</strong></td>
<td>85,270</td>
<td>(2,243)</td>
<td>(1,423)</td>
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<td><strong>Finance &amp; Capital Planning</strong></td>
<td>10,476</td>
<td>358</td>
<td>358</td>
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<td><strong>Human Resources</strong></td>
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<td>10</td>
<td>10</td>
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<tr>
<td><strong>Medical Director</strong></td>
<td>1,001</td>
<td>2</td>
<td>2</td>
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<tr>
<td><strong>Nursing</strong></td>
<td>4,529</td>
<td>44</td>
<td>44</td>
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<tr>
<td><strong>Pharmacy</strong></td>
<td>12,141</td>
<td>154</td>
<td>154</td>
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<tr>
<td><strong>Planning</strong></td>
<td>6,103</td>
<td>432</td>
<td>432</td>
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<tr>
<td><strong>Public Health</strong></td>
<td>3,992</td>
<td>134</td>
<td>134</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>139</td>
<td>151</td>
<td>151</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>211,186</td>
<td>(220)</td>
<td>600</td>
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</table>

#### STRATEGIC BUDGETS

<table>
<thead>
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<th>Budget</th>
<th>YTD</th>
<th>Baseline</th>
<th>LRP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SLAs/UNPACs/NCA</strong></td>
<td>10,690</td>
<td>(2,938)</td>
<td>(2,938)</td>
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<tr>
<td><strong>Income from other health systems</strong></td>
<td>(99,715)</td>
<td>(3,344)</td>
<td>(3,344)</td>
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<tr>
<td><strong>Depreciation, Capital Grants &amp; Asset Impairment</strong></td>
<td>59,028</td>
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<tr>
<td><strong>Provisions for Pension Costs &amp; Claims</strong></td>
<td>17,154</td>
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<td>(0)</td>
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<td><strong>Commissing from 3rd Sector</strong></td>
<td>8,979</td>
<td>85</td>
<td>85</td>
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<tr>
<td><strong>R&amp;D</strong></td>
<td>5,864</td>
<td>(1,121)</td>
<td>(1,121)</td>
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<tr>
<td><strong>Reserves &amp; Uncommitted Allocations</strong></td>
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<td>(8,439)</td>
<td>(5,675)</td>
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<tr>
<td><strong>Total</strong></td>
<td>32,286</td>
<td>(15,758)</td>
<td>(12,994)</td>
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#### TOTAL

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<th>Budget</th>
<th>YTD</th>
<th>Baseline</th>
<th>LRP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Waiting Times</strong></td>
<td>(4,334)</td>
<td>(4,865)</td>
<td>(4,865)</td>
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<td><strong>Offset by release of provisions and reserves</strong></td>
<td>16,211</td>
<td>16,211</td>
<td></td>
</tr>
<tr>
<td><strong>Reduction to SGHD brokerage</strong></td>
<td>(2,200)</td>
<td>(2,200)</td>
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<tr>
<td><strong>Total</strong></td>
<td>1,307,296</td>
<td>447</td>
<td>4,164</td>
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**APPENDIX 2**
### NHS Lothian Capital Expenditure Programme 2012/13

#### APPENDIX 3

<table>
<thead>
<tr>
<th>Schemes with Specific Funding</th>
<th>Agreed Programme £m</th>
<th>Actual Expenditure £m</th>
<th>Remaining Anticipated Expenditure £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>2.241</td>
<td>2.221</td>
<td>0.019</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>1.000</td>
<td>1.555</td>
<td>(0.555)</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>0.024</td>
<td>(0.012)</td>
<td>0.036</td>
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<tr>
<td>GDP dental premises</td>
<td>1.500</td>
<td>1.332</td>
<td>0.168</td>
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<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>4.261</td>
<td>4.237</td>
<td>0.024</td>
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<td>RIE Lifecycle Costs</td>
<td>4.520</td>
<td>4.520</td>
<td>0.000</td>
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<tr>
<td>Gullane Medical Centre</td>
<td>0.459</td>
<td>0.466</td>
<td>(0.007)</td>
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<tr>
<td>Radiotherapy - Phase 7</td>
<td>0.027</td>
<td>0.014</td>
<td>0.013</td>
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<tr>
<td>Radiotherapy - Phase 8</td>
<td>2.375</td>
<td>2.490</td>
<td>(0.115)</td>
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<td>Radiotherapy-Other</td>
<td>0.226</td>
<td>0.208</td>
<td>0.018</td>
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<tr>
<td>West End Medical Practice</td>
<td>0.571</td>
<td>0.618</td>
<td>(0.046)</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Total - SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td>17.205</td>
<td>17.650</td>
<td>(0.446)</td>
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</table>

#### Programmed, but unapproved

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<tr>
<th></th>
<th>Agreed Programme £m</th>
<th>Actual Expenditure £m</th>
<th>Remaining Anticipated Expenditure £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub Enabling Works</td>
<td>0.071</td>
<td>0.071</td>
<td>0.000</td>
</tr>
<tr>
<td>Firhill Partnership Centre</td>
<td>0.071</td>
<td>0.071</td>
<td>0.000</td>
</tr>
<tr>
<td>Blackburn Partnership Centre</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td>North West Edinburgh Partnership Centre</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Wester Hailes Healthy Living Centre</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Gullane Medical Practice</td>
<td>-</td>
<td>0.000</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>0.071</td>
<td>0.071</td>
<td>0.000</td>
</tr>
</tbody>
</table>

#### Total - SCHEMES WITH SPECIFIC FUNDING

|                                      | 17.276              | 17.721                | (0.446)                            |

#### Over/ (Under) Commitment on Specific Funding

|                                      | 0.000               |                       |                                     |

### NHS Lothian Formula and Other Funding Programme

#### Rolling Programmes

<table>
<thead>
<tr>
<th></th>
<th>Agreed Programme £m</th>
<th>Actual Expenditure £m</th>
<th>Remaining Anticipated Expenditure £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Compliance</td>
<td>1.565</td>
<td>2.980</td>
<td>(1.415)</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>10.911</td>
<td>10.901</td>
<td>0.010</td>
</tr>
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<td>E-Health Strategic Priorities</td>
<td>2.780</td>
<td>2.776</td>
<td>0.004</td>
</tr>
<tr>
<td>Backlog Maintenance</td>
<td>4.000</td>
<td>4.906</td>
<td>(0.905)</td>
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<tr>
<td>Invest to Save</td>
<td>0.437</td>
<td>0.437</td>
<td>(0.000)</td>
</tr>
<tr>
<td>Traffic Management</td>
<td>0.115</td>
<td>0.077</td>
<td>0.038</td>
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<tr>
<td>National PACS Refresh 2007-17</td>
<td>0.085</td>
<td>0.085</td>
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<tr>
<td></td>
<td>19.893</td>
<td>22.162</td>
<td>-2.269</td>
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#### Approved

<table>
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<th>Agreed Programme £m</th>
<th>Actual Expenditure £m</th>
<th>Remaining Anticipated Expenditure £m</th>
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</thead>
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<tr>
<td>Expansion of renal capacity RIE</td>
<td>0.007</td>
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</tr>
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<td>Laboratory Equipment</td>
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<td>0.068</td>
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<td>Observation Ward A&amp;E Rie</td>
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<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Birthing suite RIE</td>
<td>0.026</td>
<td>0.121</td>
<td>(0.095)</td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>0.030</td>
<td>(0.012)</td>
<td>0.042</td>
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<td>LAMS</td>
<td>0.800</td>
<td>0.852</td>
<td>(0.052)</td>
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<tr>
<td>RVH Relocations</td>
<td>1.295</td>
<td>1.241</td>
<td>0.054</td>
</tr>
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<td>HEI</td>
<td>0.096</td>
<td>0.095</td>
<td>0.002</td>
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<tr>
<td>Other Donations</td>
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<td>0.644</td>
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<tr>
<td>Labour Ward/ Maternity Unit (SJH)</td>
<td>0.463</td>
<td>0.418</td>
<td>0.045</td>
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<tr>
<td>LEAP Relocation to AAH</td>
<td>0.381</td>
<td>0.356</td>
<td>0.026</td>
</tr>
<tr>
<td>Teenage Cancer Trust, WGH</td>
<td>0.870</td>
<td>0.627</td>
<td>0.243</td>
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<td>BCI Mammography Upgrade WGH</td>
<td>1.399</td>
<td>1.234</td>
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</table>
## APPENDIX 3

### NHS Lothian Capital Expenditure Programme 2012/13

<table>
<thead>
<tr>
<th></th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
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<tr>
<td><strong>Tranent</strong></td>
<td>0.035</td>
<td>0.030</td>
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<tr>
<td><strong>6.097</strong></td>
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<tr>
<td><strong>Programmed, but unapproved</strong></td>
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<tr>
<td>Cancer Modernisation</td>
<td>0.133</td>
<td>0.154</td>
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<td>NSD Projects</td>
<td>0.157</td>
<td>0.158</td>
<td>(0.001)</td>
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<tr>
<td>Other Equipment</td>
<td>0.180</td>
<td>0.000</td>
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<tr>
<td>Endoscopy RIE</td>
<td>0.153</td>
<td>0.021</td>
<td>0.132</td>
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<td>Balfour Pavilion</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td>Closure of Edenhall</td>
<td>0.284</td>
<td>0.263</td>
<td>0.021</td>
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<tr>
<td>Community Dental and Podiatry Decontamination</td>
<td>0.682</td>
<td>0.076</td>
<td>0.606</td>
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<td>Greenbank</td>
<td>0.012</td>
<td>0.031</td>
<td>(0.020)</td>
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<tr>
<td>CEEF</td>
<td>0.788</td>
<td>0.831</td>
<td>(0.042)</td>
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<tr>
<td>St John's Hospital MRI</td>
<td>0.051</td>
<td>0.030</td>
<td>0.021</td>
</tr>
<tr>
<td>Macmillan Centre SJH</td>
<td>0.032</td>
<td>0.033</td>
<td>(0.001)</td>
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<tr>
<td>Endoscopy WGH</td>
<td>0.029</td>
<td>0.009</td>
<td>0.019</td>
</tr>
<tr>
<td>RIE additional beds</td>
<td>0.174</td>
<td>0.063</td>
<td>0.111</td>
</tr>
<tr>
<td>Completed Schemes under Review</td>
<td>(0.192)</td>
<td>(0.011)</td>
<td>(0.181)</td>
</tr>
<tr>
<td><strong>2.690</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total - SCHEMES FUNDED BY FORMULA &amp; OTHER FUNDING</strong></td>
<td><strong>28.679</strong></td>
<td><strong>29.449</strong></td>
<td><strong>(0.770)</strong></td>
</tr>
<tr>
<td>(Over)/Under Commitment on Formula</td>
<td>0.003</td>
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<td></td>
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<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td></td>
<td><strong>47.170</strong></td>
</tr>
<tr>
<td>(Over)/Under Commitment</td>
<td>0.003</td>
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SUMMARY PAPER
UNSCHEDULED CARE BRIEFING NHS LOTHIAN BOARD MARCH 2013

This paper aims to summarise the key points of the full Unscheduled Care briefing, available to board members at the meeting.

The relevant paragraph in the full paper is referenced against each point.

• The percentage compliance since November 2012 against the 4 hour Emergency standard has been in the high 80's, which is a deteriorated position based on previous months. 3.3
• The percentage compliance for March was 88.04%. 3.4
• Comparing the number of attendances for March 2012 to March 2013, demonstrates a decrease of 2061 attendees. 3.6
• Comparing the number of breaches for the same reference period shows:
  ➢ 4 hour breaches increased by 73%
  ➢ 8 hour breaches increased by 168%
  ➢ 12 hour breaches increased by 200% 3.7
• Main areas affecting flow during the reference period were:
  ➢ Numbers of patients with a length of stay greater than 28 days continues to increase on both acute and rehabilitation sites. 3.10
  ➢ The impact of Norovirus for March has had a significant impact on flow, which has impacted on Performance. Both Liberton and RIE have had several wards/ bases closed as a direct result, but the impact has started to decline towards end of March 3.11
  ➢ The number of patients Boarding has started to diminish towards the end of March and this is partially attributed to the reduction of Norovirus 3.12
• City of Edinburgh Health and Social Care have provided supported 471 discharges, over the five weeks in March, an average of 94 per week. This is ahead of target by 111 discharges over the month and 22 on average per week. The week preceding Easter however saw fewer discharges recorded (68).
NHS Lothian has invested significant monies to support Unscheduled Care, which includes capital works and an increase in workforce within certain staffing groups.

Other actions being put in place to assist in improving unscheduled care include:

- Whole system Capacity and Demand exercise
- Work progressing to create additional bed capacity at the RIE
- Action plan has been developed following Day of Care Audit at RIE
- Plan being developed to agree a model of non-acute step-down care for older people
- Dedicated Charge Nurse within Surgical Observation Unit focusing on flow
- Additional Advanced Nurse Practitioner at key periods at Emergency Department RIE
- 6 Additional Consultants have been appointed to the Emergency Departments at RIE and SJH with some sessions at RHSC also as part of the Emergency Department Workforce Plan
- Currently advertising GP posts for Emergency Department at St Johns to support safe overnight working from August.

The Scottish Government is currently developing a new national unscheduled care programme which is anticipated to be launched during the summer.

A winter de-brief event is scheduled in April to review winter 12/13 and to commence planning for winter 13/14

There is a potential risk that NHS Lothian will be unable to recruit to all posts which have been funded.

There is a potential risk that Social Work departments unable to meet demand for packages of care, as there is an increased requirement for these.

Chris Stirling  
Acting Site Director, Western General Hospital  
7 April 2013  
Chris.stirling@luht.scot.nhs.uk

Monica Boyle  
Head of Older People Social Work, Edinburgh City Council  
7 April 2013  
Monica.Boyle@edinburgh.gov.uk

Appendix 1: Unscheduled Care Briefing NHS Lothian Board March 2013
Appendix 1

NHS LOTHIAN

Board Meeting
24 April 2013

Nurse Director and Executive Lead for Unscheduled Care
Director of Health & Social Care and Executive Lead for Unscheduled Care

UNSCHEDULED CARE BRIEFING NHS LOTHIAN BOARD MARCH 2013

1 Purpose of the Report

1.1 The purpose of this report is to provide a summary to the Board, of NHS Lothian’s unscheduled care performance for March 2013.

1.2 It will provide challenges across the system and work which is being progressed to improve unscheduled care performance.

2 Recommendations

The Board is recommended to:

2.1 Receive the report outlining progress showing the latest position against the 4 hour Emergency Care standard at March 2013.

2.2 Note the ongoing work to improve compliance against the standard, for patients who attend as an unscheduled patient.

2.3 Recognise the variables, risks and areas of uncertainty around these actions including the timescales required to implement plans and deliver change to improve patient care and performance.

3 Discussion of Key Issues

Background

3.1 As reported to the Board in previous months, performance against the 4 hour standard has declined.

3.2 To address the current position, NHS Lothian has developed an action plan to improve sustained compliance against the 4 hour standard, which includes significant investment and capital works to increase unscheduled care capacity.

Current Position

3.3 Table 1 below demonstrates performance against the 4 hour standard, for the last 13 months.
3.4 Percentage compliance since November has dropped to the 80’s, with March performance reported at 88.04%.

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Breaches</th>
<th>Total Attendances</th>
<th>8hr breaches</th>
<th>12hr breaches</th>
<th>Monthly %</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>1407</td>
<td>22420</td>
<td>112</td>
<td>8</td>
<td>93.27%</td>
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<tr>
<td>April 2012</td>
<td>1745</td>
<td>20205</td>
<td>161</td>
<td>27</td>
<td>91.36%</td>
</tr>
<tr>
<td>May 2012</td>
<td>1450</td>
<td>21472</td>
<td>124</td>
<td>17</td>
<td>93.25%</td>
</tr>
<tr>
<td>June 2012</td>
<td>1555</td>
<td>20800</td>
<td>120</td>
<td>7</td>
<td>92.52%</td>
</tr>
<tr>
<td>July 2012</td>
<td>1012</td>
<td>19825</td>
<td>80</td>
<td>15</td>
<td>94.90%</td>
</tr>
<tr>
<td>August 2012</td>
<td>1366</td>
<td>21296</td>
<td>72</td>
<td>7</td>
<td>93.59%</td>
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<tr>
<td>September 2012</td>
<td>1441</td>
<td>20803</td>
<td>110</td>
<td>12</td>
<td>93.07%</td>
</tr>
<tr>
<td>October 2012</td>
<td>1457</td>
<td>20502</td>
<td>120</td>
<td>7</td>
<td>92.89%</td>
</tr>
<tr>
<td>November 2012</td>
<td>2391</td>
<td>20084</td>
<td>248</td>
<td>34</td>
<td>88.10%</td>
</tr>
<tr>
<td>December 2012</td>
<td>2734</td>
<td>20517</td>
<td>275</td>
<td>67</td>
<td>86.67%</td>
</tr>
<tr>
<td>January 2013</td>
<td>2334</td>
<td>19736</td>
<td>80</td>
<td>15</td>
<td>88.17%</td>
</tr>
<tr>
<td>February 2013</td>
<td>1642</td>
<td>18452</td>
<td>183</td>
<td>8</td>
<td>91.10%</td>
</tr>
<tr>
<td>March 2013</td>
<td>2436</td>
<td>20360</td>
<td>300</td>
<td>27</td>
<td>88.04%</td>
</tr>
</tbody>
</table>

Table 1: NHS Lothian Performance against 4 hour Emergency Care Standard

3.5 Graph 1 demonstrates the trend in performance for both 4 hour and 12 hour breaches.
3.6 The number of attendances for March 2013 compared to March 2012 has decreased by 2060, which is equivalent to -9.19%.

3.7 The number of admissions in the same period has decreased by 7%. However the median age of admitted patients has increased from 59 years of age (2008) to 72 (2013).

3.8 The number of 4 hour breaches comparing the same reference period has increased by 1029, with proportionate increases in the numbers of patients awaiting both 8 and 12 hours.

3.9 The majority of breaches are occurring in the out of hours period and are related to a combination of wait for beds either monitored or non-monitored or first assessment. The problem in performance is attributed to patient flow, length of stay, delayed discharge, Norovirus and increasingly more complex patients with multiple co-morbidities.

3.9 There is anecdotal evidence from NHS Lothian and from across NHS Scotland that the rising age profile of admitted patients corresponds to an increasing level of frailty, complexity and co-morbidity. Further analysis is required to quantify the extent of this perception. The development of new models of care for frail older people (e.g. Compass) are part of NHS Lothian’s response to this underlying trend.

3.10 The number of patients with a length of stay greater than 28 continues to rise and graphs 2 and 3 demonstrate that this is an increasing trend at both Acute and Rehabilitation sites.
3.11 The impact of Norovirus for March has had a significant impact on flow, which has impacted on Performance. Both Liberton and RIE have had several wards/ bases closed due to Norovirus throughout the month, but it is acknowledged that the number of areas affected towards the end of March has decreased. The loss of capacity within Liberton in particular has impacted on the established flows of patients from the RIE and is a significant contributor to the underlying increase in the number of patients over 28 days on that site.

3.12 An assessment of the impact of the Norovirus outbreak at Liberton by the Director of Nursing has led to a proposed reduction of ten beds over two wards to reduce the risk associated the physical layout of the wards.

3.13 The number of boarding patients is has started to diminish towards the end of March and can be partially attributed to the reduction of Norovirus.
Actions being taken to improve flow

Discharges supported by Health and Social Care

4.1 Health and social care supported 471 discharges over the five weeks in March, an average of 94 per week. This is ahead of target by 111 discharges over the month and 22 on average each week. The week preceding Easter however saw fewer discharges recorded (68). This is still 5 above the local target and 20 above the average from last year of 48 discharges per week.

Developments within NHS Lothian and the Health & Social Care Partnership

4.2 The following actions are being put in place to improve Unscheduled Care performance:

- The development of a proposal to create step-down beds for frail older patients outwith an acute setting is being taken forward. The City of Edinburgh Council are undertaking a tendering exercise to examine potential providers of this service.

- Work is progressing with the plan to create additional in-patient capacity at the RIE. An additional 31 beds will be available for Winter 2013/14 at the RIE through extension to wards 109 and 209. Planning work continues to be progressed to also increase assessment bed capacity as part of the Acute Medical Unit.

- A whole system Capacity & Demand exercise to develop a cost capacity plan to reach demand/capacity equilibrium for unscheduled care across primary, secondary and social care is being scoped, led by City of Edinburgh but jointly involving NHS
Lothian representatives from primary and secondary care and Capita have been commissioned to undertake scoping work in respect of this.

- An action plan has been developed following the Day of Care Audit at the RIE.
- A winter planning review of 12/13 is scheduled for 15 April which will allow lessons to be learnt from the recent winter and planning to commence for winter 13/14.
- A workshop on improving patient flow over 7 days is being held on 23 April
- Within the Surgical Observation Unit at RIE, a dedicated Charge Nurse has been appointed who will focus on improving flow. A process is also being established where all breaches will be reviewed with a view of reviewing pathways in line with the outcomes.
- Within the Emergency Department at RIE 25 nursing posts associated with year 2 of the Emergency Medicine workforce plan, will be filled by mid-April. This will provide additional Advanced Nurse Practitioners to cover the twilight period, which has been identified as a peak time of activity as well as the additional band 5 posts which were introduced as an alternative to the inability to fully recruit to specialty doctor grades.
- The Medical staffing element of the Emergency Medicine Workforce plan has seen the successful appointment in March of 6 additional Consultants who will work at RIE, SJH and RHSC who will commence posts in at various points over the coming six months as their specific training programme allows. Recruitment has also commenced for the additional GP posts at Emergency Department at St Johns. These posts will be receiving a tailored Emergency Medicine training programme to support their role in the department.
- In respect of the Western General triaging processes are being revisited and the amount of admission documentation is to be reduced, which will assist in improving admission flows. Ambulatory care clinics have been established with the appointment of additional Advanced Nurse Practitioner and Specialty doctor staff to increasingly shift unscheduled activity to scheduled activity.
- The new Acute Services structure is being established. Hospital Directors at RIE and WGH are working to establish stronger locality links with primary care and social care to enable different models of working to improve patient flow (SJH already has a well established primary care interface group).
- Ongoing awareness raising sessions with clinical staff in acute services through in-reach and teaching by community services (e.g. IMPACT team and Intermediate Care) to increase understanding of how to maximise the use of all available community resources.
- Planning work is underway to extend the COMPASS model (Comprehensive Assessment model for Frail older people in Edinburgh to North West Edinburgh). Progress being made through appointments in West & East Lothian to the Frailty models being developed there.
Other development to note

- The Scottish Government is currently developing a new Unscheduled Care Action Plan. The programme to support this work will be launched over the coming months. NHSL Nurse Director is representing Scottish Executive Nurse Directors on the national group (SEND). The programme is expected to focus on two programme planning streams (Care in Acute Hospitals/Care in the Community) and five strategic themes (Flow and the acute hospital (right time), promoting senior decision making (right care, right time), assuring effective and safe care 24/7 at the hospital front door (right care), making the community the right place (right place/right care) and Developing the Primary Care Response (right place/right time). NHS Lothian will adapt its existing workstreams on unscheduled care as necessary to reflect this programme as it develops.

5 Key Risks

5.1 NHS Lothian is engaged in significant investment to assist in improving Unscheduled Care, but the timescale to implement plans and deliver change to improve patient care and achieve required performance is likely to be at least 9 to 12 months.

5.2 The number of patients being discharged and requiring packages of care has increased significantly and there is a risk that Social Work teams across Lothian will be unable to meet this demand.

6 Risk Register

6.1 The risk if NHS Lothian not complaining with the 4 hour Emergency Care standard has been included on the Risk Register.

Chris Stirling  
Acting Site Director, Western General Hospital  
5th April 2013  
Chris.stirling@luht.scot.nhs.uk

Monica Boyle  
Head of Older People Social Work, Edinburgh City Council  
5th February 2013  
Monica.boyle@edinburgh.gov.uk
SINGLE OUTCOME AGREEMENTS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to receive an update and overview of engagement by NHS Lothian in development of the refreshed Single Outcome Agreements within each Community Planning Partnership in Lothian.

2 Recommendations

The Board is invited to:

2.1 Note the good progress that has been and continues to be made in the engagement and development of the key targets and outcomes within the Single Outcome Agreements

2.3 Consider that if any Board member wishes to have direct input into the process that they should make representation to those involved and leading the work as highlighted under 3.9.

3 Discussion of Key Issues

3.1 Single Outcome Agreements (SOAs) are the means by which Community Planning Partnerships agree their strategic priorities for their local area and express those priorities as outcomes to be delivered by the partners, either individually or jointly, while showing how those outcomes should contribute to the Scottish Government's relevant National Outcomes.

3.2 Community Planning and SOAs also provide the foundation for effective partnership working within which wider reform initiatives, such as the integration of health and adult social care and eventually children’s services will happen.

3.3 In December 2012, guidance was issued to Community Planning Partners, including Chief Executives and Council Leaders with advice on the scope and content of new Single Outcome Agreements which are to be agreed and signed off by the Scottish Government by 28th June 2013.

3.4 The work in influencing the development of SOAs and through joint working with the wider community planning partnerships will help NHS Lothian to work towards the implementation of the key aims within the Strategic Clinical Framework, which includes reducing health inequalities; giving children the best start in life; making care safe and effective and also of the highest quality as well. It will also help drive forward the integration agenda in its widest context.
3.5 The Guidance (which can be accessed at http://www.scotland.gov.uk/Resource/0040/00409273.doc), developed by a National Planning Group, builds on learning from previous SOA processes and states that each new SOA should:

- Set out clear and agreed priorities, rooted in the CPP’s understanding of place, for improving local outcomes;
- Show how each local outcome relates to one or more of the National Outcomes, with particular priority given to:
  - Economic recovery and growth;
  - Employment;
  - Early years;
  - Safer and stronger communities and reducing offending;
  - Health inequalities and physical activity; and
  - Outcomes for older people.
- Show what will be different for communities in 10 years and what will be done, especially what will be changed or done differently in line with the agenda for public service reform, to secure those improved outcomes on a rolling 3 year basis;
- Be clear about both the long term outcomes to be achieved over the next decade, and the contributory outcomes, indicators and targets by which progress towards these will be demonstrated over the short (1 year) and medium (3 years) terms; and
- Show how the total resource available to the CPP and partners has been considered and deployed in support of the agreed outcomes, especially in ways which promote prevention, early intervention and the reduction of inequalities.

3.6 The guidance outlines the national drive for organisations to work collaboratively at local level to improve outcomes for people living in their CPP area. The integration of health and social care services will be instrumental in supporting delivery of the SOA, overseen by the Health and Social Care Partnerships. Consideration is currently being given to where each of the Health and Social Care Partnerships sit within the context of local Community Planning Partnerships in Lothian.

3.7 NHS Lothian, through CH(C)Ps supported by Strategic Planning and Public Health colleagues, continues to be actively involved in the SOA process across Community Planning Partnerships (CPPs), with further details set out below. CH(C)Ps are actively engaged in leading the development and delivery of the health related outcomes within the SOAs, with clear performance processes in place.

3.8 The structural process for developing the SOA in each CPP is broadly similar, with thematic strategic partnerships (health, community safety, children & young people, economic development, etc.) taking responsibility for agreeing local outcomes, which form the SOA. There is support for this provided by a CPP Working Group in each area, comprising officers from statutory partners, with overarching governance and accountability resting with the CPP Board. CPP members have delegated authority for signing off local SOAs on behalf of the organisation they represent.

3.9 The following table outlines the group responsible for developing the health related outcomes and NHS membership on each CPP Board that will be involved in local sign-off for local SOAs.
3.10 Development of local SOAs has had significant involvement from NHS staff, particularly CH(C)P, Strategic Planning, Performance Reporting & Information and Public Health & Health Policy. This has involved participation in local consultation events and engagement with various themed groups. Communication across NHS staff engaged in development of the four SOAs has reinforced NHS Lothian’s priorities, e.g. aims of the Strategic Clinical Framework including prioritising prevention and reducing inequalities in health.

3.11 Where possible, there has been willingness to identify common outcomes and indicators across Lothian to enable opportunities for benchmarking and provide continuity for recording data, especially for Lothian-wide services. This has mainly been achieved across the four CPPs, however, there is some local variation due to this being a locally focused process. Examples of high level outcomes being considered across the CPPs include:

- Our Children have the best start in life and are ready to succeed
- Older people are able to live independently in the community with an improved quality of life
- We live healthier, more active and independent lives
- (Edinburgh’s) citizens experience improved health and wellbeing, with reduced inequalities in health.
- Older people are able to live independently in the community with an improved quality of life

Further examples of outcomes and indicators currently being developed across the four CPPs are included in Appendix 1.

3.12 Each SOA in Lothian is currently at different stages of development. It is expected that high level outcomes and indicators will be agreed by the beginning of May with SOAs being signed off at each CPP Board by mid June 2013. Final versions of SOAs will be brought to the June Lothian NHS Board meeting for information. Any Board member wishing to have direct input into the process should make representation to those involved and leading the work as highlighted in 3.9 above.

4. Key Risks

4.1 The main risk associated with the delivery of the outcomes within the SOAs is the partnership nature of the document. Therefore, there is a reliance on other community planning partners to deliver on targets which are out with the influence of NHS Lothian. This is mitigated through effective and timely performance monitoring reports to the relevant CPP Board.
5. **Risk Register**

5.1 There are no new risks noted from this programme for NHS Lothian’s corporate risk register.

6. **Impact on Inequality, Including Health Inequalities**

6.1 There is a strong focus in the SOAs to address inequalities through national and local outcomes which seek to improve health and social circumstances. This will be reflected in the final SOAs agreed by each CPP.

7. **Involving People**

7.1 The development of the Single Outcome Agreements across the CPP areas have included extensive involvement and engagement of people and communities. This has included stakeholder engagement events in addition to using the expertise of existing multi-agency groups currently in operation to drive forward local priorities.

8. **Resource Implications**

8.1 There are no direct resource implications associated with this report.

Mike Massaro-Mallinson  
Strategic Programme Manager - Child and Maternal Health  
9th April 2013  
Mike.Massaro-Mallinson@nhslothian.scot.nhs.uk

Alex McMahon  
Director of Strategic Planning, Performance Reporting & Information  
Alex.McMahon@nhslothian.scot.nhs.uk

**Appendices**

Appendix 1: Examples of cross cutting themes for SOAs
Appendix 1: Examples of cross cutting themes for SOAs

The following tables outline some of the common outcomes and indicators across the four Community Planning Partnerships, demonstrating the golden thread between the annual indicators and long term outcomes.

Table 1: Early Years

<table>
<thead>
<tr>
<th>Strategic Outcomes</th>
<th>East Lothian</th>
<th>Edinburgh</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>East Lothian’s children have the best start in life and are ready to succeed</td>
<td>Edinburgh’s Children and young people enjoy their childhood and fulfil their potential</td>
<td>Every Child in Midlothian has the best start in life</td>
<td>Our children have the best start in life and are ready to succeed</td>
</tr>
</tbody>
</table>

Links to Clinical Framework

- Prioritise prevention, reduce inequalities and promote longer healthier lives for all
- Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
- Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients

3 year outcome (to be in all SOAs)

To ensure that 85% of all children within Midlothian have reached all of the expected developmental milestones at the time of the 27-30 month child health review, by end 2016

Year 1 Indicator (to be in all SOAs)

100% of families are offered the 27-30 month review of children’s health and development.

Table 2: Health Inequalities

<table>
<thead>
<tr>
<th>Strategic Outcomes</th>
<th>East Lothian</th>
<th>Edinburgh</th>
<th>Midlothian</th>
<th>West Lothian</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>In East Lothian we live healthier, more active and independent lives</td>
<td>Edinburgh’s citizens experience improved health and wellbeing, with reduced inequalities in health</td>
<td>Reduce Inequality in Health Outcomes</td>
<td>We live longer, healthier lives and have reduced health inequalities.</td>
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</table>

Link to Clinical Framework aims

- Prioritise prevention, reduce inequalities and promote longer healthier lives for all
- Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
- Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
Table 3: Older People

SOAs are in the process of being revised currently across all four partnerships. Within the wider Reshaping Care for Older People agenda, NHS Lothian has a dashboard of performance indicators across all four partnerships.

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<tr>
<th>older People</th>
<th>East Lothian</th>
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<td>Enhance quality and capacity of services to support people in their own homes</td>
<td>Older people are able to live independently in the community with an improved quality of life</td>
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<td>Link to Clinical Framework aims</td>
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<tr>
<td>3 year outcome (in all SOAs)</td>
<td>Emergency inpatient bed day rates for people aged 75+ (per 1,000 pop.). Within Lothian, target of 23% reduction to be achieved by 2014/15 from a baseline from 2009/10.</td>
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<td>Indicators (in all SOAs)</td>
<td>Reduction in delayed discharges across all Lothian. A new standard (April 2013) for no patient to wait longer than 28 days. The balance of care (proportion of older people cared for <em>at home</em> as opposed to institutional settings) to be increased from current performance levels. Lothian targets vary by partnership with indicators currently being agreed.</td>
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1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note progress made in delivering NHS Lothian’s Corporate Objectives for 2012-13, and to agree the final proposed set of Corporate Objectives for 2013-14. The paper also highlights minor updates to the Strategic Clinical Framework to take account of Scottish Government priorities.

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

2 Recommendations

The Board is recommended to:

2.1 Note and provide any comment on achievement against NHS Lothian’s Corporate Objectives for 2012-13.
2.2 Agree the set of proposed Corporate Objectives for 2013-14.
2.3 Note that the corporate objectives are aligned to the six key aims of the Clinical Strategy Framework and the 2020 Vision Route Map.
2.4 Note that for the first time two new team objectives for the Executive Directors have been set on ensuring patient and staff safety and delivery of high quality patient care.
2.5 Note that there is also the inclusion of an objective on communications which will look at internal and external communications and to support the delivery of the key messages related to the ‘Values work’ and also the Strategic Clinical Framework.
2.6 Note that individual Executive Directors objectives are aligned to these corporate objectives and have taken to the remuneration Committee on the 9th April.
2.7 Note Scottish Government Route Map to the 2020 Vision for Health and Social Care and the synergy with the NHS Lothian Strategic Clinical Framework.

3 Discussion of Key Issues

3.1 NHS Lothian’s Corporate Objectives for 2012-13 comprise 57 actions. Appendix 1 details progress against each.
3.2 Significant progress has been made across the range of objectives set during 12/13 and these are highlight within the report. Of the 57 actions, progress for is Green for 38 actions, Amber for 14 and Red for 2 actions respectfully. A further 3 actions have both Green and Amber elements to report. Areas such as our performance on stroke, 4 hour A&E and delayed discharges are significant areas that we have failed to meet the agreed target/standard.
3.3 The proposed Corporate Objectives for 2013-14 comprise 50 actions, including the revised HEAT targets and standards for 2013-14.
3.4 The 13/14 corporate objectives build on the 12/13 objectives because many of the objectives relate to programmes of work over several years requiring persistent attention to achieve sustainable long term outcomes. New targets and standards set by Scottish Government have been incorporated appropriately.

3.5 NHS Scotland has developed a route map to the 202 vision for health and social care which has recently been shared with Boards (see appendix 3). The NHS Lothian Strategic Clinical Framework approved by the Board in February has been cross-checked with the 12 priorities key deliverables in the route map. While all 12 priority areas are already reflected in the Framework the following revisions have been made to reflect increased points of emphasis:

Priority: Care for multiple and complex illnesses
An action has been added to aim 2: “We will develop our models of care and responses to address the needs of people with complex and multiple morbidities.

Priority: Safe Care
"Safe" added to aim 3 to read: “Ensure that healthcare is evidence-based, incorporates best practice, and achieves safe, seamless and sustainable care pathways for patients

An action has been added to this aim: “Improving patient safety in all healthcare settings will continue to be a top priority, through our participation in the Scottish Patient Safety Programme.

Priority: Primary Care
An action has been added to 1:“We will develop the role of primary care through a new primary care strategy and support primary care teams to respond to the needs of people with complex and multiple morbidities.

A copy of the revised Strategic Clinical Framework is attached at appendix 4.

4 Key Risks

4.1 Risks associated with the delivery of HEAT targets and standards are detailed within the draft Local Delivery Plan Risk Management Plan which is also being discussed at the February Board.

5 Risk Register

5.1 Once approved, the proposed Corporate Objectives for 2013-14 will be linked directly to and where appropriate placed on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 All existing HEAT Targets and standards have been fully impact assessed as have many of the other targets within the set of objectives. A meeting is arranged on 14th March to impact assess the Delivery Plans for new HEAT Targets.

7 Involving People

7.1 Issues are highlighted within the Local Delivery Plan Risk Management Plan.
8 Resource Implications

8.1 Resource implications are highlighted within the Local Delivery Plan, Risk Management Plan and also within the financial plan that accompanies the plan.

Moray Paterson
Business Manager
12th April 2013
moray.paterson@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning
12th April 2013
alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: A Route Map to the 2020 Vision for Health and Social Care
Appendix 3: NHS Lothian Corporate Objectives 2013-14
Appendix 4: NHS Lothian Corporate Objectives 2012-13
A ROUTE MAP TO THE 2020 VISION FOR HEALTH AND SOCIAL CARE

Introduction

This paper summarizes some of the excellent achievements which have been secured in recent years through a focus on improving quality in our health and care services, and reflects that these achievements are at least partially responsible for the high regard with which Scotland is held internationally.

However, over the next few years the demands for health and social care and the circumstances in which they will be delivered will be radically different. It is our job to ensure that we can continue to provide the high quality health and care services the people of Scotland expect and deserve into the future, securing the best possible outcomes for people from the care and support they receive. We must therefore collectively recognise and respond to the most immediate and significant challenges we face. These include Scotland’s public health record and level of inequalities, our ageing population, the increasing expectations arising from new drugs, treatments and technologies and the specific impact of inflation on the health service.

This paper sets out a new and accelerated focus on a number of priority areas for action in the form of a ‘Route Map’ to the 2020 Vision for Health and Social Care in Scotland. It has been designed to make measurable progress to the 2020 vision, with specific deliverables in 2013/14. The key features of the Route Map are that it:

- recognises the importance of the public service reform agenda as a framework for delivering the 2020 Vision for Health and Care;
- maintains the commitment to pursuing the 2020 Vision for Health and Social Care through a focus on improving quality at scale across Scotland (building on success e.g. Family Nurse Partnerships, Scottish Patient Safety Programme etc.);
- Pursues opportunities to work with other public sector and business partners to drive transformational innovation, providing growth in the Scottish economy;
- identifies particular areas for accelerated improvement and enhanced roles in unscheduled and emergency care, in primary care in services for people living with multi morbidities providing a whole system response to improve the patient pathway in order to reduce pressure on A&E departments;
- supports our commitment to shift the balance of power to, and builds up and on the assets of individuals and communities through a focus on achieving social change (more people able to care, volunteer etc.), support for the self-management of long-term conditions and personal action (drinking, exercise, diet and engagement) through working in partnership in CPPs and the new Integrated Health and Social Care Partnerships and
- Develops our strategy for engaging and empowering our workforce, providing our response in Scotland to addressing many of the issues raised by the Mid-Staffordshire/Francis Inquiry, and equipping them to work in an integrated way which reflects the different needs of different people and different places across Scotland.
The 2020 Vision for Health and Care in Scotland

‘The Scottish National Health Service will be a publicly funded and publicly delivered health care service free to all our citizens. We will have a world-leading healthcare service where everyone is able to live longer and healthier lives at home, or in a homely setting. We will have a focus on reducing health inequalities, on prevention, anticipation and supported self-management. When hospital treatment is required, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.’

We must be bold enough to agree and pursue the key actions which will allow us to turn this 2020 vision into a reality. It is only by doing this that we will secure the health and social care services in Scotland that will best meet the needs of future generations, and demonstrate our ability to deliver a world leading high quality health and care service to the people of Scotland.

Our record of excellence

In Scotland we have considerable experience and success in delivering and improving high quality and sustainable healthcare services which is already recognised internationally as world-leading. In particular our record of successes include:

- legislation to ban smoking in public places,
- significantly reducing premature mortality from cancer, heart disease and stroke through a number of initiatives including most recently the high profile detect cancer early programme
- delivering enhanced patient safety with major reductions in levels of Healthcare Associated Infections (HAI)
- massively reducing waiting times and delayed discharge from hospital and effective management of a £12bn budget.

These and other successes are recognised internationally as innovative and aspirational both for what they have delivered to date and for their future scope and potential for improving health, health and social care in Scotland.

We have achieved these successes through working in partnership across Scottish Government, the wider public sector and with staff. Looking ahead, our model remains one of integration, collaboration, outcomes focus, values trust and innovation. We continue to categorically rule out the disruptive type of reforms and upheaval being put in place in NHS England and are committed to continuing to provide high quality health and social care to the people of Scotland that reflects the true values of the people delivering health and social care services in Scotland. Our recognition of the importance of local ownership of decision making and service delivery complements our unified system for governance and accountability in NHSScotland.
During the current spending review we have committed to protecting the health spending by giving a real terms resource increase recognising the very specific inflationary and service pressures facing the delivery of health and care services. Efficiency savings identified by territorial health boards amounting to over £1bn in the last 4 years have been retained by them and used to further enhance local services.

The Challenges

Over the next 10 years the proportion of over 75s in Scotland’s population – who are the highest users of health and care services - will increase by over 25%. By 2033 the number of people over 75 is likely to have increased by almost 60%. Over the next 20 years demography alone could increase expenditure on health and social care by over 70%. These challenges will augment the specific impact of inflation on health and care services. The impact of these and other pressures are demonstrated in the charts set out in Appendix 1.

Despite efforts to address the challenge of health inequalities in Scotland over recent years we have made very little progress. This remains a key priority area.

There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia. Estimates suggest that the number of people with dementia is set to rise from 71,000 to 127,000 within the next 20 years. If we do not dedicate resource to dementia there will be tremendous financial costs to the NHS and Social Services as well as the health and costs impact on carers. Compared with non-caregivers, carers of people with dementia are more likely to take prescribed medication, visit their GP and to report higher levels of stress and physical symptoms.

The 2020 Vision Route Map

The accelerated pursuit of the 2020 vision through the Route Map set out below, building and developing on our model for integrated health and social care delivery will demonstrate competency through our recognition as a world leader in high quality health and care services.

Public Service Reform

It is also important to confirm that the approach makes a vital contribution to our commitment to the 4 pillars of public service reform set out in our response to the Christie Report - reflecting our commitment to achieving outcomes which matter to the people of Scotland while ensuring the financially sustainability of our public services.

Working in partnership is fundamental to achieving progress in each of the priority areas – partnership across the NHS in Scotland, with local government, with the Third Sector, with industry, with central government and with people. This partnership approach is particularly vital for one of our three Quality Ambitions: that
all the services we develop and deliver are person-centred. The focus in the Route Map on developing the workforce and leadership capacity also makes an important contribution to the people pillar. The 2020 Route Map clearly identifies prevention as a priority area of activity around population health, but it is also fundamental to the approaches we will develop to improve care for people with multi-morbidities, and in support of older people through an integrated system. Finally, we will be driving improvement across the range of priority areas using the Framework for Improvement which has measurement and performance as one of its key features.

We continue to support the focus on performance across NHSScotland through the annual process of agreeing Board Local Delivery Plans with improved monitoring and assessment of outcomes. Ensuring that HEAT targets evolve to reflect the key priorities set out in the 2020 Route Map will make an important contribution, alongside a focus on supporting NHS Boards to strengthen their governance roles, and the commitment to work through Community Planning Partnerships and Integrated Health and Social Care Partnerships to ensure that SOAs properly reflect health and social care priorities and that local boards will be held to account for their effectiveness in the delivery of these priorities and for ensuring the effectiveness of CPPs generally.

The Route Map describes 12 priority areas for action for pursuing our 2020 vision for high quality sustainable health and social care services in Scotland in three domains; the quality of care, the health of the population and value and financial sustainability. These domains are often referred to as the ‘Triple Aim’. For each of these domains there will be a small number of priority areas for action, often building on existing work and all requiring focussed attention and acceleration.
1. Further improving the quality of the care we provide with a particular focus on:

- **Increasing the role of Primary Care** - There is now a strong consensus on the urgent need for an expanded role for primary care and general practice in particular. This is at the heart of our 2020 Vision, specifically focussed on keeping people healthy in the community for as long as possible and represents a critical prerequisite to tackling health inequalities and the challenges facing unscheduled care.

**Key deliverables for 2013/14:**
- Implementation of new GP contract with benefits fully explored and realised
- 2020 Vision for expanded primary care developed
- New Models ‘place-based’ primary care developed including a model for remote Primary Care implemented and evaluated

- **Integrating Health and Social Care** - Integration of adult health and social care is a key part of the Scottish Government’s commitment to public service reform in Scotland. We will continue to drive forward the widely endorsed commitment to integrating health and social care services in Scotland.

**Key deliverables for 2013/14:**
- Bill introduced to Parliament and gaining Royal Assent
- Preparatory work with Health Boards, Local Authorities, third and independent sector partners and including development and delivery against new SOAs and the building of effective CPPs

- **Accelerating our programme to improve safety in all healthcare environments** - Building on the world-leading and recognised success of the Scottish Patient Safety Programme, we will continue the ground-breaking extension of this programme into primary care, maternity services, paediatrics and mental health, and will embark on the development of a new Scottish Patient Safety Index to accelerate our progress in driving down harm in acute care settings.

**Key deliverables for 2013/14:**
- Further increase in safety in Scottish Hospitals as measured by HSMR and HAI
- New broader measure of safety developed to increase impact of improvement (SPSI)
- Maternity, mental health and primary care safety programmes implemented with measureable improvement

- **Improving the way we deliver unscheduled and emergency care** - A new Expert Group has been established to identify and agree high impact actions to transform the way that unscheduled care is delivered with a focus on reducing the number of people who present at A&E departments through action in the community, in primary care and to improve the flow of patients out of A&E. Specific work will be done to improve services at weekends and out of hours in both urban and remote and rural areas

5
Key deliverables for 2013/14:

- Develop out of hospital Care as part of the National Unscheduled Care Action Plan
- Achieve a sustainable performance on 4 hour A&E waits by end of December
- Improve Patient Care in hospitals by increasing flow through the system

- People-powered health and care services – through the Patient Rights Act and ground-breaking work to develop more person-centred health and care services we will give the public a voice on their experiences to drive up the quality of care but also promote personal responsibility for health and wellbeing, and support self-management so that people are better able to maintain their health and to manage periods of ill health. This will include a focus on improving resources and support to people to help them navigate and understand the system, so that they become more involved and engaged in their healthcare.

Key deliverables for 2013/14:

- Person-Centred Health and Care Collaborative being implemented with measureable improvements locally in experience for patients, their carers and for staff
- Support and clear accessible information will be available to enable people and their carers to manage confidently at home and during times of transition

- Improving our approach to supporting and treating people who have multiple and chronic illnesses - will deliver improved outcomes for people living with multiple morbidities, including mental health conditions. We will consider the whole pathway of care with a focus is on people aged <65 years in areas of deprivation and high levels of health inequalities. This work will link closely with the work to expand the role of primary care, to improve unscheduled care, to put people at the centre and to integrate health and care services. Much of this work will require strong partnership working, and will be supported by Health and Social Care providers playing a full role in Community Planning Partnerships and the development of Single Outcome Agreements, and through the new Integrated Health and Social Care Partnerships.

Key deliverables for 2013/14:

- Key pressure points in the entire patient pathway for most commonly occurring combinations of chronic term illnesses will be identified and actions for address these will be agreed
- Through more detailed analysis of existing data, people will be identified as ‘at risk’ and anticipatory plans will be agreed
2. Improving the health of the population with a particular focus on:

- **Early years** - We will drive forward the Early Years Collaborative, breaking new ground in improvement methodology across the full range of public partners involved in a child’s early years, building on successes such as Family Nurse Partnerships and working on the ambition to make Scotland the best place for children to grow up.

**Key deliverables for 2013/14:**
- The world’s first national multiagency quality improvement programme will be implemented across partner organisations to give our children the best start in life

- **Reducing health inequalities** – We will refocus our efforts on health inequalities particularly in the context of benefits cuts which will impact most on those most at risk of ill-health. We will do this by targeting improvement resources into primary care in the most deprived areas of Scotland including staff and equipment such as tele-health facilities, learning from and rolling out successful initiatives such as the Deep-End Practices in Glasgow.

**Key deliverables for 2013/14:**
- There will be a new focus on targeting resources to the most deprived areas
- The successful approach developed in the ‘Deep-end’ GP practices will be rolled out more widely across relevant areas of Scotland reducing the risk of admission to hospital and improving outcomes for people in Scotland’s most deprived communities

- **Preventative measures on alcohol, tobacco, dental health, physical activity and early detection of cancer** - Despite significant improvement in health outcomes in recent years, Scotland continues to have a poor record of healthy life expectancy. Alongside the commitment to refocus energy on targeting health inequalities, we will continue to pursue a preventative agenda in partnership across the public sector, concentrating on tackling Scotland’s relationship with alcohol, smoking and increasing levels of physical activity. We will also continue to invest in the hugely important programme of work to increase the early detection of cancer. Once again, much of this work will require strong partnership working, and will be supported by Health and Social Care providers playing a full role in Community Planning Partnerships and the development of Single Outcome Agreements, and through the new Integrated Health and Social Care Partnerships.

**Key deliverables for 2013/14:**
- There will be a measureable increase in early detection of cancer across Scotland, and particularly in deprived areas resulting in better outcomes
- Implementation of new restrictions on tobacco advertising will result in a reduced rate of smoking amongst teenagers
3. Securing the value and financial sustainability of the health and care services we provide:

- **Establish a vision for the health and social care workforce for 2020, and setting out a clear plan of actions which have immediate effect** – We will take forward a major programme to work in partnership with staff, professional bodies, and unions to establish and agree a vision for the health and care workforce required to realise the 2020 vision. We will develop a detailed action plan with key deliverables which start to have a significant positive impact for staff and patients in 2013/14 and each year thereafter. One of the early actions will be a focus on workforce planning to ensure that we have the right people, in the right numbers in the right jobs.

**Key deliverables for 2013/14:**
- 2020 Vision for NHSScotland workforce published in June 2013 following extensive consultation
- Detailed action plan agreed to deliver 2020 Workforce vision through modernisation, leadership and management by Summer 2013

- **increase our investment in new innovations which both increase quality of care, and reduce costs and simultaneously provide growth in the Scottish economy** - The new Innovation Partnership Board which has been established to take forward the joint Statement of Intent between Government, NHS and Industry will additionally be asked to oversee a new Innovation Fund which will be tested through 2 initial pilots before role out to scale. The approach is an ambitious one and aims to target high value fundraising through philanthropy, European funding, and assessing other models of fundraising.

**Key deliverables for 2013/14:**
- A new fund to provide pump-priming for innovative approaches in healthcare will result in more small/medium Scottish companies working with NHS Scotland to develop and test solutions which improve the quality of care and contribute to Scottish economic growth
- A new procurement portal will be established to encourage small/medium enterprises and other partners, including Third Sector, to work with NHSScotland

- **Increase efficiency and productivity through more effective use of unified approaches coupled with local solutions and decision making where appropriate** - We will fully implement the Efficiency and Productivity Portfolio of action at scale, including a specific focus on implementing shared services where possible and appropriate, reducing drug costs through a single programme management focus on prescribing savings, which better coordinates both the national and local work in this area and optimise the use of management information to highlight areas for improvement.
**Key deliverables for 2013/14:**
- A review of national services to NHSScotland will be carried out with recommendations to increase shared services and to achieve further contributions to the shift required of resources from management to front line services, where this does not negatively impact on quality of care.

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<th>Triple Aim</th>
<th>Quality Ambitions</th>
<th>12 Priority Areas for Improvement</th>
<th>25 Key Deliverables for 2013/14</th>
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<td>Person Centered Care</td>
<td>1 Person-Centred Health and Care Collaborative implemented</td>
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<td>Safe</td>
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<td>Care for Multiple and Chronic Illnesses</td>
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<td>Early Years</td>
<td>9 Out of hospital care action plan</td>
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<td>Innovation</td>
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<td>18 ‘Deep-end’ GP practices approach rolled out more widely across relevant areas</td>
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<td>Value and Sustainability</td>
<td>Efficiency and Productivity</td>
<td>19 Early detection of cancer</td>
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<td>20 New restrictions on tobacco advertising</td>
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<td>25 Recommendations to increase shared services</td>
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*APRIL 2013*
Our Health, Our Future
NHS Lothian Strategic Clinical Framework
2013 – 2020
1 Introduction

We have developed this strategic clinical framework to underpin NHS Lothian’s approach to deliver Scotland’s vision for achieving sustainable, quality health care services and deliver a healthier future for everyone.

This framework sets out the principles we will embrace in planning and delivering services and care in Lothian, and identifies how, through integrated working with partners and redesigning services around and with people, we will promote good health and deliver safer, more effective and person-centred healthcare.

It affirms our public service ethos based on social justice and valuing our workforce, and our role in public service reform as a socially responsible organisation promoting equality and protection for the most vulnerable in society.

It is clear that future models of delivering health and healthcare will need to be different and we will be engaging staff, patients and stakeholders in this whole system programme of change and redesign.

We want to embed a culture of continuous improvement to ensure our staff can fully contribute to achieving the best possible health and healthcare based on evidence and best practice.

Starting with our most pressing challenges around waiting times and access to optimal care and support for vulnerable groups including the very young and the very elderly, we need to develop integrated care pathways to ensure that services are consistently high quality, efficient and safe.

This approach will drive the development of our workforce and the use of our financial and capital assets to ensure that everything we do delivers value for patients and the public.
2 The vision for health and healthcare in Scotland

The Cabinet Secretary for Health, Wellbeing and Cities set out a statement of intent for delivery of health and healthcare in September 2011. This recognised the need for health care to be delivered in radically different ways if NHS Scotland is to continue to provide high quality services in the context of significant challenges. These challenges include Scotland’s public health record, its changing demography and the economic environment.

The Scottish Government’s vision for health care is that by 2020:

- Everyone is able to live longer healthier lives at home, or in a homely setting.
- We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management.
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Scotland’s vision for health promotion and public health remains focused on:

- developing a fairer society and reducing inequalities in health
- addressing the needs of disadvantaged groups
- promoting health in all policies and prioritising prevention, for example by ensuring children get the best start in life.
3 The NHS Lothian context - challenges and opportunities

Our framework sets out the principles and themes we will adopt in NHS Lothian to deliver the Cabinet Secretary’s vision for achieving sustainable quality healthcare services, which will deliver a healthier future for everyone.

There are specific challenges which we need to address and which mean that we need to change how we operate:

- Between 2011 and 2020 the population of Lothian is predicted to increase by 9.3%, from 846,104 to 925,207. The greatest increase will be in the over 75 age group, which will increase by 22.2% over the same period.

- The Lothian population aged 0-15 years is also growing, with a projected 14.6% increase in the number of children and young people by 2030.

- While the overall health of our population is improving, evidenced by reductions in deaths from coronary heart disease and stroke, there remains a fivefold socioeconomic gradient in the rate of premature death from heart disease. In addition, the risk of multiple morbidity increases with increasing age and lower socioeconomic status. The overall incidence of cancer is expected to rise by 1.4% per annum, and the prevalence of dementia to increase by 70% over the next 20 years. Issues such as obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol present significant public health challenges and are often closely associated with long term conditions such as cardiovascular disease and diabetes.

- Despite some good progress, inequalities remain in health outcomes across different social groups in Lothian and people in our poorest communities continue to die younger and live less healthy lives.

- The shape of our workforce is changing. There will be fewer doctors overall and where doctors skills are needed in specialist areas of care, these may need to be provided on fewer sites to ensure that services are safe. There are however opportunities to develop and use the skills of many staff groups and professional disciplines more effectively.

- The global economic downturn means that real terms growth in health spending is not expected to return to the level of 2009/10 until 2025, so we have to deliver better health and healthcare while making best use of limited public resources.
Key principles of our planning framework are therefore to:

- ensure services are safe, clinically effective and person-centred
- focus on prevention and early intervention to help people keep well and anticipate care needs
- take a whole system approach to planning and managing integrated pathways of care working with partner agencies in local authorities and voluntary sector
- reduce unnecessary variation in the way patients are cared for
- deliver services with the appropriate mix of staff skills, ensuring viable clinical staff rotas
- reduce spend on property and buildings as hospital stays reduce to release money for direct patient services
- consider the continued use of active treatments which have not been shown to extend the length of life or improve quality of life
- identify services that are not sustainable in longer term and proactively plan a new way of delivering care.
- make sure we stop procedures and treatments which add no clinical value
- maximise the opportunities for use of new technologies to support health and healthcare.

4 Our strategic aims

We have identified six strategic aims to ensure we can deliver safe effective and person-centred health and social care to meet the needs of the people of Lothian:

1. Prioritise prevention, reduce inequalities and promote longer healthier lives for all
2. Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
3. Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
4. Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
5. Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
6. Use the resources we have – skilled people, technology, buildings and equipment - efficiently and effectively

The specific areas of focus and the actions we will pursue to achieve each of these aims are described in more detail in the following pages.
Aim 1

Prioritise prevention, reduce inequalities and promote longer healthier lives for all

Everyone should have the same opportunities to enjoy good health as a matter of fairness. The NHS provides health care to everyone free at the point of need and has a role to play in:

- providing services designed to prevent future illness,
- taking opportunities to provide advice and support to people to help them to take care of their own health
- working with partners to promote the health and well being of communities and the whole population.

On average, people who are better off have better health than those who are less well off. Social inequalities in health are widest between the most well off and the least well off, with people living in poverty more likely to die at a younger age and to have more than one illness than the rest of the population. Health inequalities are an example of social injustice.

Health services play an important role in improving the health of all people as society changes, but more can be done to make sure the NHS improves health outcomes for people at higher risk of ill health, particularly for people living in hard-pressed circumstances. Care needs to be taken to make sure that changes to the health service do not benefit only those who are better off and unintentionally maintain or increase health inequalities.

We have identified five key actions which must be in place to prioritise prevention, to promote longer healthier lives for all, and to ensure that we reduce inequalities in health:

- We must make sure health services deliver high quality care to the whole population. We will measure the way people use health services and the health outcomes for different population groups. This will help us make sure services are working well for everyone.
- We will tailor services and health interventions to people who are at highest risk of ill health to prevent illness where possible and reduce socioeconomic differences in health.
- We will strengthen the role of clinical services in preventing illness and supporting people who have health problems to access the help and support they need to maintain their well being and social and economic welfare. For example developing the role of the NHS in pathways which support employability and retention of employment and access to welfare rights advice.
- Our primary care services are central to identifying the majority of people who are at highest risk of ill health while they are still healthy. We will work with GPs and other community health professions to offer evidence based interventions, identify and reduce risk, and make the most of contacts with patients as opportunities for prevention and health promotion.
• We will develop the role of primary care through a new primary care strategy and support primary care teams to respond to the needs of people with complex and multiple morbidities.

• We will work closely with local authorities and other agencies to address the social determinants of health, to make sure people have the best chance of living a healthy life and that places they live are designed to promote good health.

Aim 2

Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care settings

Working with our partners in local authorities and the voluntary sector, through health and social care partnerships we will integrate care delivery so that services are organised around the needs of the patient/client.

We will jointly plan our new models by looking at the needs of the local population and work with local authorities and other partners to meet health and social care needs and improve health outcomes.

We will provide more and better care at home and in community settings, supporting individuals to stay at home for as long as possible.

Partnerships will deliver 24/7 community responses including integrated elderly care teams to prevent the negative impact of avoidable admissions to hospital.

We will develop our models of care and responses to address the needs of people with complex and multiple morbidities.

Partnerships will work together to ensure families have access to tailored programmes of support, such as the Family Nurse Partnership, to give every child the best start in life.

We will also work in partnership with other key stakeholders, including those in the private sector where appropriate.

Aim 3

Ensure that healthcare is evidence-based, incorporates best practice, and achieves safe, seamless and sustainable care pathways for patients

Care will be designed on the basis of evidence-based pathways and care bundles, ensuring staff have the appropriate skills needed to deliver these.

We will pro-actively manage the care of those patients with the most complex needs. This will mean putting in place systems to ensure that care plans are delivered and co-ordinated across settings, including multi-disciplinary case conferences to plan jointly with patients and carers.

We will encourage and support patients and clinical staff to develop anticipatory care plans.
We will develop standardised care protocols which support collaboration among health and care professionals, ensure equitable access to best practice and reduce unnecessary variation in the care patients receive.

Patient information will be shared with relevant professionals in real-time along pathways to support timely clinical decisions.

Improving patient safety in all healthcare settings will continue to be a top priority, through our participation in the Scottish Patient Safety Programme.

Using evidence, we will identify best practice and adopt it as an innovative learning organisation. We will continuously assess and improve our performance at individual, care condition and organisation level through transparent information sharing and learning discussions across care settings.

We will plan with other health boards how care pathways for those using our regional cancer services can be developed to meet increasing patient numbers and changed care needs.

We will continue the development of the palliative care strategy to deliver care at home, in a hospice or in an appropriate hospital setting so that patients and families are fully supported in their final days.

Through our partnerships with further education institutions we will contribute to teaching, training, research and innovation, and maximise the healthcare benefits of collaborative working.

**Aim 4**

**Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting**

We will work with the local community to enable people to make best use of the services of general practices, community pharmacies, out-of-hours primary care centres and the minor injury service, and reduce unnecessary attendance at emergency departments.

We will increase the focus on prevention, including raising awareness of health risk factors which allow people to anticipate health problems and develop anticipatory care plans to prevent or minimise their impact.

Patients’ emergency care needs will be met on an ambulatory basis rather than being admitted to hospital when possible, using agreed care pathways to enable rapid access to assessment, diagnosis, treatment and practical care and support at home.

When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm for most planned hospital care.

For those who do require inpatient care, admission and discharge to their home or community environment will be safe and timely, with no boarding, unnecessary delays or avoidable re-admission.

We will reduce the length of stay in hospital, including in our specialist treatment and rehabilitation facilities for many patients. Hospital teams will work with colleagues in community health and social services to ensure seven-day discharge from hospital.
Both elective (planned) and unscheduled care will be provided through robust and reliable specialist capacity to meet patient needs in a timely and efficient way.

We will improve availability of generalist healthcare, especially for those with complex needs, while facilitating access to expert specialist health advice when required.

**Aim 5**

**Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families**

Care will be provided to the highest standards of quality, safety and equity, whatever the setting, with the person at the centre of all decisions.

We will reaffirm our core values, engaging with staff teams and with patients to develop, share and demonstrate our beliefs about what excellent quality care means for patients, carers and staff.

We will ensure stronger public involvement in the design and delivery of health services, and recognise the value that can be added by such participation.

As well as partnership input to designing our pathways of care, we will use patient experience and feedback to check the outcomes and impact.

We will encourage and support individuals to care for their own health through early identification of health issues, providing information and developing self-care plans for those with long term conditions.

We will encourage and support people of all ages to be able to participate positively to health and wellbeing in their local communities.

**Aim 6**

**Use the resources we have – skilled people, technology, buildings and equipment - efficiently and effectively**

**People**

We will ensure that our management culture, organisational vision and values base support and engage all staff to contribute positively to the implementation of this strategic clinical framework within the ethos of public service.

As an employer we will ensure that our recruitment, retention and workforce development approaches are socially responsible and promote social justice and reduce inequalities.

We will engage fully with staff and their representatives across the care spectrum to maximise their contribution to delivering better services; this will include reviewing the balance of generalist versus specialist teams, facilities and services.

We will ensure service models are based on sustainable service capacity and workforce plans, withdraw from unsafe clinical staff rotas and redesign services to ensure high quality and safe care.

Professionals’ skills will be fully utilised with staff skills and roles developed and aligned to maximise effectiveness so that care is delivered by the most appropriate member of the team.
We will continue to work across regions and Scotland to ensure specialist skills and facilities are shared and developed, recognising our role as a regional centre for more specialist services.

Technology
Telehealth and telecare facilities will be coordinated across health and social care to enable remote access to care and monitoring, and support self-management, helping people to live independently at home.

We will always treat information about patients and their care confidentially, but appropriate sharing of information between health and care professionals and with patients themselves should be the norm. Information about patient history and treatment plans will be shared electronically with professionals involved, and the patient/client, to ensure best possible decisions.

The Clinical Portal being introduced will provide a simple and secure way for clinical professionals to review a patient’s medical information from multiple sources in a single, secure on-line location, assisting decision-making about care.

We will also develop a Patient Portal which will allow patients secure electronic access to information on their health and care and to information to support self care and involvement in decisions.

Value for public money
We will focus our funding where it has the biggest impact on people’s health and wellbeing and where appropriate disinvest in services of low clinical value.

We will manage our costs to be financially sustainable while maintaining or improving health outcomes through waste reduction, lean processes and enabling staff to work to their full potential.

Care pathways will be designed to reduce wasteful activities for patients and staff: unnecessary duplication of tests, appointments, recording of information; unnecessary waiting for patients; avoidable transfers and travel.

Buildings and Estates
We will look at the physical space and land that we own and make decisions, based on clinical need, on opportunities to safely move off sites, reducing land and property running costs, reducing our environmental impact and releasing funding to be invested in other services.

We will continue a programme of primary care premises development providing accessible community-based healthcare facilities.

Less hospital inpatient care may mean we need fewer hospital beds, with those that we do need provided in appropriate and fit for purpose accommodation.

We will continue to have three acute hospital sites at the Royal Infirmary of Edinburgh, St John’s, Livingston and the Western General Hospital, reviewing what services are delivered at each as we redesign care pathways.

We will develop a new Royal Hospital for Sick Children and Department of Clinical Neurosciences on the Royal Infirmary of Edinburgh site at Little France.
We will review the future model for delivery of specialist rehabilitation services in hospital and the community.

We will re-develop the Royal Edinburgh Hospital site as a shared campus for mental health and other related services such as learning disability, brain injury and acquired brain injury and neurological conditions.

We will develop a new model of care for community hospital services in East Lothian.

We will review the future of some of our smaller sites such as the Astley Ainslie Hospital, Corstorphine Hospital and Liberton Hospital, which provide a less than optimal setting for patient care in terms of privacy, dignity and safety, as we modernise the facilities and locations in which the care of older people is provided.

We will ensure that our sites contribute to the development of a healthy built environment that they contribute to delivering Scotland’s targets for sustainability and support the local economy.

5 Addressing our immediate priorities

NHS Lothian is facing particular and immediate challenges to ensure that we are able to provide treatment to patients within an acceptable length of time, and we are taking action to provide additional short term capacity for planned care. Access to responsive and timely unscheduled care particularly for older people is also an area where we know there is a need to do better.

Our initial priorities will therefore be:

- integrated older people’s care pathways focusing on care and support for frail/elderly patients with complex needs
- consistency of care for older people with complex needs accessing high volume elective surgical pathways such as urology and orthopaedics
- improved condition-specific pathways associated with long term conditions such as CHD, stroke, respiratory diseases, diabetes.

We are already working closely with our local authority partners to develop new models of care and put in place plans to ensure we can jointly meet the care needs of our population. Our response to the Government’s proposals on the integration of health and social care, and local joint commissioning plans for older people and children’s service plans, are fully aligned with the aspirations this framework sets out for improved health and healthcare for the people of Lothian.

6 The process we will adopt

We need to engage staff, patients and other partners to develop new ways of working across integrated pathways for major patient groups and conditions over the next 3-5 years.

Whole system redesign teams will be established with a long term remit and a continuous improvement ethos to plan and implement changes to how care is delivered. Each team will be led by front-line health and social care practitioners with
voluntary sector, patient and carer input, supported by health and social care partnerships to:

- systematically review our major clinical care pathways across care settings
- use research evidence, best practice guidance, and staff and patient experience
- design, implement and sustain improved service delivery outcomes
- develop effective primary care, secondary care and social care interfaces
- deliver joined-up care for patients.

Priority areas of focus for teams will be:

- identifying the target (high risk) populations through analysis of patient level data
- setting up enabling processes e.g. access to specialist consultation, protocols and pathways
- allocating resources to deliver care at the right time and in the right location to best meet needs
- using real-time reporting and tracking and shared information to monitor patient progress.

Corporate resources and systems will be aligned to support these service teams, including organisational development, health information analysis, e-health, lean process improvement and quality improvement teams. Teams will have access to a programme of education and support from redesign experts.

Alongside taking steps to improving our services as a priority, we are working with our staff to create the more positive and supportive organisational culture that is essential to achieve our aims. Through affirming our vision and shared values with staff, and developing leadership capability at all levels, we will ensure that staff are able to contribute fully to delivering better health and healthcare.

Appendices:

1. Future state diagram - unscheduled elderly care model
2. Future state diagram - planned care model
3. List of Stakeholder Groups engaged in development of the Framework
Future State Unscheduled Elderly Care Model

**HOME:**
- Self-care
- Primary care
- Social care

(prevention, telehealth and telecare, early intervention, community support)

**Accident & Emergency**

- Minor Injuries

- Elderly care specialist team (Compass)

- 24/7 specialist advice

**Hospital assessment units**

**Acute**

- Hospital assessment units

**No Boarding**

**Community Hospital**

- Rehabilitation

**Intermediate care / Step down facility**

**Residential care / Long-term care**

(LOS <2 years)

**HOME:**
- Self-care
- Primary care
- Social care

(reablement, crisis care, health improvement, telehealth and telecare, community support)

Integrated care pathway supported by: shared information, evidence based protocols, engaged patients and carers, lean processes, optimised staff skills
Future State Planned Care Model

App 2

Future State Planned Care Model

Prevention/Early Detection

Diagnosis

Treatment

Follow up

18 weeks

HOME:
- Self-care
- Primary care
- Social care
- Screening & Monitoring
- Prevention
- Early Intervention

GP

Other community professional

One-stop clinics

Outpatient assessment and treatment

Day Case X%

Inpatient stay complex cases

Hospital outpatient follow-up complex cases only

Phone, e-follow-up, surveillance

HOME:
- Self-care
- Primary care
- Social care
- Screening & Monitoring
- Prevention
- Early Intervention

Surgical Pre-assessment

pro-active after-care planning

Enabled by electronic booking, shared patient records
NHS Lothian Clinical Strategy Engagement Events

- Strategic Planning Directorate
- Public Health and Health Policy Directorate
- UHD Senior Management Team
- Clinical Strategy Event – public / patient (x2)
- Area Clinical Forum
- East Lothian CHP Sub Committee (x2)
- Lothian Partnership Forum (x2)
- Allied Health Profession meeting
- Staff Governance Committee
- Clinical Board
- Informatics Board
- Service Redesign Committee
- Lothian Area Division of Psychiatry
- Directorate Governance Group
- Pharmacy Senior Management Team
- Carers Action Midlothian
- Lothian Cancer & Planning Implementation Group
- Lothian Faith Group
- Primary Care Forward Group
- Lothian Area Pharmaceutical
- Lothian Area Medical Committee
- Nurse Directors Meeting
- West Lothian CHCP sub-committee
- Edinburgh CHP sub-committee
- Carers of West Lothian
- Managed Clinical Network representatives
- West Lothian Community Planning Partnership
- East Lothian Community Planning Partnership
- Health Promotion Department
- The Grand Rounds - RIE
- Lothian Psychology Committee
- Edinburgh Partnership Board
- Midlothian Partnership Board
- Corporate Management Team
  - Midlothian CHP sub-committee
- Edinburgh Health & Social Care SMT
- Edinburgh Joint Board of Governance
| OBJECTIVE 1  
TO TRANSFORM THE MANAGEMENT CULTURE OF THE ORGANISATION | TIMING                | LEAD CMT MEMBER | COMMENTS             |
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<tbody>
<tr>
<td>Ensure that the major performance challenges around waiting times, unscheduled care and finance are tackled with an open, participative and approachable management style.</td>
<td>Ongoing, by March 14</td>
<td>All</td>
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<tr>
<td>Implement the specific Organisational Development Action Plan which flows from the work of the Management Culture Steering Group including specific Board Development and Senior Manager Development programmes.</td>
<td>March 14</td>
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<tr>
<td>Develop the team coaching methodology for Corporate Management Team members and their direct reports to reinforce exemplar behaviours.</td>
<td>March 14</td>
<td>All</td>
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<tr>
<td>Endorse and further develop the work on vision and values as part of the Management Culture review.</td>
<td>June 13</td>
<td>AMcM/AB</td>
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### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

**OBJECTIVE 2:**
TO PLAN AND DELIVER THE WAITING TIMES RECOVERY PLAN TO CLEAR THE BACKLOG OF PATIENTS AND DEVELOP RECURRING DEMAND/CAPACITY EQUILIBRIUM

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Ensure the implementation of the revised Standing Operating Procedures, the required training programme for staff and the phased centralisation of the management of waiting times staff.

Ensure comprehensive monthly performance monitoring to the NHS Board on performance against targets, recovery plan and waiting times management compliance.

Ensure the delivery of a sustainable financial framework to support recovery and maintain performance thereafter.

Ensure delivery of the comprehensive system of compliance monitoring of waiting times systems including real-time scrutiny of changes made on TRAK.

Develop and implement costed capacity plans by specialty to ensure recurring demand/capacity equilibrium, including specific clinical workforce plans, leading to the phased reduction in reliance on external capacity.

| MARCH 14   | AMCM            |          |
| ONGOING    | SG              |          |
| JUNE 13    | AMCM            |          |
**OBJECTIVE 3: TO IMPROVE UNSCHEDULED CARE PERFORMANCE**

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- Develop and implement a costed capacity plan to reach demand/capacity equilibrium for unscheduled care across primary, secondary and social care.

- Create effective surge capacity for mixed economy of home care, care home and NHS beds able to be deployed rapidly to respond to peaks in demand for specialist health and/or social care through the work of the Unscheduled Care Group.

- Achieve sustained improvement of performance towards the 98% 4 hour access standard, reduction in boarding and eradication of 12-hour trolley waits.

- Develop and implement costed clinical workforce plans to sustain vulnerable 24/7 front door clinical services, ensuring that contingency plans are in place to mitigate the impact of staffing vacancies that may arise.
### OBJECTIVE 4:
**To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements.**

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<td><strong>June 13</strong></td>
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<tr>
<td><strong>To develop a strategic planning process to integrate existing</strong></td>
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<td>and emerging clinical strategies with workforce, finance, capital investment and property strategies, incorporating a refreshed Vision and Values Framework.</td>
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<td><strong>May 13 and ongoing</strong></td>
<td>AMcM/SG</td>
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<td><strong>To develop a site master-planning process for the four main</strong></td>
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<td>inpatient sites of RIE, WGH, SJH and REH to support the implementation of existing and emerging clinical strategies for unscheduled care, elective care, laboratory medicine, children's services, cancer services, mental health services and learning disability services.</td>
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<td><strong>March 14</strong></td>
<td>JF, PG, DS and AMcM</td>
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<tr>
<td><strong>Ensure implementation of innovative plans with our 4 Council partners to secure the integration of primary, secondary and social care to drive performance improvement across health and social care.</strong></td>
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<td><strong>March 14</strong></td>
<td>AMcM, MH and DF</td>
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<tr>
<td><strong>Continue to promote the clinical pathways model to secure management of patients' journeys across service boundaries through our systems wide managed clinical networks</strong></td>
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<td><strong>March 14</strong></td>
<td>AMcM, MH and DF</td>
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<tr>
<td><strong>Implement revised organisational arrangements which tangibly integrate the management of primary, secondary and social care services and deliver whole-system approaches to the management of unscheduled care.</strong></td>
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<td><strong>June 14</strong></td>
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<tr>
<td><strong>Review and refresh the maternity strategy and capacity plan</strong></td>
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<td><strong>March `14</strong></td>
<td>AMcM</td>
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## OBJECTIVE 5: EFFECTIVE INTERNAL AND EXTERNAL COMMUNICATIONS

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<td>May 2013</td>
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<tr>
<td>On-going</td>
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Implement NHS Lothian’s Communications Strategy.

Develop and Implement Communications Plan for Strategic Clinical Framework.

Supporting the communication is relation to ‘Our Values Into Action’

## OBJECTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY

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Prepare NHS Lothian 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.

Achieve a 30% reduction in adverse events

Achieve a 20% reduction in HMSR against 2006/2007 baseline

Ensure the current Safe Care Patient Safety Programme
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

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<th>OBJECTIVE 6: CORPORATE TEAM OBJECTIVE</th>
<th>TIMING</th>
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<tr>
<td>TO IMPROVE PATIENT AND STAFF SAFETY</td>
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<td>measures are met and reported</td>
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<tr>
<td>Ensure the new work streams for the patient safety programme are tested and implemented</td>
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<tr>
<td>• Venous thromboembolic prevention</td>
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<td>• Sepsis prevention programme</td>
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<td>• Mental health</td>
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<tr>
<td>• Maternity services</td>
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<tr>
<td>• The Warfarin management bundle across general practice</td>
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<tr>
<td>Ensure NHS Lothian’s staphylococcus aureus bacteraemia cares are 0.2% or less per 100,000 acute occupied days, and the rate of clostridium difficile infection in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.</td>
<td>March 14</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>To ensure participation and benefit from involvement in the new Maternity Safety programme.</td>
<td>March 14</td>
<td>AMcM/MH/DF</td>
<td></td>
</tr>
<tr>
<td>Ensure that GP practices across NHS Lothian as well as NHS Lothian as an employer benefits from full participation in the primary care patient safety programme</td>
<td>March 14</td>
<td>DF/DS</td>
<td></td>
</tr>
<tr>
<td>Complete the Year 1 action plan for the Equality Outcomes Framework 2013-17, and publish a mainstreaming report and equal pay statement in order to meet legal requirements and ensure that the patient experience is as equitable and safe as possible for all individuals.</td>
<td>March 14</td>
<td>AB/All</td>
<td></td>
</tr>
<tr>
<td>Work towards a reduction in the number of staff assaults</td>
<td>March 14</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>
# NHS Lothian – Corporate Objectives 2013/14

## Relates to Aims 1, 2, 3, 4, 5 and 6

<table>
<thead>
<tr>
<th>Objective 7: Corporate Team Objective</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of the Patient Centred Collaborative</td>
<td>March 14</td>
<td>DF/MH</td>
<td>Ensue that NHS Lothian participates in and implements the patient centred collaborative methodology</td>
</tr>
<tr>
<td>Improve Patient Experience:</td>
<td>March 14</td>
<td>MH/DF/All</td>
<td>Ensure that the targets for the implementation for the Liverpool care pathway are implemented as are our targets on end of life care replacement of death.</td>
</tr>
<tr>
<td>Ensure that the NHS Lothian Board receives a regular report on the quality of care provided within NHS Lothian services</td>
<td>Monthly</td>
<td>DF/MH</td>
<td></td>
</tr>
<tr>
<td>Ensure that the key learning points are taken from the Francis report and are implemented locally</td>
<td>Ongoing</td>
<td>DF/MH</td>
<td></td>
</tr>
<tr>
<td>Ensure that NHS Lothian and its four council partners fully participate in the Early Years Collaborative and to use this to inform our revised children’s and young people’s strategy</td>
<td>March 14</td>
<td>AMcM</td>
<td></td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 8: TO LIVE WITHIN AVAILABLE FINANCIAL RESOURCES, DEVELOP A SUSTAINABLE FINANCIAL PLAN AND DELIVER THE CAPITAL INVESTMENT PLAN</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To achieve a break-even position for 2013/14 to live within the Revenue Resource limit.</td>
<td>March 14</td>
<td>SG/All</td>
<td></td>
</tr>
<tr>
<td>To deliver a cash efficiency savings programme to secure the resourcing of the local reinvestment plan for 2013/14</td>
<td>March 14</td>
<td>SG/All</td>
<td></td>
</tr>
<tr>
<td>Achieve the implementation of the Board’s Capital Investment Plan with the Capital Resource Limit.</td>
<td>March 14</td>
<td>SG/All</td>
<td></td>
</tr>
<tr>
<td>Proceed with the development of the new RHSC/DCN facilities</td>
<td>March 14, ongoing</td>
<td>SG/DF</td>
<td></td>
</tr>
<tr>
<td>Proceed with the first phase of the new REH re-provision programme</td>
<td>March 14</td>
<td>DS/SG</td>
<td></td>
</tr>
<tr>
<td>Take forward the redesign of the front door and bed model within the RIE to support delivery of improved patient experience and safety</td>
<td>Nov 13</td>
<td>MH/SG/AM cM</td>
<td></td>
</tr>
<tr>
<td>Improve performance management of the Consort RIE contract</td>
<td>Ongoing</td>
<td>SG</td>
<td></td>
</tr>
<tr>
<td>To develop a savings programme for implementation in 2014/15 and beyond.</td>
<td>Ongoing</td>
<td>SG/All</td>
<td></td>
</tr>
</tbody>
</table>

8
# NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

## OBJECTIVE 9:
**TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 14 AKM/All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 14 AKM/All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing AKM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summer 13 AKM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summer 13 AMcM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summer 13 AMcM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 14 MH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Continue reducing the socio-economic gradient in healthy life expectancy and amenable mortality across Lothian by developing, influencing and delivering evidence-informed policies with partners on smoking, Keep Well health checks and alcohol availability and consumption.**
- **Strengthen ill-health prevention and early intervention by ensuring population screening and immunisation programmes, achieve prescribed standards for uptake, coverage, waiting times, quality and outcomes.**
- **Protect the public health by assuring emergency preparedness, identifying and implementing appropriate interactions that protect health and limit risk to our communities from communicable diseases and environmental hazards.**
- **Ensure that NHS Lothian meets the demand for increase immunization across children, adults and housebound patients during 13/14.**
- **Ensure the review of our children and young people’s strategy is commenced and consulted on during 2013.**
- **Commence the review of the learning disabilities strategy, in line with the review milestones and the REAS re-development.**
- **Continue to strengthen Public Protection arrangements by delivery of the 2013/14 action plan.**
# NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 10:</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.</td>
<td>March 14</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>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>March 14</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.</td>
<td>March 14</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>To achieve 2268 completed child healthy weight interventions over the three years ending March 2014.</td>
<td>March 14</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>Universal smoking cessation services to achieve at least 11686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.</td>
<td>March 14</td>
<td>JF/AKM</td>
<td></td>
</tr>
</tbody>
</table>
NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 10: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce suicide rate between 2002 and 2013 by 20% and to review further actions in line with this direction of travel.</td>
<td>March 14</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.</td>
<td>March 14</td>
<td>SG</td>
<td></td>
</tr>
<tr>
<td>Reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.</td>
<td>March 14</td>
<td>AB</td>
<td></td>
</tr>
<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.</td>
<td>March 14</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete by April 2015.</td>
<td>March 14</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>To support 2% shift in the balance of care in the rates of attendance at A&amp;E between 2009/10 and 2013/14.</td>
<td>March 14</td>
<td>MH/PG</td>
<td></td>
</tr>
<tr>
<td>To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.</td>
<td>March 14</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Eligible patients will commence IVF treatment within 12 months by 31 March 2015.</td>
<td>March 14</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Further reduce healthcare associated infections so that by March 2016 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate</td>
<td>March 14</td>
<td>AKM</td>
<td></td>
</tr>
</tbody>
</table>
### NHS Lothian – Corporate Objectives 2013/14

<table>
<thead>
<tr>
<th>Objective</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 10:</strong> To have a robust system of performance management and reporting aligned to delivery of Government targets.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.</td>
<td>Monthly</td>
<td>MH/PG/All</td>
<td></td>
</tr>
<tr>
<td><strong>Heat Standards</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.</td>
<td>Monthly</td>
<td>DF/AMcM</td>
<td></td>
</tr>
<tr>
<td>90% of planned / elective patients to commence treatment within 18 weeks of referral.</td>
<td>Monthly</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census)</td>
<td>Monthly</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
<td>Annual</td>
<td>DS</td>
<td></td>
</tr>
<tr>
<td>90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>March 14</td>
<td>AMcM/PG</td>
<td></td>
</tr>
<tr>
<td>To achieve a sickness absence rate of 4% across NHS Lothian.</td>
<td>March 14</td>
<td>AB</td>
<td></td>
</tr>
<tr>
<td>NHS Lothian and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td>March 14</td>
<td>JF/PG/DS and AMcM</td>
<td></td>
</tr>
<tr>
<td>To continue to strive to achieve the target of 90% of stroke patients being admitted to a stroke bed within 24 hours of initial diagnosis</td>
<td>March 14</td>
<td>MH/DF</td>
<td></td>
</tr>
</tbody>
</table>
## OBJECTIVE 1:
**DEVELOP THE NHS LOTHIAN CLINICAL STRATEGY TO PROVIDE A FRAMEWORK FOR SERVICE REDESIGN ACROSS THE ORGANISATION**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013</td>
<td>AMcM</td>
<td>Framework will go to the Feb Board meeting for sign off. Strategic Planning Group established and will oversee the development of future strategies and implementation. Modernisation Team/Improvement Support is aligned to this work.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>AB / AMcM / MH</td>
<td>Work programme being developed and will go to the February Strategic Planning Group in the first instance</td>
</tr>
</tbody>
</table>

- Develop a clinical framework to support the redesign of clinical services which will meet the changing needs of our population and which are available to all of them who may benefit. Adopt evidence based best practice and models of health care which focus on patients and clients to ensure that we achieve the best outcomes for our population, using tool such as LEAN as appropriate.

- Design and implement phased changes to roles and working patterns to deliver the future service models.

## OBJECTIVE 2:
**FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Ongoing / October 2012 | DF / SG | Weekly waiting times meeting chaired by the Chief Executive monitoring progress towards reducing the backlog of patients requiring out patient/day case/in patient treatment. Senior operational managers meet every Friday morning to review the implementation of Demand and capacity plans to ensure that there are sustainable solutions to meet the 12 week Treatment Time Guarantee and 18 week Referral To Treatment Target.

- Continue to develop capacity plans and supporting financial plans to support the delivery of national access targets across all specialities, working with the Scottish Government Team to put plans in place which are sustainable, including the 12 weeks treatment time guarantee (TTG) for inpatient and day case treatment coming into effect from 1 October 2012; and for delivery of the 90% composite target for 18 week Referral to Treatment across appropriate specialities.

- Financial budgets agreed. Step up in capacity now being reviewed for scrutiny at March JMT.
### OBJECTIVE 2: FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>DF</td>
<td>Weekly monitoring of both 31 &amp; 62 day treatment times continue. Latest monthly review shows performance above 95% for both standards.</td>
</tr>
</tbody>
</table>

Continue to deliver the Scottish Government standard for 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013</td>
<td>AMcM</td>
<td>Following approval of the committee structure, the Corporate Governance &amp; Value for Money Manager and Associate Director of Analytical Services have started to meet with Chairs and Executive Leads to review each committee’s information needs. In particular, the Corporate Governance &amp; Value for Money Manager is using a Board Assurance Map model to set out the main assurance topics for the Board and indicate the various sources of assurance, with sources categorised into:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- First Line of Defence – management controls and reporting;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Second Line of Defence – Board and committee oversight; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Third Line of Defence — independent review or regulatory oversight.</td>
</tr>
</tbody>
</table>

Develop a Performance Management System to ensure quality and transparent data is routinely reported to appropriate Board Committees.
<table>
<thead>
<tr>
<th>OBJECTIVE 2:</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBJECTIVE 3:</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>TO PROMOTE AND ENSURE THAT ALL EMPLOYEES ARE SUPPORTED APPROPRIATELY IN LINE WITH STAFF GOVERNANCE POLICIES WITHIN NHS LOTHIAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete the Critical Incident investigation in regard to Waiting Times and follow up actions as appropriate.</td>
<td></td>
<td>AB</td>
<td>COMPLETED</td>
</tr>
<tr>
<td>Complete the review of management culture within NHS Lothian and follow up actions as appropriate.</td>
<td></td>
<td>CHAIR /CE</td>
<td>THIS IS A TWO YEAR PROGRAMME AND WILL TAKE ON BOARD THE 5X5X5 VALUES WORK WORK TO DATE IS ON TARGET</td>
</tr>
<tr>
<td>Refresh and implement the HR&amp;OD Strategy, in light of findings from recent investigation(s) and reviews.</td>
<td></td>
<td>Ongoing AB /CE</td>
<td>REFRESHED AT NOV 2012 BOARD</td>
</tr>
<tr>
<td>NHS Boards to achieve a sickness absence rate of 4%.</td>
<td></td>
<td>Ongoing AB</td>
<td>CURRENTLY CIRCA 4.2%</td>
</tr>
</tbody>
</table>

| OBJECTIVE 4: | TIMING | LEAD CMT MEMBER | COMMENTS |
| FURTHER DEVELOP WORK RELATING TO NHS LOTHIAN UNSCHEDULED CARE IN ORDER TO SUPPORT THE ORGANISATION TO ACHIEVE REQUIRED STANDARDS OF PATIENT CARE | | | |
| Continue to work with Partner Authorities to deliver the Delayed Discharge targets contained in the Local Delivery Plan - no people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015. | March 2013 | AMcM | Delayed discharges are still above the trajectory to meet this target. The March 2013 figures where that 24 people were delayed longer than 28 days, 10 people were delayed longer than 6 weeks and 120 people were delayed overall. |
**OBJECTIVE 4: FURTHER DEVELOP WORK RELATING TO NHS LOTHIAN UNSCHEDULED CARE IN ORDER TO SUPPORT THE ORGANISATION TO ACHIEVE REQUIRED STANDARDS OF PATIENT CARE**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>AMcM</td>
<td>Winter Business Continuity Plan delivered and being implemented as per the plan. NHS Lothian along with other Boards did not achieve our desired performance on 4 and 12 hours and delays during the winter period. This year winter planning will be embedded within the operational management. A winter de-brief is planned for the 16th April.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>MH</td>
<td>This remains a challenge but an agreed action plan is now in place and is being driven forward through both the Joint Management Team and the Unscheduled Care Group. March performance was 88.04% against a 98% target.</td>
</tr>
</tbody>
</table>

Ensure that winter pressures are effectively managed and that activity is managed to reflect seasonal pressures.

Develop work to support the delivery of the HEAT standard - 98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.
### OBJECTIVE 5:
DRIVE FORWARD THE WORK ON THE INTEGRATION OF HEALTH AND SOCIAL CARE

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>AMcM/PG/JF/DS</td>
<td>Significant progress made and NHS Lothian and council partners are at the forefront of this agenda in Scotland. Shadow arrangements in place in WL/Edinburgh and will be in place in East Lothian and Mid in April/May this year. Staff engagement underway, partnership agreements being developed, initial services being reviewed are Learning Disabilities; Mental Health; Complex Care; Substance Misuse; Prisons; Health Promotion. Next tranche are Dentistry, Children and aspects of acute care during 13/14.</td>
</tr>
</tbody>
</table>

Continue to drive forward the Integration of Health and Social Care as directed by SG guidance.
<table>
<thead>
<tr>
<th>OBJECTIVE 6: IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Implement the Quality Improvement Strategy. | March 2013 | DF | A 1-year update on the implementation of the Quality Improvement Strategy (2011-14) was reported to the Board in July 2012. There have been sustained improvements in:-  
  - HSMR and Adverse Event Rate (see below under SPSP)  
  - 20% reduction in Falls with Harm  
  - Reduction in medication errors. Many of the key measures have been incorporated into the Quality Report which is reported at every Board meeting. |
| Continue to implement the Scottish Patient Safety Programme to deliver reductions in standardised hospital mortality rate (HSMR) and in adverse events recorded. | March 2013 | DF | A 5-year update on SPSP was reported to the Board in November 2012, plus the positive findings of the Autumn Harvest visit from Healthcare Improvement Scotland. Sustained improvements in HSMR against (2006/07 baseline) national 20% reduction goal for 2015: WGH ↓5%, SJH ↓6.30% and RIE ↓10%. The WGH remains the lowest mortality rate in Scotland. We have sustained the reduction in the Adverse Event Rate by 46% against baseline. A HSMR plan was presented to the Board in January 2013 to support further improvements. New workstreams: VTE, SEPSIS, Maternity, Mental Health and rollout of the programmes to General Practice – 91% of practices are taking part. |
| Continue to improve patient experience through “Delivering Better Care”. | March 2013 | MH | Progressing as planned. Work of Hub and Person Centred Programme working with social services, 3rd sector and independent care sector. |
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>OBJECTIVE 6: IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHilst IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure robust arrangements are in place for both emergency planning and business continuity in order to support the management of major incidents.</td>
<td>Ongoing</td>
<td>AKM / AMcM</td>
<td>Through representation at the Lothian and Borders Emergency Planning SCG by the Director of Public Health &amp; Health Policy. Through exercise and training opportunities we evaluate and improve staff abilities to prepare for and manage major incidents and outbreaks. The NHS Lothian Emergency Planning Strategic Advisory Group (EPSAG) is responsible for ensuring that the requirements for emergency planning at a strategic level, in conjunction with the requirements of a Category 1 responder under the Civil Contingencies Act, 2004 are identified and addressed across NHS Lothian. NHS Lothian ensures that this can happen by close working between the Director of Public Health and the Director of Planning, Performance Reporting and Information. NHSL Business Continuity Management (BCM) programme continues to link into Scottish Government guidelines and frameworks to ensure arrangements are current and robust. Formalised reassurance protocols are in place to ensure individual business areas are compliant with the BCM programme, along with triggers of escalation if required. Particular focus is given to plan maintenance and exercising on an annual basis. The corporate risk is now removed for BCM, due to controls in place and the evaluation of the effectiveness of the said processes.</td>
</tr>
</tbody>
</table>
## OBJECTIVE 6: IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>AKM</td>
<td>The large outbreak of Legionella during June 2012 required a multidisciplinary response by the whole of the Public Health department led by the Health Protection Team. NHS Lothian and IMT debriefs have been held and the final report for the outbreak is with the Central Legal Office for final sign-off. While the C.Diff target is likely to be met (see objective 12 for details), the team is pursuing targeted actions in areas where new approaches are needed to drive down antibiotic use and to prevent infections, particularly recurrent infections. Since September/October the target for SAB has been off trajectory. There is no single cluster – each case is investigated and feedback to staff. A significant proportion are elderly people who have multiple morbidities who have repeated contact with the healthcare system and further work is underway to identify strategic priorities for improvement.</td>
</tr>
<tr>
<td>Quarterly</td>
<td>DF</td>
<td>Continue to implement NHS Lothian’s Risk Management Policy and Procedure to further embed. A Risk Management Steering Group has been established, chaired by the Chief Executive. As part of a review of governance committees at the Board, Risk Management now reports through the Audit &amp; Risk Committee as a standing item. Draft Corporate Risk Register was reported to the Board in January 2013 and risks pertinent to the 3 governance committees of the Board are being reviewed, and will inform committee agenda setting.</td>
</tr>
</tbody>
</table>

Ensure robust arrangements are in place to manage communicable disease outbreaks and healthcare associated infection with targeted plans in place to deliver continued reduction in rates of healthcare associated infection (this includes the HEAT Target).

Risk Management arrangements reviewed regularly by both Healthcare Governance & Risk Management Committee at bi-monthly meeting and by Audit committee.
## OBJECTIVE 6:
**IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop the complaints function to ensure single point of access, pro-active response and learning across the organisation as well as meeting targets to ensure a timely response.</td>
<td>March 2013</td>
<td>SW</td>
<td>A review is set to take place on the future shape of Complaints Department to ensure it is meeting the needs of the organisation as set out in objectives</td>
</tr>
<tr>
<td>Ensure robust systems are in place to manage Freedom of Information requests within the guidelines.</td>
<td>Ongoing</td>
<td>AB</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Complete the action plan for the Equality &amp; Human Rights Scheme 2010-13, and develop future equality &amp; diversity objectives in order to meet legal requirements and ensure that the patient experience is as equitable and safe as possible for all individuals.</td>
<td>March 2013</td>
<td>AB</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Refresh / renew the involving people strategy, taking account of the requirements of the Patients Rights Act, to ensure the involvement and communication with our patients and communities.</td>
<td>March 2013</td>
<td>MH</td>
<td>Draft currently under development.</td>
</tr>
<tr>
<td>OBJECTIVE 7: ENSURE APPROPRIATE STAFFING ARRANGEMENTS ARE IN PLACE ACROSS NHS LOTHIAN AS REQUIRED, INCLUDING MEDICAL STAFF, NURSING, AHPS AND OTHERS</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Manage the national phased reduction in overall doctors in training numbers through workforce and financial planning and alternative professional role development.</td>
<td>March 2013</td>
<td>DF / SG</td>
<td>At a national level the further reductions have been paused in a number of specialties. The NHS Lothian 2013 financial plan includes provision for key areas where there are medical workforce pressures; Emergency Medicine, O&amp;G and Paediatrics. This funding is in place to enable these areas to recruit to both medical and non-medical replacements. The Nurse Director is undertaking a scoping exercise to determine the demand for advanced practice roles. A medical workforce risk assessment process is currently underway within all service/specialties, this will profile risk within the Trained, Training and Non-medical replacement workforces. The assessments will then be used to highlight and address areas of high risk.</td>
</tr>
<tr>
<td>Ensure robust workforce planning models continue to be developed to support service redesign across the system</td>
<td>Ongoing</td>
<td>AB</td>
<td>Model developed, risk matrix being implemented</td>
</tr>
</tbody>
</table>
### OBJECTIVE 8:
CONTINUE TO DEVELOP STANDARDS OF CARE FOR BOTH OLDER PEOPLE SERVICE AND MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2016</td>
<td>CH(C)P GMs</td>
<td>At Nov 2012 – average 42% East – 57% West – 33.6% Mid – 41% Edinburgh – 31.4%</td>
</tr>
<tr>
<td>March 2013</td>
<td>CH(C)P GMs</td>
<td>All Change Fund plans are being implemented. Mid term reviews have been conducted across all partnerships/plans. Discussions now about future areas of investment and these will take place through corporate and local change fund plan groups. Primary and community based responses are the main focus of this investment as are hospital based services to assist the patient pathway and ‘flow’ management. There are two more years of funding till March 2015.</td>
</tr>
<tr>
<td>March 2013</td>
<td>MH</td>
<td>Vulnerable peoples Steering Group established in August 2012. New programme of education has been developed and now available. Resource Packs available during February. Dementia champions now in place and a further cohort being recruited to.</td>
</tr>
<tr>
<td>March 2013</td>
<td>AMcM</td>
<td>Implementation of the strategy is well progressed. Significant work on driving the actions forward and the redevelopment of the Royal Edinburgh Hospital. Work on tackling issues related to social justice; inequalities; needs of those in prison and also wider work on psychological therapies and dementia well progressed.</td>
</tr>
<tr>
<td>OBJECTIVE 9: ENSURE THE CAPITAL PROGRAMME IS DELIVERED WITHIN A ROBUST FINANCIAL PLANNING AND GOVERNANCE FRAMEWORK</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Continue to work with Consort to deliver the required service as stipulated under the service legal agreement, ensuring compliance with all aspects of the agreement.</td>
<td>Ongoing</td>
<td>SG / AB</td>
</tr>
<tr>
<td>Continue to drive forward the Reprovision of the RHSC &amp; DCN projects.</td>
<td>Ongoing</td>
<td>SG</td>
</tr>
<tr>
<td>Continue to develop the business plan for the Reprovision of the Royal Edinburgh Hospital.</td>
<td>Ongoing</td>
<td>DS / SG</td>
</tr>
<tr>
<td>Work closely with partner agencies in developing the proposed bio quarter adjacent to RIE site.</td>
<td>Ongoing</td>
<td>SG/ DF</td>
</tr>
<tr>
<td>Continue to take forward other capital projects across the organisation as agreed as part of the Capital Plan.</td>
<td>Ongoing</td>
<td>SG</td>
</tr>
</tbody>
</table>
| OBJECTIVE 10:  
FINANCIAL BALANCE | TIMING | LEAD CMT MEMBER | COMMENTS |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Ensure a robust financial planning and governance framework is in place, encompassing both capital and revenue, to support NHS Lothian’s strategic objectives, to deliver financial balance, and which manages risk in relation to the economic position.</td>
<td>March 2013</td>
<td>SG</td>
<td>Financial balance forecast for 12/13. Financial Plan 13/14- 17/18 approved by Joint Management Team. Finance and resources Committee reviewed in February.</td>
</tr>
<tr>
<td>Ensure the Efficiency &amp; Productivity Programme delivers the required recurring savings for 2012/13, and progress is made on detailed, deliverable plans for 2013/14 and beyond</td>
<td>March 2013</td>
<td>SG</td>
<td>Efficiency &amp; Productivity Delivery 2012/13 – shortfall of £12m but plans for 2013/14 incorporate this and fully developed plan now in place for 13/14.</td>
</tr>
<tr>
<td>Develop the Integrated Resource Framework as a financial planning tool and to support wider management decision making, particularly in relation to the integration agenda.</td>
<td>March 2013</td>
<td>SG / AMcM</td>
<td>Business Case for future funding to develop this system wide is being reviewed.</td>
</tr>
</tbody>
</table>
**OBJECTIVE 11: CONTINUE TO DRIVE FORWARD THE PUBLIC HEALTH AGENDA**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
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</thead>
</table>
| Ongoing | AKM            | • By the end of September, 2494 Keep Well checks were completed, we are on track to meet our annual target of 4800 checks by the end of March 2013 and the phased ‘roll-out’ of Keep Well is on target.  
• Plans for action required to minimise the risk of home-grown measles and rubella have been developed and agreed by JMT. WHO revised the target dates for evidencing elimination of home-grown measles and rubella. 2013 is now the first performance review point. The revised target year to evidence delivery is 2017.  
• The Fair Warning process is an example of action taking place to improve information governance practices and embed best practice across all NHSL staff. Information governance risks will be recorded on the corporate risk register and reviewed regularly.  
We continue to improve the health of the population and work with partners to address the social determinants of health on a number of fronts. This work is encapsulated in the WHO ten essential Public Health Operations (2012): |
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>OBJECTIVE 12: ACHIEVE REQUIRED HEAT TARGETS AND STANDARDS AS EXPECTED WITHIN THE STATED TIMESCALES BY THE SCOTTISH GOVERNMENT</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15.</td>
<td>March 2015</td>
<td>AKM</td>
<td>As at January 2013, details of local trajectories for the three cancers were still to be agreed with the Scottish Government. ISD continues to work on this for all Boards as it is proving difficult to count - this is not routine data.</td>
</tr>
<tr>
<td>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>March 2015</td>
<td>AMcM</td>
<td>Have agreed definitions and reporting. On track for delivery.</td>
</tr>
<tr>
<td>Improve oral health by providing preventative interventions: ensure at least 60% of 3 and 4 year olds in each SIMD quintile have fluoride varnishing twice a year by March 2014.</td>
<td>March 2014</td>
<td>AKM</td>
<td>Latest figures in January 2013 show that in the year from Oct 2011 to September 2012 a total of 25.4% of registered 2-5 year-old children in Lothian received one fluoride varnish application. Mainland Boards range from 11.0% to 32.7%. In the same time period, 4.8% of registered 2-5 year-old children in Lothian received two fluoride varnish applications. Mainland Boards range from 1.8% to 7.0%.</td>
</tr>
<tr>
<td>Deliver agreed completion rates for child healthy weight intervention programme through combined approach of prevention and treatment (NHS Lothian is required to deliver 1,475 interventions by March 2013 reaching a cumulative total of 2,268 by March 2014).</td>
<td>March 2014</td>
<td>AKM</td>
<td>Over the period July to Dec 2012 interventions were delivered to a total of 348 overweight and obese children (provisional figure yet to be validated by Scottish Government). We are currently recruiting additional schools to take part for the final weeks of 2012/13 and start 2013/14. Funding to deliver these additional programmes has been identified within Public Health budgets. Arrangements have been made to perform the measurements in as sensitive and confidential way as possible to minimise potential harm. With this plan in place we would expect to meet or exceed the target by March 2014.</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>Due Date</th>
<th>Responsible Officer</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver smoking cessation services to support the reduction in the number</td>
<td>March 2014</td>
<td>JF/AKM</td>
<td>Target achieved. Smoking cessation amongst the 40% most deprived within-Board SIMD areas over the period 2011/12 to 2013/14 was targeted to be 7,011. This target was reached by September 2012. We are on trajectory to achieve the 2011-14 target.</td>
</tr>
<tr>
<td>reduce in the number of people smoking by 2014 (NHS Lothian is required</td>
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<td>to reach 4,836 successful quits by March 2013 reaching a cumulative total</td>
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<tr>
<td>of 7,011 by March 2014).</td>
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</tr>
<tr>
<td>Reduce suicide rate between 2002 and 2013 by 20%.</td>
<td>March 2013</td>
<td>AMcM</td>
<td>There were 128 suicides in Lothian in 2011 (16.5% of the Scottish total). This is an increase on 2010 (122) but lower than 2008 (136). 2008 was the highest yearly total in the last 25 years. The 2011 total is made up of 96 males and 32 females. Much of the variation in the Lothian figures over the last 5 years appears to be due to changes in male suicide. Female deaths from suicide have been between 30 and 34 in that period.</td>
</tr>
<tr>
<td>Reduce energy-based carbon emissions and to continue a reduction in</td>
<td>March 2013</td>
<td>AB</td>
<td>Reduce Carbon Emissions - 6.36% v -8.73% target</td>
</tr>
<tr>
<td>energy consumption to contribute to the greenhouse gas emissions</td>
<td></td>
<td></td>
<td>Reduce Energy Consumption – 0.94 v -2.97% target.</td>
</tr>
<tr>
<td>reduction targets set in the Climate Change (Scotland) Act 2009.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks</td>
<td>March 2013</td>
<td>MH/ AMcM</td>
<td>Work is progressing well in achieving the 26 wk CAMHS target. Further workforce developments and eHealth developments to take place.</td>
</tr>
<tr>
<td>referral to treatment for specialist Child and Adolescent Mental</td>
<td></td>
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</tr>
<tr>
<td>Health Services (CAMHS) services from March 2013, reducing to 18 weeks</td>
<td></td>
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<tr>
<td>by December 2014.</td>
<td></td>
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</tr>
<tr>
<td>Deliver an 18 weeks referral to treatment waiting time for Psychological</td>
<td>December 2014</td>
<td>AMcM</td>
<td>Initial work in East/Midlothian now being rolled out on the back of the publication of the demand, capacity and queue work completed. Strategic plan developed. Mental health is under the TTG and therefore we are addressing reporting as well as ensuring definitions are clear. eHealth support is ensuring a migration from PIMS to Trak by March 13 captures all the information needs aligned to meeting this target and other information needs within mental health systems.</td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>Start Date</th>
<th>Responsible Parties</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>March 2013</td>
<td>AMcM /AKM</td>
<td>January 13 figures show NHS Lothian at just (1.9%) below the performance trajectory to achieve target of 90% of new patients beginning treatment within 3 weeks of referral. In fact, 85.2% of 358 new patients started their treatment within three weeks of referral. In addition, over 93% of patients started treatment within 5 weeks of referral.</td>
</tr>
<tr>
<td>Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15 (NHS Lothian will reach the target of 4,971 by March 2013, 4,799 by March 2014 and 4,629 by March 2015).</td>
<td>March 2015</td>
<td>AMcM</td>
<td>The trajectory for emergency bed days for those 75+ yrs continues to rise above NHS Lothian’s agreed stretch target but actions through the unscheduled care and change fund will assist in this being delivered by 2015.</td>
</tr>
<tr>
<td>Improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.</td>
<td>March 2013</td>
<td>MH</td>
<td>Not on trajectory because of Unscheduled Care flow. Current February 2013 position is 66% against target. Action plan now in place.</td>
</tr>
<tr>
<td>Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.</td>
<td>March 2013</td>
<td>AKM</td>
<td>SAB: SAB target by 31/03/2013 = 0.26 cases per 1000 Acute Occupied Bed Days (213 episodes). Current SAB rate (December 2012) = 0.28 (189 episodes). Therefore, we are not on trajectory to achieve the 2013 target. CDi: CDi target by 31/03/2013 = 0.39 per 1000 Total Occupied Bed Days (326 episodes). Current CDi rate (December 2012) = 0.34 (206 episodes) and we are therefore on trajectory to achieve the 2013 target.</td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

| Support shifting the balance of care by achieving a 2% reduction in the rates of attendance at A&E between 2009/10 and 2013/14 (NHS Lothian will achieve a rate of 1,944 by March 2013 and 1,959 by March 2014). |
| March 2014 | MH / PG |
| In December 2012, NHS Lothian’s performance continued to be 5% above the trajectory for accident and emergency attendances. Total number was 17,699 attendances. Work to redesign the St John’s Hospital Primary Assessment Area standard operating procedures will, where appropriate, direct patients out of an admitted pathway into an ambulatory care pathway, therefore reducing the number of A&E attendances recorded in the future. This has been notified to ISD and Scottish Government and there is an annual review of T10 on the 5th March. The T10 workstream will now sit within the unscheduled care group. |

<table>
<thead>
<tr>
<th>HEAT STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
</tr>
<tr>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Survey, NHS Lothian was at 80% against the 90% target</td>
</tr>
</tbody>
</table>

| Maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources. |
| Ongoing | AMcM |
| Lothian sits at approx 60% patients on the register above the initial target. |

| 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. |
| Ongoing | AMcM/AKM |
| NHS Lothian has led the ABI programme on behalf of partners in the 3 Lothian ADPs. The HEAT standard has been achieved and by December 12,793 ABIs had been delivered. The ABI implementation team has trained an additional 604 professionals in 2012/13 to deliver ABIs in a number of organisations including Lothian and Borders Police, Lothian and Borders Fire Brigade, HMP Edinburgh, HMP Addiewell, Local Authorities and Higher Education establishments in Lothian. |
Support the implementation of the Palliative Care strategy to achieve a shift in the balance of care in respect of place of death (local targets):

- Decrease the proportion of deaths occurring in Acute Hospitals from 42.3% of all Lothian deaths (2008 baseline) to 38% by 2015
- Increase the proportion of deaths occurring in community residential settings from 34.4% of all Lothian deaths to 38.8% by 2015.

<table>
<thead>
<tr>
<th>March 2015</th>
<th>AMcM</th>
<th>Performance in relation to deaths occurring within the acute hospital setting has increased. We are currently reviewing this target and actions required to support this as we see this as a quality and dignity issue.</th>
</tr>
</thead>
</table>
SHADOW HEALTH & SOCIAL CARE PARTNERSHIP BOARDS MEMBERSHIPS

1 Purpose of the Report

1.1 This paper seeks Board approval of the following appointments to the Shadow Health & Social Care Partnership Boards for East Lothian, Edinburgh and Midlothian.

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

2 Recommendations

2.1 It is recommended that the Board confirms the following appointments:

East Lothian Shadow Health & Social Care Partnership -

Non-Executive Board Member: Alison Meiklejohn
Non-Executive Board Member: Graeme Warner

Edinburgh Shadow Health & Social Care Partnership -

Professional Advisory Committee Member: Dr Carl Bickler
Professional Advisory Committee Member: Dr Gordon Scott

Midlothian Lothian Shadow Health & Social Care Partnership -

Non-Executive Board Member: Julie McDowall
Practicing Clinician Member: vacancy to be filled

3 Discussion of Key Issues

3.1 East Lothian Shadow Health & Social Care Partnership - The Board is asked to approve the establishment of a Shadow Health & Social Care Partnership Board for East Lothian. The Board has already approved the appointment of Mike Ash as Chair and Thomas Miller as Partnership Representative.

It is proposed that the remaining two NHS members should be Alison Meiklejohn and Graham Warner.

Proposals for clinical engagement in the East Lothian Shadow Health & Social Care Partnership Board will be developed separately.
3.2 Edinburgh Shadow Health & Social Care Partnership - An appointments panel was arranged for the Professional Advisory Committee. All 35 members were invited to nominate themselves and 7 candidates came forward. The interview panel comprised the Chair of the Edinburgh Community Health Partnership (ECHP) with the General Manager, Medical Director and Nurse Director of the ECHP. The recommended appointments from this panel were Dr Carl Bickler, Clinical lead for South East Edinburgh & Dr Gordon Scott, Clinical Lead for Sexual Health. Both these individuals understand that their remit is to represent all clinical opinion within the Professional Advisory Committee.

These appointments are for a maximum of one year, pending guidance from the Scottish Government which is anticipated in the next 12 months and will be linked to the Bill currently being finalised for Parliament. During the next 12 months the appointment process, membership and arrangements for the Professional Advisory Committee will be kept under review and relevant professional leads on the Shadow Board will be fully engaged in this process taking account of the guidance received from the Scottish Government.

3.3 Midlothian Shadow Health & Social Care Partnership - The Board approved the establishment of a Shadow Health & Social Care Partnership Board for Midlothian in January 2013. The Board has already approved the appointment of Peter Johnston as Chair and Patsy Eccles as Partnership Representative. It is proposed that the other Non-Executive Board member should be Julie McDowall.

It is proposed that the fourth NHS member should be a practicing clinician in Midlothian and that their role will be to represent the healthcare needs of the whole population of Midlothian and to undertake the responsibilities of an NHS member of the Shadow Board. The proposed process to select the fourth member is to invite expressions of interest from all directly employed NHS staff and NHS independent contractors in Midlothian. This will be followed by a short listing and interview process led by the Chair of the Shadow Board. The proposed appointment will be subject to approval by the Chair or Vice Chair of the Board and homologation by the Board.

4 Key Risk

4.1 If members are not appointed, the Shadow Health & Social Care Partnerships may have difficulties in obtaining a quorum.

5 Risk Register

5.1 There are no implications for NHS Lothian’s Risk Register

6 Impact on Inequality, Including Health Inequalities

6.1 Not required as this is an administrative matter.

7 Involving People

7.1 The Board Vice Chair has discussed these proposals with the members concerned.
8 Resource Implications

8.1 There are no resource implications and no additional cost attaches to these appointments.

Peter Reith
Secretariat Manager
19 April 2013
peter.reith@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 This report is to seek the agreement of the Board to the establishment of a shadow Health and Social Care Partnership Board and the establishment of the post of Joint Accountable Officer in East Lothian.

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

2 Recommendations

2.1 The Board is recommended to:

2.2 Approve the arrangements for a shadow Health and Social Care Partnership Board in East Lothian

2.3 Note that these arrangements are interim and may be subject to change following legislation.

2.4 Approve the establishment of the post of Joint Accountable Officer for East Lothian.

2.5 Note that a similar report will be submitted to East Lothian Council on 23rd April 2013 for approval.

3 Discussion of Key Issues

3.1 Shadow Health and Social Care Partnership

3.2 On November 15th 2012, a meeting between the Chairman and Chief Executive of NHS Lothian, the Chairman of East Lothian CHP sub committee, the Leader and spokesperson for health and social care and the Chief Executive of East Lothian Council agreed that detailed planning towards the establishment of a Health and Social Care Partnership (HSCP) in East Lothian should commence, taking account of national guidance and legislation as available. This joint agreement
included the establishment of a shadow partnership board and the appointment of a Joint Accountable Officer.

3.3 East Lothian Council will consider a report on these proposals at its meeting on 23\textsuperscript{rd} April 2013. This is attached at Appendix 1.

3.4 Prior to the establishment of a HSCP created by legislation, it is intended that this shadow partnership board will be created in East Lothian to allow detailed planning and development in advance of formal constitution. East Lothian CHP sub committee will continue to function as a governance mechanism, but measures will be established to ensure congruence of business across the structures.

3.5 Joint work across the NHS and East Lothian Council is currently underway to finalise terms of reference for this shadow group including its remit, function and membership.

3.6 The shadow HSCP Board will comprise 8 voting members, 4 from NHS Lothian and 4 from East Lothian Council. Nominations from East Lothian Council will be agreed on 23\textsuperscript{rd} April.

3.7 The appointment of Mike Ash as Chair for the first two years and Thomas Miller as NHS partnership member of the shadow HSCP Board was approved by the NHS Board on 27\textsuperscript{th} March 2013.

3.8 Discussions are underway on how to engage professionals and others in supporting the shadow Board.

3.9 Planning progress has already been made across a number of areas with a detailed workplan being finalised for approval. Five principal workstreams mirroring national structures have been agreed, to be led jointly by senior Council and NHS officers. The workstreams are Finance and IT, Governance, Outcomes, Strategic Commissioning and HR and Workforce Development.

3.10 As a pivotal element of planning, a Joint Commissioning plan for Older People has been developed through the work of the Change Fund and will provide the initial direction of travel for older people’s services. This plan has been submitted to Scottish Government in keeping with their required timescales but with the caveat that it will be considered for approval at an initial meeting of the Shadow Board.

3.11 A key aspect of this work will be to ensure we build the views of staff, service users and carers into our plans.

3.12 These proposals are based on the Scottish Government response to the consultation on integration of health and social care. The Scottish Government intends to legislate for the establishment of HSCPs and these proposals may be subject to change based on legislation and should be considered to be interim.

3.13 Joint Accountable Officer

3.14 The Scottish Government response to the consultation on integration of health and social care was issued in February 2013. This made it clear that the Scottish Government would proceed to legislate for the establishment of partnerships
across Scotland and the creation of the post of Joint Accountable Officer where the model of integration is a “body corporate”.

3.15 This is the model already in place in Edinburgh and West Lothian, already agreed for Midlothian and is the model proposed East Lothian.

3.16 In order to achieve the clarity of direction and leadership required to establish the East Lothian partnership and to oversee the development of the shadow board into a formal health and social care partnership it is proposed that the post of “Joint Accountable Officer” is established for the East Lothian health and social care partnership.

3.17 The Director of Human Resources and Organisational Development will lead the process of agreeing the job description and appointment process on behalf of the NHS Board and East Lothian Council.

3.18 Given that the current arrangements for management of East and Midlothian CHPs cover both Midlothian and East Lothian, it has been agreed that the appointment process will be managed on the same timescale as the Joint Accountable Officer appointment in Midlothian.

3.19 The establishment of these posts will remove the post of General Manager of East and Midlothian CHPs from the organisational structure of NHS Lothian.

3.20 Each post will take on responsibility for NHS services in East Lothian and Midlothian respectively and will report to the relevant CHP sub committee for NHS services during the shadow period. Each post will also carry Lothian wide NHS responsibilities which are still to be agreed.

3.21 The postholders will work together to manage the transition period from the current arrangements to the full establishment of health and social care partnerships in order to ensure strong management and governance of NHS and Council services.

3.22 The appointment process will be managed in accordance with the policies of NHS Lothian and East Lothian Council.

4 Key Risks

4.1 Implementation of Joint Accountable Officer posts in Midlothian and East Lothian will require subsequent review of NHS management arrangements. It will be important to ensure that governance remains strong during this period.

5 Risk Register

5.1 CHPs are working together to define the risks created by these changes and they will be included in CHP risk registers.

5.2 A robust process of regular review on progress towards the establishment of a HSCP in East Lothian will ensure that risks are identified, addressed and escalated as required, minimising the need for any to be added to the NHS
Lothian risk register. The shadow Board, as an integral element of its workplan, will develop a dedicated risk register.

6 Impact on Inequalities Including Health Inequalities

6.1 The creation of a partnership between health and social care will enhance the capacity to address health inequalities experienced by our population. The emphasis on ‘localism’ will make it more likely that health inequalities occurring within particular communities will be actively considered and addressed.

7 Involving People

7.1 A key aspect of the planning and development work for the HSCP will be to ensure we build the views of staff, service users and carers into our plans. Workstream leads will establish appropriate mechanisms to enable the views of these groups to be heard. The individuals affected by this proposal have been fully engaged in this process. The lead partnership representative for East Lothian has been engaged in the process.

8 Resource Implications

8.1 The costs of the Joint Accountable Officer post will be met equally by NHS Lothian and East Lothian Council. NHS Lothian will fund its share of the post through revenue released by organisational change.

David Small
General Manager
East and Midlothian CHPs
11th April 2013

Alan Boyter
Director of Human Resources and Organisational Development

11th April 2013

Appendix 1: East Lothian Council paper on Integration of Health and Social Care
REPORT TO: East Lothian Council

MEETING DATE: 23 April 2013

BY: Chief Executive

SUBJECT: Integration of Health and Social Care: Proposed Shadow Partnership Arrangements

1 PURPOSE

1.1 The Purpose of this report is to;

i) Seek approval for the establishment of a Shadow Partnership to plan for the establishment of a formal Health and Social Care Partnership in East Lothian

ii) Seek approval to appoint a Jointly Accountable Officer.

2 RECOMMENDATIONS

2.1 Members are asked to;

i) Approve proposals to establish a Shadow Partnership

ii) Nominate four elected members to serve on the Shadow Partnership

iii) Nominate one elected member to act as the Vice-Chairperson of the Shadow Partnership

iv) Approve the process of appointment for the Jointly Accountable Officer set out at paragraph 3.10

v) Note that all seven existing Heads of Service and the existing General Manager of East and Midlothian Community Health Partnership will make up the pool of candidates for this post.
3 BACKGROUND

3.1 At its meeting on 26 February 2013, the Council received a report providing an update on the integration of health and social care. Members approved a recommendation to “request that a report with proposals to establish shadow partnership arrangements is brought forward for approval by April 2013”. This paper brings together the key elements of discussion surrounding the development of a Shadow Health and Social Care Partnership that have taken place to date and synthesises the main points into a specific set of proposals.

3.2 The Shadow Partnership’s purpose will be to ensure that the Single Outcome Agreement for East Lothian is progressed by supporting the national Integration Outcomes which the Partnership will become accountable for. The Partnership’s remit is set out at Appendix 1.

3.3 The Scottish Government will legislate for arrangements that confer voting rights on statutory members of the Health and Social Care Partnership Committee, and strengthen these arrangements by legislating to require additional membership of the Committee covering professional, carer, user and public interests.

3.4 In advance of the establishment of the formal Health and Social Care Partnership Committee, a Shadow Partnership will be required. There will be eight members of the Shadow Partnership comprising four Non-Executive NHS Board Members (one of whom will be the Partnership representative) and four elected members of East Lothian Council. The Council is invited to nominate four members to attend the Board, and it is suggested that this includes three members of the Administration and one member of the Opposition.

3.5 In the event that formal decisions are required, these will be the voting members. The Shadow Partnership will be strengthened by additional membership of the committee covering professional, carer, user and public interests.

3.6 For the first two years, the Chairperson will be selected from the NHS Lothian members whilst the Vice Chair will be selected from the Council elected members. These positions will alternate annually thereafter with a member of the Council assuming the chair in 2015.

3.7 The position of Chairperson has now been filled by Mr Mike Ash, who is currently the Chair of East Lothian Community Health Partnership Sub-Committee and a member of Lothian Health Board. The Council is invited to nominate a Vice-Chair for the period up to 2015.

3.8 The Partnership will also include the two Chief Executives who will not be voting members but will attend meetings and provide advice and oversight.

3.9 The Scottish Government has reaffirmed its commitment to the appointment of a Jointly Accountable Officer for each partnership. This post will be at Chief Officer level for the Council and its equivalent in the Health Board.

3.10 Discussions are now well advanced with NHS Lothian regarding the process for making this appointment in East Lothian. A job description is currently being finalised for assessment and grading by both parties. A recruitment timetable has
been provisionally agreed. Arrangements for the appointment process are as follows;

- The appointment process will follow the model previously used to appoint Chief Officers to the Council in 2012
- The appointment panel will be made up of the four elected members and four NHS non-executive members of the Shadow Partnership; the Chief Executives of the Council and NHS Lothian; a senior HR advisor from NHS and the Council; an independent external adviser (see 3.11)
- Applications will be invited between 24th April and 3rd May 2013 with interviews anticipated at some point after 13th May 2013.
- Prior to completion of the appointment process by the appointment panel, an induction process for members of the Shadow Partnership will be arranged. This will enable members to discuss the role of the Partnership and prepare them for the appointment process
- The aim is to conclude the appointment process before the summer recess
- The successful candidate will be appointed with effect from 1st August 2013 and will be based in John Muir House. It will up to the successful candidate to decide whether they wish to be an employee of the Council or the NHS.

3.11 Recognising the significance of the proposal being made, it will be necessary to appoint a suitably qualified and experienced independent adviser to assist and act as a sounding board to the Chief Executives. An external management consultant will need to be procured to:

- Provide an expert opinion on the process itself
- Provide expert advice and guidance and act as Independent HR Adviser throughout the appointment process

3.12 In addition to their role within Adult Wellbeing services, the Jointly Accountable Officer will take on responsibility for NHS services in East Lothian and will carry Lothian wide NHS responsibilities which are still to be agreed. The postholder will be accountable to the Chief Executives of both the Council, and the Health Board.

3.13 The postholder will be expected to work together with Chief Officers within the Council and the Health Board, elected members and non-executive Health Board directors as well as the complete range of stakeholders to manage the transition period from the current arrangements to the full establishment of the Health and Social Care Partnership in order to ensure strong management and governance of NHS and Council services.
3.14 The Partnership will be supported by senior strategic officers from both the Council and the CHP who will attend Board meetings.

3.15 The Shadow Partnership’s remit will be to establish a Health and Social Care Partnership (HSCP) for Adult Services and to direct the workstreams required for this. The Partnership will work with East Lothian Council and NHS Lothian to consider extending the range of service provision that could be included in the Partnership’s scope e.g. Children’s Services.

3.16 It is important to note that the Partnership’s role at this point is not to manage services. Current service management, reporting and accountability arrangements will remain in place up until the point that the HSCP assumes formal responsibility for these, although the Partnership will develop management arrangements following the appointment of the Jointly Accountable Officer.

3.17 Senior Officers will prepare a workplan for the Partnership that is based upon the five strategic workstreams already underway to plan for the integration of health and social care. Workstreams will be delivered jointly by senior officers from both the Council and the CHP bringing in other stakeholders as and when required. Strategic leads for the workstreams have already been identified by the Council, and parallel leads from the NHS will now need to be agreed. The key workstreams are:

- Finance and IT
- Governance
- Outcomes
- Strategic Commissioning
- HR and Workforce Development.

3.18 The Shadow Partnership will meet for the first time in spring 2013 to agree its remit and its workplan. The Partnership will ensure the frequency of its meetings is aligned with the Community Planning Partnership Board, Council and NHS Lothian meeting cycles. Workstream groups will meet as frequently as required to fulfil agreed reporting intervals to the Partnership.

3.19 It has been agreed in principle that once established, the Health and Social Care Partnership will become an integrated element of East Lothian’s Community Planning structure that is built into the emerging Resilient People’s Board. However, as the Shadow Partnership’s role is to pave the way for the introduction of the HSCP, it is appropriate that during the shadow period, its reporting routes should remain as present to Council and NHS Committees. This should take the form of progress reports until the point where a formal HSCP is being proposed for approval.

4 POLICY IMPLICATIONS

4.1 The establishment of a Shadow Partnership Board and appointment of a Jointly Accountable Officer are consistent with the Council’s approach to reshaping care for older people and adults, the Council Plan and the Single Outcome Agreement.
5 EQUALITIES IMPACT ASSESSMENT

5.1 This report is not applicable to the well-being of equalities groups and an Equalities Impact Assessment is not required.

6 RESOURCE IMPLICATIONS

6.1 Financial – The costs associated with the establishment of the Jointly Accountable Officer post will be shared equally on a 50/50 basis between the Council and NHS Lothian and will be met from within existing resources.

6.2 Personnel - The appointment of the Jointly Accountable Officer will comply with both Council and NHS Lothian recruitment policies. The Council’s existing management arrangements will remain in place until such time as the Jointly Accountable Officer reviews and develops a new management structure, which will be the subject of a separate Council report. It is anticipated that the new management arrangements will be brought forward within 18 months of the Jointly Accountable Officer taking up post. (1st August 2013) The current Heads of Service and the relevant trades unions have been consulted on the proposals outlined above and the potential implications this may have on the current Chief Officer structure. Other - None

7 BACKGROUND PAPERS

7.1 Report to East Lothian Council on 26 February 2013 “Integration of Health and Social Care Update”.

<table>
<thead>
<tr>
<th>AUTHOR’S NAME</th>
<th>Laura Marsh</th>
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<td>Sue Cormack</td>
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<td>HR Manager</td>
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| CONTACT INFO      | Tel. 8142         |

| DATE              | 02 April 2013     |
The Shadow Partnership will focus on rethinking the model of health and social care services in East Lothian taking account of the changing demographic profile of the area, financial restraint on the Council, the NHS and our partners, and opportunities to improve the health and wellbeing of our communities.

Specifically, the shadow Partnership will;

a) Create a shared vision for the future model of health and social care in East Lothian
b) Plan towards the formation of a Health and Social Care Partnership
c) Approve a workplan containing the five workstreams described in paragraph 3.17 of the report to the Council, and seek updates from workstream leads at regular intervals
d) Ensure that its plans for the establishment of a Health and Social Care Partnership are consistent with emerging legislation and guidance
e) Create opportunities to work in partnership with families, carers, service users, communities and non-statutory partners to deliver the partners’ shared vision
f) Create the climate for excellent service delivery building on best practice and feedback from service users
g) Ensure that the Health and Social Care Partnership is founded upon a robust financial framework supported by first class service delivery and performance management systems
h) Oversee the delivery of key aspects of East Lothian’s Single Outcome Agreement
i) Ensure delivery of the national outcomes for health and social care integration.
NHS LOTHIAN

Board Meeting
24 April 2013

Chief Executive

COMMUNICATIONS RECEIVED

1 Purpose of the Report

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Government:

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<tr>
<td>1</td>
<td>PCA(P)(2013)007</td>
<td>Pharmaceutical services: Amendment to annex A: Discount Clawback scale for Proprietary Drugs</td>
<td>26/03/2013</td>
<td>PCCO</td>
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<td>CEL(2013)007</td>
<td>Hospital Eye Services</td>
<td>26/03/2013</td>
<td>MD</td>
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<td>3</td>
<td>NMC(2013)001</td>
<td>Guidance for local supervising authorities annual report submission to the Nursing and Midwifery Council practice year 1 April – 31 March 2013</td>
<td>26/03/2013</td>
<td>DN</td>
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<td>4</td>
<td>PCS(AFC)(2013)01</td>
<td>New injury allowance provisions</td>
<td>28/03/2013</td>
<td>DHR&amp;OD</td>
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<td>5</td>
<td>PCA(P)(2013)008</td>
<td>Pharmaceutical services: Discount Clawback scale for Proprietary Drugs</td>
<td>02/04/2013</td>
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Douglas Weir  
Corporate Services Manager  
15 April 2013

AFC  Agenda for Change
CEL  Chief Executive Letter  
(The designation for general circulars)
CMO  Chief Medical Officer
SAN  Safety Action Notice  
(A standard priority notice where action can be planned rather than immediate)
HAZ  Hazard Notice  
(A high priority notice where immediate action is required)
MDA  Medical Devices Agency
PCA  Primary Care Administration  
(Circulars relating to Primary Care staff i.e. P - Pharmacy, D - Dentistry)
PCS  Pay & Conditions of Service  
(Circulars relating to the pay and conditions of service of staff)
SHS  Scottish Health Service
SPPA  Scottish Public Pensions Agency
SSI  Scottish Statutory Instrument