NHS LOTHIAN

BOARD MEETING

DATE:       WEDNESDAY 23 JANUARY 2013
TIME:       1:30 P.M. - 4:00 P.M.
VENUE:      BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

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

For further information please contact Peter Reith, ☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
3.6. Midlothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 27 September 2012

4. Chairman’s Report (2.00pm - 2.10pm)  

5. Governance (2:10pm - 2:45pm)

5.1. Quality Report  
5.2. Healthcare Associated Infection Update  
5.3. Establishment of the Shadow Board of the Midlothian Health & Social Care Partnership  
5.4. Corporate Risk Register  
5.5. Improving Care for Older (Vulnerable) People in Acute Hospitals  
   Healthcare Improvement Scotland Inspections - January 2013 Update

6. Performance Management (2.45pm - 3.40pm)

6.1. Waiting Times Progress and Performance  
6.2. Performance Management  
6.3. Financial Position

7. Other Items (3.40pm - 4:00pm)

7.1. Royal Infirmary of Edinburgh Campus Redevelopment  
7.2. Internal Audit Report - NHS Waiting Times Arrangements  
7.3. Communications Received

8. Date, Time and Venue of Next Meeting: Wednesday 27 February 2013 at 1:30 p.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

9. Resolution to take items in closed session

Dates of Meetings in 2013:  
27 March 2013  
24 April 2013  
22 May 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, 28 November 2012 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 Dr A K McCallum (Director of Public Health and Health Policy).

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

In Attendance: Dr E Doyle (Associate Medical Director for Item 101); Mr J Forrest (Director, West Lothian Community Health and Care Partnership); Mr P Gabbitas (Director, Health & Social Care, City of Edinburgh Council); Professor B Reid (Dean of Postgraduate Medicine for Item 101); Mr A Jackson (Associate Director of Planning for Item 109); Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information); Ms F Mitchell (Director of Operations, Women and Children’s Services for Item 101); Mr D A Small (General Manager, East and Mid Lothian Community Health Partnership); Ms J Thwaites (Management Trainee, shadowing Mr Boyter); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications and Public Affairs).

Apologies for absence were received from Mr M Ash, Professor J Iredale and Ms A Meiklejohn.

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 Kay Blair declared an interest as a Non Executive Board member of NHS 24 which impacted on a number of Agenda items. Mr Walker also declared a non-financial interest on the Agenda item on Paediatrics as his partner was a Consultant in Obstetrics and Gynaecology at St John’s Hospital.

Re-Ordering of the Agenda

The Chairman sought and received permission to re-order the Agenda to allow the Paediatrics paper to be discussed immediately following the Minute section of the Agenda.
97. Minutes of the Previous Meeting of Lothian NHS Board held on 24 October 2012

97.1 The Minutes were approved as a correct record.

98. Matters Arising

98.1 Diabetes – Dr Farquharson referred to debate at the previous Board meeting about levels of diabetic patients receiving amputations in Lothian. It was noted in Lothian 0.6% of Type 1 diabetes patients received amputations compared to the Scottish Average of 0.8%. The position in respect of Type 2 diabetes was 0.5% which was the same as the Scottish average. In the last decade the position had reduced from 1% overall in 2002 to a level of 0.6%. In terms of further work undertaken on the integrated resource framework it had been demonstrated that over the previous 3 years there had been a fall in inpatient costs probably related to better self treatment.

98.2 Royal Hospital for Sick Children – Mrs Goldsmith advised that the 11 lenders had now signed off on the final agreement on enabling work. Work was underway to identify a revised OJEU (Official Journal of the European Union) advertisement date.

98.3 Standards of Care for Older People – Mrs Hornett reminded the Board that an unannounced Older People’s Inspection had been undertaken at the Royal Infirmary of Edinburgh at the end of August. The work previously advised to the Board to address identified shortcomings continued as did work around the Vulnerable People’s Action Plan previously agreed by the Board.

98.3.1 It was noted since the previous meeting a more focussed approach had been taken to making improvements in some parts of the Royal Infirmary of Edinburgh site.

98.3.2 Mrs Hornett advised from 22 November until the end of March 2013 in the first instance in 14 key areas additional registered nurse input would be provided to allow Charge nurses in a supervisory capacity to better manage the care of patients.

98.3.3 The Chief Executive commented there were links between this issue and the later agenda item on Unscheduled Care which demonstrated ongoing pressures in the system. He felt some of the criticism of the Royal Infirmary of Edinburgh by Inspectors was in part related to the number of patients presenting for treatment which the system had difficulty in dealing with. It was therefore important to bear in mind the pressures experienced and the very real mitigating actions being taken for the benefit of patients.
99. Committee Minutes

99.1 Audit and Risk Management Committee – Minutes of the Meeting held on 9 October 2012 – The Board adopted the tabled Minutes which reflected the Committee Chair’s comments. It was noted the NHS Lothian revised Risk Register had been considered and referred back to the Risk Management Steering Group for further detail. An update on the Risk Register would be submitted to the Board in January 2013.

99.1.1 Mr Brettell reported that the Committee had been concerned about the number of outstanding management actions in respect of Internal Audit Reports which it was felt were currently too high. The Chief Executive reported that actions were underway to address this issue.

99.2 Finance and Performance Review Committee – Minutes of the Meeting held on 10 October 2012 – the Board adopted the Minutes. Mrs Goldsmith advised good progress had been made around the backlog maintenance agenda with a framework contract about to be signed for between £8-10m across a number of sites. In respect of the reopened wards at the Royal Victoria Hospital it was not anticipated there would be any immediate implications although this would need to be revisited if the facility remained open beyond March 2013.

99.3 Service Redesign Committee – Minutes of the Meeting held on 8 October 2012 – the Board adopted the Minutes.

99.4 West Lothian Community Health and Care Partnership Sub Committee – Minutes of the Meeting held on 18 October 2012 – the Board adopted the Minutes noting the debate around the outcomes of the “Looked After Children’s Reform Bill and Violence Against Women”.

100. Chairman’s Report to Lothian NHS Board

100.1 The Chairman drew the Board’s attention to the positive progress being made with Local Authority colleagues in respect of the move towards Health and Social Care Integration. He advised there had been a slight delay in appointing Chairs to the East and Midlothian Partnership Boards and this would now occur during February 2013. The Board noted there was still a strong likelihood of shadow arrangements being in place across all of Lothian by 1 April 2013. Councillor Toner undertook to provide the Chair with a formal note advising of West Lothian Council’s proposed approach.

101. Paediatric and Neonatal Medical Workforce Update

101.1 The Chairman welcomed Dr Doyle, Ms Mitchell and Professor Reid to the meeting.

Dr Farquharson confirmed the Board’s commitment to provide 24/7 paediatric services at St John’s Hospital although this was dependant upon addressing challenges around medical staff. It was noted by May 2013 Trainee Doctors numbers would have reduced by 33%. This was critical as the service was
dependant upon Trainees to provide 24/7 cover. Dr Farquharson advised during periods of challenge that the South East and Tayside (SEAT) Planning Group agreed a hierarchy of priorities when allocating Trainees to the service.

101.2 Dr Farquharson reported in the long term work was progressing to support the service with trained Doctors and Nurse Practitioners. In addition the following 3 strands of activity had been agreed with the Scottish Government Health Directorates:-

- Approval of a Business Case for 4 Neonatal Fellows
- An international recruitment campaign
- Development of a Scottish based strategy to support advanced Nurse Practitioners

101.3 Dr Farquharson assured the Board that no stone was being left unturned in working towards a solution to provide services at St John’s although it was important to stress that these needed to be safe, consistent and practical. He explained to the Board the role of the Neonatal Fellows.

101.4 Mr Johnston questioned what further recruitment was needed to provide sustainable services at St John’s to stop the reliance on trainees. Dr Doyle advised 9 people were required to provide cover and that these needed to have a range of competencies to make decisions safely and these could be Consultants, specialty doctors or advanced Nurse Practitioners.

101.5 The Chief Executive advised in respect of the recruitment to the additional staff posts that Mr Boyter was leading an international recruitment exercise. Dr Doyle reminded the Board there had been an ongoing series of recruitment plans and further worldwide focus was now being applied to what was an iterative process. Mr Boyter reported that the forthcoming international exercise would include targeted creative advertisements in the British Medical Journal and equivalent international journals. Specialist agency and job seeker arrangements would be put in place assisted by the creative use of Google. Mr Boyter advised with the exception of 4 specific areas because of ethical considerations the recruitment process would go worldwide. Links would be made with Fife and Borders NHS Boards in respect of the recruitment process. The posts would be advertised on a permanent basis with the Scottish Government Health Directorate providing the vast majority of resources needed to launch the recruitment plan.

101.6 Ms Mitchell and Dr Doyle explained some of the reasons for the difficulties being experienced in recruiting to the St John’s posts and the reasons therefore for linking the jobs between Edinburgh and St John’s to make them more attractive in a competitive recruitment market. It was noted recruitment to Neonatal services had been easier because St John’s was a thriving medium size unit with a special care baby unit and therefore provided viable jobs for medical and nursing staff. The position on paediatrics was different because the unit was small with low levels of activity and non complex cases and this affected peoples recruitment choices.
101.7 Dr Doyle advised there had been a reduction in inpatient activity at St John’s because the success of the consultant presence meant less patient activity with consultants discharging patients earlier with proper management plans.

101.8 Professor Reid advised the difficulties being experienced were not unique to Lothian and represented a regional and national problem. He reminded the Board that previously the Royal College of Paediatric and Child Health had pointed out specific issues around the viability of small units. It was reported units south of the border had closed because of the rationalisation of services. He commented that NHS Lothian’s commitment to maintaining and keeping hospital services open had been impressive. Professor Reid advised he had been attending crisis meetings in Lothian for about 4 years.

101.9 Councillor Toner expressed concern that from the detail contained in the paper he could find no evidence base for making the recommendations and it offered him no security of ward. He noted also that there was no Appendix detailing the SEAT outcome of the review. Councillor Toner reminded the Board that when the issue around paediatrics had come to light it was reported that this was the first of many such pressures. He commented he would welcome more information than provided in the paper about the reasons for the service gap.

101.10 The Chief Executive commented that colleagues had been working for a period of months to come up with an action plan and SEAT would be meeting later in the week to finalise its review. The outcome of the review would be circulated to Board members when available and would also form part of a comprehensive engagement process with patients and families. Professor Reid reported that paediatric trainees like other trainees had prescribed training experiences to undertake to provide them with experience of a wide range of decisions before later working in district general hospitals to apply their experience gained over the first 2 years. He advised that maternity leave was a challenge for the programme and had been extremely high and represented one of the main reasons for the gap in rotas across the United Kingdom. An additional key factor was the reduction in hours that trainee doctors were permitted to work which was now 48 hours per week and adherence to that was heavily policed. Professor Reid commented the paediatrics programme was one of the best in the UK and part of its success meant people stepped out of the programme to undertake PhDs and other vocational based training. Changes in the UK border agency rules had meant that the UK was no longer as attractive a place for people from the rest of the world to come and work in. Professor Reid advised currently there was a reliance on the locum pool to fill the gap in the rota.

101.11 Councillor Toner welcomed the fact people were not being encouraged to work long hours and stated that the feminisation of the workforce was also positive. He commented in respect of SEAT prioritisation that the paper suggested that training would no longer be available in wards at St John’s Hospital. Professor Reid referred back to the independent review undertaken by the Royal College to advise on how trainees would be deployed and the fact this had advised that the volume and nature of experience received was not sufficient and a plan had been set not to deploy trainees from August 2013 with this having been advised to SEAT. Professor Reid felt there would be issues beyond February 2013. It was noted
there was sufficient activity to engage trainees during the day but not enough patients to warrant trainees being resident on site.

101.12 The Chief Executive commented that Lothian, Borders and Fife NHS Boards had to agree how posts were distributed and to ensure that clinical priorities matched the training needs. He advised the consequences of services closing meant patients needed to go elsewhere for treatment for example to Edinburgh. It was important to maintain the busiest services dealing with critically ill patients in a manner that offered the best training. In that respect the distribution of trainees needed to be agreed with Professor Reid.

101.13 Dr Doyle stressed the importance of recognising the range of other children’s services available in West Lothian and the rest of Lothian. He advised the outpatient service was thriving for general and specialist services. Day case surgery also represented a positive story. It was noted these other available services were all provided by trained doctors. Dr Doyle commented the context of the current paediatrics position was important given the breadth of the rest of available children’s services in NHS Lothian.

101.14 Ms Blair suggested contingency planning over the winter period would be important. The Chief Executive reiterated that NHS Lothian would leave no stone unturned to maintain services although there was a need for a contingency which would replicate the one put in place during the summer. He reminded the Board that even currently a lot of patient activity went straight to the Royal Hospital for Sick Children. Dr Doyle reported there had been a multi-agency meeting in May 2012 with a clear consensus amongst clinicians, primary care, Scottish Ambulance Service and the Lothian Unscheduled Care Service that the biggest direct risk was to have an unplanned and unmanaged inability to staff a service and this had led to the recommendation leading to the July position which as previously stated remained the contingency position. He commented that the patient pathway only changed for less ill children as all emergency paediatric surgery and major trauma went to the Royal Hospital for Sick Children.

101.15 The Chief Executive stressed should a temporary and more urgent change to services at St John’s be required to maintain patient safety, NHS Lothian would require to undertake an immediate and extensive interim process of informing those directly affected by this temporary reduction in service. This would include media coverage, Public Partnership Forum networks, the St John’s Stakeholder Group, information for frontline staff to pass onto parents and families, linking into West Lothian Council’s public networks and contact systems as well as informing key service providers such as GPs, NHS 24, Scottish Ambulance Service and related clinical teams. The PFPI engagement process in relation to the longer term options would need to start as soon as possible in early January with a draft plan currently being developed.

101.16 Mr Gabbitas provided further context by advising that during his 6 year tenure as Chief Executive of the former West Lothian NHS Trust paediatrics had even at that time represented the single biggest risk. He had struggled with viability issues and had been directly involved in crisis meetings with Professor Reid’s predecessor. He was clear if the former Trust’s position had continued the current situation would have been reached much earlier. He was confident that the Board and
Edinburgh based colleagues owned the problem and it was a tribute to them that they had managed to keep services going for so long.

101.17 Dr Williams advised he was assured to hear no stone had been left unturned. He understood the position about small numbers of patients and the lack of complex cases and questioned whether consideration had been given to the possible input from GPs in training and also the use of GPs with a paediatric qualification. Dr Doyle commented the GPs based at St John’s Hospital did not have the confidence to undertake out of hours work. It was noted that previously Mr Boyter had written to GPs with only 5 expressions of interest having been received. It was agreed Mr Boyter would repeat the exercise through the engagement process.

101.18 Mr Walker recognised the need to deliver the right kind of care at the right time by the right people. He commented it had been useful to learn of the re-establishment of the staffing group. He commented he needed reassurance that a pan-Lothian solution was being pursued as he currently did not get the feeling there was much flexibility at the Royal Hospital for Sick Children to operate on a pan-Lothian basis. In respect of activity not being suitable for training he questioned whether this could not be redirected with consideration being given to the balance of activity. He also questioned whether the on-call neonatologist could cover the Unit. Mr Walker also sought details of the numbers of people “out of programme” and why they could not work on the on-call rota as was the case elsewhere in Scotland.

101.19 Dr Doyle advised in respect of consultants in Edinburgh covering St John’s that the units at the Royal Hospital for Sick Children and the Simpsons Memorial Material Pavilion were extremely busy units supporting the rest of Scotland. The neonatologist at SMMP was trained in the speciality and was a long way from being a paediatrician and for clinical governance reasons it would not be reasonable to ask for cover to be provided. Consultants in Edinburgh were in specialist roles and ran sub-specialist rotas and therefore already had out of hours commitments. Dr Doyle commented that the rezoning of patients was a possibility.

101.20 Ms Mitchell commented consideration had not been given to children in Edinburgh moving to St John’s although she suspected in clinical governance and public perception terms this would be unacceptable. Dr Doyle commented in respect of people out of programme he was aware of one person being on the out of hours rota. He advised 4 people were currently out of programme not all in Edinburgh and they were all aware of the availability of shifts in the regional rota.

101.21 The Vice Chair noted the issues around recruitment and working time regulations and suggested a development plan needed to take account of the whole region in order to understand what was happening in neonatology and paediatrics over the next few years. Dr Doyle commented this was a sensible suggestion and advised obstetrics was likely to be the next pressure point.

101.22 The Chief Executive advised medical staffing issues featured high on the risk register although it was important to recognise that knowing about a problem did not mean it was capable of being resolved. It was noted that SEAT had agreed to undertake a specific risk assessment across all medical specialities. He advised that the recruitment model that would sustain services would be one which would use the hook of high volume and complexity to attract candidates with there being
an inbuilt requirement to cover low volume less complex work at St John’s with this approach already having proven to be successful in recent recruitment initiatives.

101.23 The Board noted that the announcement about the Scottish Nurse Practitioner Strategy was important and was part of the medium to longer term solution with the key issue being about how to manage the service in the interim.

101.24 Dr Bryce stressed that the engagement process should be about debate and not presenting participants with options that had already been worked through. She commented patients would be concerned to know that transport arrangements between St John’s and Edinburgh were in place. The perspective of families and their concerns needed to be heard and responded to. Parents would be looking for peace of mind that their children were getting to the correct hospital quickly and they would be able to visit them. Dr Bryce suggested if this engagement was handled properly this would help with public confidence.

101.25 Councillor Toner made it clear he could not support the recommendations in the paper for the reasons previously described. The Board noted Councillor Toners position and agreed the following amended recommendations containing suggestions from Mr Johnston:-

- Note the forecast position regarding gaps in the paediatric middle grade rotas in the South East of Scotland from February 2013 and the service and patient safety risks that this presents for all of the services in the region.

- Endorse the Board’s absolute commitment to working to ensure the sustainable delivery of 24/7 paediatric and neonatal services at St John’s Hospital and to ensure the continued provision of safe services for babies and children in all acute facilities across the South East Region.

- Approve the immediate actions to be taken with the intention of ameliorating the pressures in the short term, including a further international recruitment initiative using external agency support to attempt to fill rota gaps left by trainee vacancies.

- Confirm the need to identify and implement a long term sustainable solution for paediatrics and neonatal services including the provision of 24/7 paediatric and neonatal services at St John’s Hospital and across Lothian and the rest of the South East.

- Approve the immediate development and implementation of a comprehensive engagement process with stakeholders between December 2012 and February 2013 to explore all options for achieving that outcome.

102. Quality Report

102.1 Dr Farquharson advised that the focus of the current report was on the clinical effectiveness measures around cancer performance. He provided detailed information to the Board on the Scottish Patient Safety Programme. In respect of SMRO Data there was a particular challenge in meeting the 20% reduction target
by 2015 given the positive benchmark position from which NHS Lothian had started.

102.2 Mrs Hornett commented in respect of pressure sores that the data collection process was in its infancy although better standardisation of information was becoming available.

102.3 Councillor Henderson noted in respect of formal complaints that there was an upwards trajectory and questioned whether this was an issue of concern. Mr Boyter as lead Executive Director reminded the Board that people were encouraged to complain and in one respect increasing complaints could be viewed as positive. He undertook to bring a more detailed paper to a future Board meeting covering trends by hospital and category as well as actions taken to address complaints. The Chair suggested the paper should be categorised as feedback rather than complaints. Mr Boyter advised he would also include details of compliments received.

102.4 Mr Walker questioned the position in respect of incident reporting and the need to conclude this within 60 days commenting there appeared to be slippage in this area. He asked for details of the steps being taken to address this issue in light of recent media attention. Dr Farquharson advised of a Health Improvement Scotland assessment process which had as a key focus the need to learn from incidents, escalation processes and responsibility for closing down incidents. NHS Lothian would be assessed by HIS in 2013. Mrs Hornett commented in terms of the slippage that the people responsible for meeting the 60 days timelines were the same people who were dealing with challenges around unscheduled care, waiting times and workload issues. It was noted both she and Dr Farquharson were discussing providing additional resource to provide capacity in this important area.

102.5 The Board agreed the recommendations contained in the circulated report.

103. Healthcare Associated Infection Update

103.1 Dr McCallum commented that the circulated paper represented her regular update on progress and actions to manage and reduce healthcare associated infection across NHS Lothian.

103.2 The Board noted the system was currently in the Norovirus season. Dr McCallum commented Lothian was fortunate to have good infection control practice in place allowing Norovirus to be restricted to bays rather than the whole ward with very few staff affected. She commented however, there were parts of the organisation where patients were cared for in old bays and open areas where the infection was harder to control and contain.

103.3 Dr McCallum advised challenges continued with patients coming to hospital and developing staphylococcus aureus bacteraemia and that each case was investigated. Further work in this area was underway with Health Improvement Scotland. It was noted that NHS Lothian as a tertiary and academic system was constantly on alert for new organisms. Dr McCallum commented it was difficult at this stage to provide comparative data on the current spread of Norovirus.
benchmarked against previous years although she had a sense that the pattern had occurred earlier in the season each year and with different strains. It was also no longer the case that once a patient had contracted Norovirus that they would be immune in future.

103.4 The Board noted the recommendations contained in the circulated report.

104. Management Culture Work Programme Progress Report

104.1 The Chairman introduced a circulated paper advising this had been prepared in response to discussion at the previous meeting. He detailed the membership of the Management Culture Steering Group advising this was supported by senior management input and was accountable to the Scottish Government Health Directorate. The Board noted the paper set out a summary of the various workstreams which were being undertaken in parallel with a 5x5x5 project focussing on discussing with staff issues around the Lothian values. The Board noted from the report the significant level of work being undertaken.

104.2 Mr Boyter advised that 2,000 staff had been contacted through the workshop sessions with more engagement planned. He advised if staff were unable to attend the workshop designated for their own workplace then they were able to attend any other session within Lothian. Mr Boyter commented his Team had been as flexible as possible to ensure staff engagement was as consistent as it could be across all sites.

104.3 The Chair reported the intention was to produce a statement on how people should work within the NHS in Lothian and the expectation of employees was important in what would essentially become a cultural contract which as well as covering NHS Lothian staff would extend to other partners that NHS Lothian worked with.

104.4 The Chair advised he would bring further updates to the Board as appropriate.

104.5 The Board received the update report on the work of the Management Culture Steering Group.

106. Performance Management

106.1 Professor McMahon advised that performance issues around the 4 hour access target, unscheduled care and waiting times would be covered under other headings. The other key issues related to the 62 day cancer target and stroke. It was noted actions had been put in place to improve performance in these areas.

106.2 The Chief Executive commented in respect of cancer activity that spikes in urgent referrals could displace elective activity although it was positive that people were coming forward for treatment early as this lead to better outcomes. Professor McMahon anticipated there would be an activity spike around endoscopy.
Mrs McDowell questioned under the revised Committee structure whether this issue would come under the Audit and Risk Management Committee. Mr Brettell reported the Audit and Risk Management Committee would look at systemic risk and risk associated with individual departments which would continue to rest within the local areas. The Chair commented dependent upon circumstances risk might be escalated to the Corporate Risk Register. Mrs Goldsmith advised the intention was that the Healthcare Governance Committee would be responsible for risk in clinical areas and should ensure mitigation was in place and if necessary ensure issues were escalated upwards. She commented that there was a need to move towards identifying areas of high level risk starting with the Corporate Risk Register. The Chief Executive suggested that all Board performance committees should include risk as a standing agenda item.

Dr Bryce questioned in respect of the profile of suicides when evidence would be available around access to psychological therapy. Professor McMahon advised he had been discussing with the Scottish Government Health Directorates the issue with the challenge being set that by the summer robust information would be available to provide a sense of how the system was meeting demand within the available capacity.

Mr Walker questioned what actions were being taken in respect of delayed discharge performance and whether this was included on the Risk Register. Professor McMahon advised delayed discharge was on the Risk Register and that actions were being taken forward through the unscheduled care work. Mr Walker commented clarity was not yet evident in the paper around elements or performance and who was responsible for taking action. Mr Small reported that East Lothian trends were out of alignment with remedial actions being discussed and agreed with Professor McMahon.

Mrs Hornett advised delayed discharges were being discussed by the Unscheduled Care Group because they were an integral part of the problem. Mr Walker stressed future reports needed to be clear about where responsibility for delayed discharge performance sat in terms of responsibility as well as providing an understanding of the transitional process.

The Chair questioned whether it was over ambitious to attempt to cover all performance issues in a single paper and suggested it should be limited to HEAT targets with reporting on other issues via a separate paper. Professor McMahon would progress.

The Board noted the Performance Management paper.

**Unscheduled Care**

Mrs Hornett advised that the circulated paper reported on the October position which was reporting performance overall of 93% against a 98% target for 4 hour emergency access. She advised however the position had worsened in November. The Board noted that the implementation of actions continued through improved decision making by consultants at the front door and in primary care.
107.2 The Board noted that social care pressures continued although there had been some impact from investments as detailed in the paper. It was reported although capacity and investment in social care was rising so was demand. Mr Gabbitas and Mrs Hornett were working with Scottish Government Health Directorate colleagues to undertake an analysis of the reasons behind the trend.

107.3 Mr Gabbitas reported there had been a modest improvement in the delayed discharge position in November. He commented there had been a £5m recurrent increase in investment in care at home capacity. The number of admissions remained constant. The anticipated reduction in delayed discharges had not occurred and the work with Scottish Government Health Directorate colleagues would allow a move away from anecdote to an understanding of the issues behind the figures.

107.4 The Board supported the recommendations contained in the circulated paper.

108. Acute Services Unscheduled Care Capacity

108.1 Mrs Hornett explained the need for urgent extra capacity to be provided at the Royal Infirmary of Edinburgh site and reminded the Board that the November performance against the 4 hour emergency access target had been poor. She advised that many patients were experiencing lengthy waits in the Emergency Department and 15 elective surgery cases had been cancelled in November due to lack of bed availability. Norovirus outbreaks have caused additional pressure because of the need to close wards and restrict patient transfer to limit the spread of infection. Mrs Hornett commented in the past 2 weeks at the Royal Infirmary of Edinburgh the pressure had been immense and could not be a sustainable model to meet patient safety hence the urgent need to increase capacity. She advised the quickest way to achieve this was to reopen closed capacity including some areas at the Western General Hospital opening in January 2013 as part of winter planning.

108.2 The Board were advised by Mrs Hornett that the decision to reopen wards 1 and 2 of the Royal Victoria Hospital had been taken with patients moving in over the course of the next 2 weeks. Mrs Hornett commented the move back to the Royal Victoria Hospital was a short term solution to a clinical inpatient safety issue and she would hope that the Royal Victoria Hospital was utilised for a short a period as possible. She advised that the facility would be used for patients who no longer needed a medical intervention.

108.3 Mrs Hornett reported there was a longer term need to increase beds at the Royal Infirmary of Edinburgh. Proposals for potentially 60-70 beds were being worked up as were costs and timescales with a view to beds being available by late summer 2013. It was noted the Business Case would be considered by the Finance and Resources Committee and this would hopefully provide the exit plan for the Royal Victoria Hospital.

108.4 The Chief Executive stressed that the Royal Infirmary of Edinburgh was too small and that there was a need to create extra capacity although phasing issues meant capacity could not be turned off at the Royal Victoria Hospital. There would
however be a need to stop admissions to the Royal Victoria Hospital once capacity was available at the Royal Infirmary of Edinburgh and work would continue with Mr Gabbitas and his Team in this respect. The Chief Executive commented some patients did not neatly fit a specialty model and there was a need to introduce general capacity to meet the complex needs of patients and this approach had the unanimous support of senior clinicians.

108.5 Mr Wilson questioned why the Board had not received a paper in the months leading up to the current position. The Chief Executive reminded colleagues that at his first Board meeting 7 months previously he had set out the challenges around unscheduled care and the need for additional investment. He commented additional capacity had been opened from the previous winter and had not been stepped down during the summer months. The Chief Executive advised the system would not have survived winter without opening additional capacity and for that reason the urgent operational decision had been taken to reopen the Royal Victoria Hospital facility.

108.6 Mrs Hornett commented although a winter plan was in place the system was experiencing considerable pressure including outbreaks of Norovirus earlier than in previous years. Mr Wilson felt the position was more fundamental than solely the onset of winter.

108.7 Dr McCallum reported that around 50% of emergency admissions were associated with deprivation with there being an increased risk of admission once people reached 40-45 years of age. She advised multiple morbidity in Scotland was now mapped and provided better evidence on which to manage service provision. She commented evidence from other countries suggested there would be a negative impact associated with the recession. She commented there was a range of excellent services available for vulnerable people to avoid admission to hospital as well as speeding up discharge.

108.8 Dr Williams welcomed the comments that the Royal Infirmary of Edinburgh was undersized and stated that GPs had at the time stressed the need for an increase in resources in Primary Care before the Royal Infirmary of Edinburgh opened. He advised although he was delighted that hospital doctors were on board with the proposed direction of travel it would also be important to engage with Primary Care. Dr Williams stressed the importance of not falling into the same trap with the new Royal Hospital for Sick Children as had been experienced with the Royal Infirmary of Edinburgh. Mrs Goldsmith commented the previous difficulties would not recur as a completely new commissioning model was in place. She commented however that there would be significant construction work on the Royal Infirmary of Edinburgh site which would not be without challenge.

108.9 The Chief Executive advised in respect of developing long term clinical capacity that a key issue was to put a number of stakes in the ground and the need to increase capacity at the Royal Infirmary of Edinburgh provided the opportunity to be creative. The Board noted a strategic development event for the Board would be held on the 18 December. The Chief Executive reminded the Board that the population would increase by 10% in the next 10 years and there was therefore a need for future proofing of services.
108.10 Mr Walker felt that the direction of travel represented smart pragmatic thinking by the Executive Team and he had raised at the former Finance and Performance Review Committee the need for a master plan across the 3 main acute sites in Lothian. He stressed the master plan needed to reflect the 3 sites and not just the Royal Infirmary of Edinburgh. He felt that developing capacity at the Royal Infirmary of Edinburgh would not be straightforward.

108.11 The Chief Executive concurred with Mr Walker advising that the strategic debate scheduled for 18 December would be the start of the process to plan and develop services across Lothian and would include St John’s Hospital which would be a vibrant part of NHS Lothian’s future plans. He advised however that the Board needed to be aware that the Royal Infirmary of Edinburgh was currently uniquely compromised in its ability to treat patients.

108.12 Mr Wilson questioned the position in identifying a funding source for 60 beds which were being tendered at a cost of around £1.4m. Mr Gabbitas advised he was from a City of Edinburgh Council perspective proceeding in order not to lose out on capacity to self-funders even although the funding was not currently identified. The Chair commented as Mr Wilson was a member of the Edinburgh CHCP he could assist in the process of identifying suitable resource.

108.13 The Chief Executive stressed that the tendering process was being led by the City of Edinburgh Council not NHS Lothian. He commented there was a need to develop a joint older peoples’ commissioning strategy and that specific care home capacity in the City of Edinburgh would be at the heart of this process.

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

109. Waiting Times Progress and Performance

109.1 Dr Farquharson advised that good progress continued to be made although there remained a number of inpatients requiring complex procedures and suffering from complex medical problems for whom solutions continued to be sought by the end of December. In respect of outpatients waiting more than 12 weeks the numbers were falling through continued use of the See and Treat model. It was important to recognise that the See and Treat model was not appropriate for all patients.

109.2 The Board noted that the work ongoing to reduce the long delays being experienced by patients waiting for surveillance and other “repeat” endoscopies and the timescales to resolve the difficulty had reduced from 18-24 months to 12.

109.3 Dr Farquharson commented that the paper also described the appointment to additional consultant posts and theatre staff. Mr Jackson provided the Board with a PowerPoint presentation covering progress to date; activity; inpatients and day case waiting lists and the outpatient waiting list. The Vice-Chair stressed the need not to underestimate the extent and importance of back office tasks. She commented there was also a need for future reports to incorporate the patient view. The Chief Executive commented this was possible and provided positive feedback on a recent visit to the external provider office which had provided some rich patient data.
109.4 Mr Brettell commented in respect of paragraph 9.2 of the report that the Audit and Risk Committee had discussed and welcomed the Audit Report on Waiting Times and the development of the framework dashboard indicator. Mr Brettell commented the waiting time numbers appeared to have remained static in respect of the total list size and there was a need to better understand the numbers. Mr Jackson suggested there would be merit in holding a development session for Board members in order to look at data at the correct level of detail.

109.5 Mr Walker questioned the position in respect of unavailability and sought clarity on the new guidance. Mr Jackson advised that the standing operating procedures had been updated and circulated to staff. Further central advice was being sought and would be shared with staff as soon as it became available.

109.6 The Board agreed the recommendations made in the circulated paper.

110. Mid Year Review and Financial Position to 31 October 2012

110.1 Mrs Goldsmith commented the Mid Year Review forecast that NHS Lothian would deliver financial breakeven in the current year. It was noted that an increase in resource for waiting times was required although this incorporated the recovery plan for surveillance scoping and double running costs. Costs had increased from initial estimates because case mix had become more complex than initially anticipated.

110.2 The Board noted that the Local Reinvestigation Plan (LRP) target had been adjusted for the year reflecting the impact of the projected prescribing benefit of £5.2m. In addition a favourable movement in balance sheet provision, including clinical negligence, had been identified as part of the Mid Year Review process and was now reflected in the reported financial position. Mrs Goldsmith reported that £12.2m of LRP had been identified on a non-recurrent basis and she felt the system would require 2 years to get back into recurrent balance given the requirement for investments in capacity and waiting times. She advised that the financial plan would be discussed by the Finance and Resources Committee and thereafter by the Board.

110.3 Ms Blair suggested there was a need for the Board to receive assurance around key risks and questioned how these would be reported back. Mrs Goldsmith advised in the first instance this would be through the Finance and Resources Committee and then to the Board. It was noted a workshop had been held the previous week to look at plans and opportunities.

110.4 Mr Walker commented what was being reported represented a good outcome. He requested moving forward there was a need for reports to link activity data with financial investment. Mrs Goldsmith agreed commenting it would also be important to do a similar read across for the waiting times report.

110.5 The Board noted the financial position and the projection that financial breakeven would be achieved.
111. **Human Resources and Organisational Development Strategy – Update and Revisions**

111.1 Mr Boyter advised that the strategy had been approved by the Board the previous year and ran from November 2011 through to March 2014. He commented the Board paper took account of developments in-year including the Bowles report. Appendix 2 set out progress against the first 12 months of the strategy.

111.2 Ms Mitchell commented there was nothing in the paper detailing the level of activity and focus in workforce planning, redesign and modernisation. Mr Boyter advised workforce planning was the largest workstream and commented at the previous Service Redesign Committee a detailed presentation had been provided which he would be happy to share with colleagues. The presentation had anticipated workforce demands and the key challenges facing the system. Mr Boyter referred back to the detailed debate held earlier in the meeting around paediatrics and commented that this in conjunction with medical staffing being identified as a key risk confirmed that workforce planning was at the heart of the work undertaken by the Human Resources and Organisational Development Department.

111.3 Mr Johnston advised he was pleased to note that NHS Lothian had over delivered in making available employment placements to 16-24 year olds and that this deserved recognition in difficult economic times. The Board agreed the recommendations contained in the circulated paper.

112. **Integration – Hosted Services**

112.1 Professor McMahon advised the paper updated on discussions held with the Senior Leadership Group at an event held on 31 October involving staff from various agencies including Councils and Social Care. It was reported 6 areas had been identified for further discussion and these were detailed in the paper.

112.2 Professor McMahon advised that the paper either confirmed some services would stay the same under integration or that a new model was needed through engagement with clinicians and this work would progress to a 31 March 2013 timescale. Areas had been identified where further consideration was needed for example in dentistry and children’s services and work also continued in these areas.

112.3 The Board noted the progress being made in the integration of Hosted Services.

113. **Standing Financial Instructions and Scheme of Delegation**

113.1 The Board agreed the Standing Financial Instructions and Scheme of Delegation and agreed that these should be issued to all Board Committee Chairs to confirm they had received and understood them.

114. **Committee Memberships**
114.1 The Board agreed to appoint Professor J Iredale and Mr R Wilson as Non Executive Board members of the Service Delivery Group and to appoint Ms Kay Blair as a member of the Finance & Resources Committee as well as Vice-Chair of the Shadow Edinburgh Health & Social Care Partnership Board.

115. Shadow Health & Social Care Partnership Board Memberships

115.1 The Board agreed the proposed membership for the Edinburgh and West Lothian Shadow Health & Social Care Partnership Boards as detailed in the circulated paper.

115.2 The Chairman advised recommendations for appointment to the Shadow Health & Social Care Partnership Boards for Mid Lothian and East Lothian would be brought forward to a future Board meeting.

116. Scottish Patient Safety Programme – 5 Year Update

116.1 Dr Farquharson commented when he had reflected on what had been achieved on the Scottish Patient Safety Programme agenda he had felt it was so powerful that he wanted to share it with the Board. He reported in the first year of the Programme Lothian had no Fellows with their now being 10 which demonstrated commitment to the Programme. Another positive indicator was that 575 days had passed without a central line infection. The surgical safety briefings had also been well received by clinical staff. It was noted from a Primary Care perspective positive progress had been made on Warfarin management.

116.2 The Board noted the positive progress being made.

117. Date and Time of Next Meeting

117.1 The next meeting of the Lothian NHS Board would be held at 1:30pm on Wednesday 23 January 2013 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

118. Invoking Standing Order 15.2b

118.1 The Chair sought permission to invoke Standing Order 15.2b to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke Standing Order 16b. The requirement arose from the need to discuss items of commercial confidentiality that would not be appropriate at a meeting in public.
PAEDIATRIC STAFFING

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on paediatric and neonatal workforce issues across the SEAT region.

2 Recommendations

The Board is recommended to:

2.1 Note the actions that have been taken since the Board meeting in November 2012 to manage these issues.
2.2 Approve the actions underway to mitigate the risks associated with the current shortages in paediatric and neonatal staffing.

3 Discussion of Key Issues

3.1 The key issues were presented to the Board on 28 November 2012.
3.2 Since then the SEAT Boards have undertaken a world wide recruitment campaign to attract consultant paediatricians, consultant neonatologists, specialty doctors in paediatrics, clinical fellows in paediatrics, neonatal clinical fellows, advanced neonatal nurse practitioners and advanced paediatric nurse practitioners to the paediatric and neonatal units in the region. This campaign is being coordinated by Havas, a leading recruitment agency with experience of recruiting to hard to fill medical posts.

3.2.1 The campaign comprises a series of measures
- Research to identify overseas talent
- Targeting of passive jobseekers
- A Google Ad words and Display Network Campaign
- A Linkedin campaign
- Production of a microsite on the internet to showcase the posts in Borders, Fife and Lothian
- Engagement of a medical recruitment search / headhunting agency
- Advertisements in paper and electronic versions of a number of leading paediatric and neonatal journals and the Sunday Times

3.3 During December 2012 and January 2013 the Medical Director and Director of Human Resources and Organisational Development had several meetings with paediatricians and neonatologists at St John’s, the Royal Infirmary and the Royal Hospital for Sick Children to better understand the fine detail of the staffing challenges facing paediatric and neonatal services in Lothian and more widely and to discuss potential measures to mitigate these.

3.4 The Director of Human Resources and Organisational Development has written to local General Practitioners to assess the number of General Practitioners who
have the necessary competencies to work at middle grade trainee level in paediatrics and neonatology and to assess the level of interest among those people in undertaking shifts in hours and out of hours particularly at St John’s to help sustain paediatric and neonatal services there.

3.5 The anticipated staffing situation for middle grade paediatric trainees across the region from February is shown below. The situation is fluid and staffing at the neonatal unit at RIE and the paediatric intensive care unit at RHSC is expected to be reduced further during the spring and early summer.

<table>
<thead>
<tr>
<th>Borders General</th>
<th>Victoria Kirkcaldy</th>
<th>RHSC Edinburgh</th>
<th>PICU Edinburgh</th>
<th>Simpson’s Neonatal Edinburgh</th>
<th>St John’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainees required for a viable OOH rota</td>
<td>5.0</td>
<td>10.0</td>
<td>13.0</td>
<td>5.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Trainee numbers for OOH from February 2013</td>
<td>3.0</td>
<td>7.7</td>
<td>12.2</td>
<td>5.0</td>
<td>7.5</td>
</tr>
</tbody>
</table>

3.6 Scottish Government have committed to introduce a training programme within Scotland for advanced neonatal and paediatric nurse practitioners.

3.7 Each of the units is working to produce workable rotas for the period from February onwards using a combination of the allocated middle grade trainees, locums and consultants acting down into resident registrar shifts (with the consequent impact on clinical activity the day before and the day after the out of hours shift).

3.8 The planning group chaired by the Director of Operations for Women, Children and Neurosciences NHS Lothian, Mrs Fiona Mitchell, which managed the similar situation in the spring and summer of 2012 has been reconvened. This group comprises staff from the three sites in Lothian along with the Regional Workforce Adviser and will meet fortnightly to monitor the staffing situation on each site in real time and to consider contingency plans.

3.9 Planning for a public information campaign on the risks to paediatric and neonatal services in each Board area and the potential need to redesign these is underway.

4 Key Risks

The key risks are

4.1 Inadequate medical staffing of the Edinburgh paediatric intensive care unit impacting on emergency admissions and complex planned surgery.

4.2 Inadequate medical staffing at the Edinburgh neonatal intensive care unit impacting on the provision on neonatal intensive care for South East Scotland.

4.3 Short notice inability to staff St John’s paediatric unit and the clinical risk presented by an unplanned change in the service provided on that site.

4.4 Inability to recruit adequate staff to sustain the paediatric inpatient unit at St John’s.

5 Risk Register

5.1 The risk associated with the paediatric and neonatal workforce is on the Board risk register which will be updated to reflect the risk associated with the position from February.
6 Impact on Health Inequalities

6.1 An equality and impact assessment has not been undertaken. An assessment will be required if proposals for planned service change on any site are put forward.

7 Involving People

7.1 There will be a full engagement process to ensure that services users, potential service users and other key stakeholders are made aware of the ongoing situation.

7.2 NHS Lothian’s Public Involvement and Communication representatives have met with the Scottish Health Council to agree an action plan on full engagement over the next few weeks and months.

7.3 This engagement process will be to explain the background to the situation, what NHS Lothian is doing to solve the issues and what contingencies are in place if those solutions do not bear fruit.

7.4 The public engagement process will be supported by an internal and external communications plan using all available communications tools.

8 Resource Implications

8.1 The additional short term costs of sustaining paediatric and neonatal services at St John’s are unlikely to be less than the £65K per month seen during the spring and summer of 2012.

8.2 Locum usage at RHSC and RIE is likely to be required to help cover gaps at those sites with further additional cost pressures.

8.3 The costs of the recruitment campaign are being partly underwritten by the Scottish Government.

8.4 Scottish Government has committed £600K of non-recurring funding over two years to the additional costs of staffing the units within Lothian.

8.5 Recurring funding will have to be made available for substantive posts filled as a result of the current recruitment campaign.

8.6 A financial plan will need to be developed to fund an increase in trained staff in the NHS Lothian paediatric and neonatal services.

David Farquharson
Medical Director
18 January 2013
david.farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Summary of recruitment campaign.
Appendix 2. Copy of advertisement in British Medical Journal.
Appendix 3. Copy of letter to General Practitioners in NHS Lothian.
The following table sets out the recruitment campaign plan with associated timelines and progress update notes.

<table>
<thead>
<tr>
<th>METHOD / ACTION</th>
<th>DESCRIPTION</th>
<th>Timelines</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research to Identify Overseas Talent</td>
<td>Research to identify where the overseas talent currently exists that we wish to target. Identify competing salary/benefits packages. Research will take place in the following countries; UK, Ireland, Australia &amp; New Zealand, Canada, India, Spain</td>
<td>w/e 14th Dec to commence research work 14th Jan – Desk research complete 14-25th Jan – Primary research (35 interviews 28th - 31st Jan – analysis &amp; reporting 1st Feb – report to client</td>
<td>Work has commenced on the secondary research phase to source and analyse information available in the public domain, including job boards and relevant industry and government news and statistics in each location to provide insight into the current market size and structure. Primary phase of the research involving targeted research interviews will follow thereafter. Work has commenced to create the target lists.</td>
</tr>
<tr>
<td>Target Passive Jobseekers</td>
<td>Advertisements E-shot to target UK hotspots and c300 potential candidates by email asking if they can network for us. Responses will be passed back to NHS Lothian to follow up. This will include Northern and Southern Ireland.</td>
<td>w/e 14th Dec, to commence Advertisements campaign, starting with creating the target lists. Candidates will be approached during the period late January to early March.</td>
<td></td>
</tr>
<tr>
<td>Google Ad words and Display Network Campaign</td>
<td>3 months google campaign to target our adverts to appear only to users who are actively searching for the advertised roles, across North America, Canada, Australia, New Zealand, UK, Spain, Southern Ireland and parts of India.</td>
<td>w/e 14th Dec, in conjunction with launch of microsite</td>
<td>The Google search/ad campaign started on 14th December. (Activity summary analysis below)</td>
</tr>
</tbody>
</table>
The following table sets out the recruitment campaign plan with associated timelines and progress update notes.

<table>
<thead>
<tr>
<th>METHOD / ACTION</th>
<th>DESCRIPTION</th>
<th>Timelines</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td>LinkedIn Campaign</td>
<td>To target LinkedIn members across North America, Oceania, UK, parts of India, Spain and Ireland who have Paediatrics &amp; Neonatology on their profiles (an estimated target audience of 111,263 members). The ads will be displayed and work on a pay per click, whereby we only pay when an interested potential candidate clicks the advert.</td>
<td>w/e 14th Dec in conjunction with launch of microsite</td>
<td>The LinkedIn ad campaign started on 14\textsuperscript{th} December. (Activity summary analysis below)</td>
</tr>
</tbody>
</table>
| NHS Lothian’s Paediatric Microsite | Review NHS Lothian’s Paediatric Microsite and refresh for relaunch. [www.nhslothianmedicaljobs.co.uk](http://www.nhslothianmedicaljobs.co.uk) | w/e 14th Dec, subject to copy and site map sign off at the beginning of that week. | Microsite launched on 14\textsuperscript{th} December. The microsite promotes NHS Lothian, NHS Borders & NHS Fife and is advertising the following posts;  
  - Consultant Paediatrician  
  - Consultant Neonatologist  
  - Specialty Doctor – Paediatrics  
  - Clinical Fellow – Paediatrics  
  - Perinatal Clinical Fellow  
  - Advanced Nurse Practitioner – Paediatrics and Neonatology  
  Awaiting activity report |
| Journals/online advertising    | Advertise posts through SHOW & the national NHS Medical Jobs Microsite. Both are accessible worldwide.  
  Creative adverts in BMJ for Paeds &  
  [12th Jan] | w/b 17\textsuperscript{th} Dec | The posts attached with this campaign are also advertised on the SHOW website.  
  Creative adverts finalised awaiting |
The following table sets out the recruitment campaign plan with associated timelines and progress update notes.

<table>
<thead>
<tr>
<th>METHOD / ACTION</th>
<th>DESCRIPTION</th>
<th>TIMELINES</th>
<th>PROGRESS UPDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatology (hardcopy &amp; online) (refresh previous adverts June 2012)</td>
<td>Creative adverts in Infant Journal &amp; Infant Grapevine Advanced Nurse Practitioners Paediatrics and Neonatology (hardcopy &amp; online). These journals are alternate bi monthly publications</td>
<td><strong>Publication</strong> (conditional to booking by midday 4(^{th}) Jan)</td>
<td>Creative adverts finalised awaiting publication date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>16(^{th}) Jan Infant Journal publication</strong> (conditional to booking by midday 4(^{th}) Jan)</td>
<td>Additional creative advert for Paediatric ANP currently in progress (additional cost c£5.5k)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>15(^{th}) Feb Infant Grapevine publication</strong> (conditional to booking by midday 5(^{th}) Feb)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Mid Jan publication</strong></td>
<td></td>
</tr>
<tr>
<td>Creative advert in Sunday Times (hardcopy &amp; online)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Recruitment Search / Headhunting Agency</td>
<td>Consider using a recruitment agency specialising in headhunting medical professionals UK &amp; overseas (for example; Global Medirec)</td>
<td><strong>To be confirmed</strong></td>
<td>Global Medirec have quoted their charge of 20% of full earnings of each appointment. Potential for further discount subject to us confirming the anticipated number of appointments.</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>ACTIVITY SUMMARY ANALYSIS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Google Ad words and Display Network Campaign</td>
<td>The UK, India, Spain &amp; Ireland search campaigns have a high click through rate indicating that searchers find the advertising and keywords highly relevant. This is a key indication that the campaign is running well.</td>
</tr>
<tr>
<td></td>
<td>The display network campaign also has a strong click through rate though it is naturally lower than the search campaign as it targets the passive, rather than active job seeker.</td>
</tr>
<tr>
<td></td>
<td>Particularly high levels of interest generating from UK, India, Spain &amp; Ireland, with low interest so far from North America, Canada, Australia &amp; New Zealand</td>
</tr>
<tr>
<td></td>
<td>A source code is being added to the ‘How to Apply’ page of the microsite <a href="http://www.nhslothianmedicaljobs.co.uk/apply">www.nhslothianmedicaljobs.co.uk/apply</a>. This will enable us to track and measure how many searchers click on the ‘How to Apply’ page and provide greater insight into the % of searchers who are interested in applying for our roles.</td>
</tr>
</tbody>
</table>
NHS Lothian, NHS Borders & NHS Fife are working together to ensure that patient care in the fields of Paediatrics & Neonatology, is offered at the highest possible standards across NHS Scotland’s south east region. With this in mind, we are looking to recruit to a range of permanent and locum opportunities across the following key roles to help us achieve our goal:

- **Consultant Paediatrician**
- **Consultant Neonatologist**
- **Specialty Doctor – Paediatrics**
- **Clinical Fellow – Paediatrics**
- **Perinatal Clinical Fellow**
- **Advanced Nurse Practitioners - Paediatrics and Neonatology**

For full details of each position along with informal contacts and information on how to apply, please visit, [www.nhslothianmedicaljobs.co.uk](http://www.nhslothianmedicaljobs.co.uk)
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For full details of each position along with informal contacts and information on how to apply, please visit, [www.nhslothianmedicaljobs.co.uk](http://www.nhslothianmedicaljobs.co.uk)
To All GPs in Lothian

Date 14th January 2013
Your Ref
Our Ref DIMF/AT
Enquiries to Audrey Trotter
Extension 35818
Direct Line 0131 465 5818
Fax 0131 465 5403
Email Audrey.Trotter@nhslothian.scot.nhs.uk

Dear GP Colleague

St John’s Paediatric Staffing support

As you may be aware, we are continuing to have challenges with the availability of Paediatric Medical Trainees in the South East Scotland region and from February next year, these will start to affect all units, including St John’s Hospital.

NHS Lothian has launched a major recruitment campaign, along with NHS Fife and Borders to help address this, but it has also been suggested that there may be GPs in Lothian who might be able and interested to work at St John’s specifically.

The Paediatric Trainee gaps are particularly affecting out-of-hours rotas, ie nights and weekend day time and we would particularly welcome interest in supporting these periods. Doctors covering these times are rostered to work a shift in the hospital, with a Consultant Paediatrician providing on call cover from home.

Trainees currently support both the Paediatric assessment and inpatient service and the Neonatal service. Ideally, we would be looking for other doctors who could do the same, but it is recognised that most GPs will not have current skills in neonatal care, however, they may have acute paediatric assessment and management skills which could still be of benefit to the St John’s service. We would also look to provide refresher/ skills updating support for any GP who was interested but felt they needed this.

The key competencies required are:

- Level 2 Child Protection training
- Competencies equivalent to an ST3+ Registrar in assessing and managing acute paediatric presentations and general paediatric inpatients
- To be able to assist and manage deliveries needing neonatal input and manage the Special Care Baby Unit, including neonatal resuscitation and endotracheal intubation
- Key skills: Intravenous cannulation in children and neonates, lumbar puncture in children and neonates
If you are interested in this type of work but feel you do not have the competencies, please contact us so that we can discuss what development you require to fulfil this role.

All enquiries in the first instance should be to Dr Farquharson, Medical Director, tel: 0131 465 5818 or e-mail david.farquharson@nhslothian.scot.nhs.uk.

Yours faithfully

[Signature]

DAVID FARQUHARSON
Medical Director

ALAN BOYTER
Director of Human Resources and Organisational Development
Minutes of the NHS Lothian Audit & Risk Committee Meeting held at 2.00 pm on Monday, 15 November 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr J Brettell (in the Chair); Councillor D Grant and Ms J McDowell.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Mrs S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D Woods (Chief Internal Auditor); Mr A Payne (Corporate Governance & Value-for-Money Manager); Mr A Perston (Audit Scotland); Mr J Sherval (Public Health); Ms L Livingstone (Internal Audit) and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr Peacock, Dr Bryce, Councillor Henderson, Councillor Johnstone and Mr Ash, Mr Davison. Ms J McDowell stood in as a Non Executive to ensure the meeting was quorate.

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.

32. Minutes of the Previous Meeting

32.1 Minutes of the Previous Meeting held on 9 October 2012—previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 9 October 2012 were approved as a correct record.

33. Matters Arising

33.1 Matters Arising from the Meeting of 9 October 2012—the Committee noted the previously circulated paper detailing the matters arising from the Audit & Risk Committee meeting held on 9 October 2012, together with the action taken and the outcomes.

33.1.1 Mrs Goldsmith advised the Committee that she would bring forward a report on the private patient activity to the Audit and Risk Committee in February 2013.

33.1.2 There was some discussion surrounding the resources available to the internal audit team and some proposed changes to the internal audit structure to utilise resources better. Mrs Goldsmith agreed to brief Mr Brettell out with the meeting.
33.1.3 Mrs Bennett advised the Committee that addressing the cultural aspects of risk management will be progressed through the work of the Risk Management Steering Group.

33.1.4 Mr Payne confirmed that the chairs of Committees will be sent the SFIs for them to confirm that they have read them, in line with the previous request made by the Board Chairman.

33.2 The Committee agreed to note the action taken in respect of the Matters Arising.

34. **Risk Management**

34.1 Terms of Reference for the NHS Lothian Risk Management Steering Group – the Committee noted the previously circulated paper advising how the terms of reference were being set out.

34.2 The Committee requested that, to comply with the requirements and duties of its own terms of reference, the terms of reference of the RMSG be amended to state that the Audit & Risk Committee would expect at every meeting to receive:
- A briefing on updates to the risk register
- A report on any major changes

Ms Bennett confirmed that she will bring forward the corporate risk register for review at the February Committee meeting before it is presented to the Board.

34.3 The Committee suggested that the Risk Management Steering Group should reconsider the quorum outlined in the terms of reference. Given the small number of members a quorum of 8 may prove to be ambitious. Ms Bennett agreed to raise this matter at the next Risk Management Steering Group.

35. **Internal Audit**

35.1 Internal Audit – Progress Report November 2012

35.1.1 Mr Woods gave a brief overview of the report and highlighted progress made with the 2012 audit plan. He advised that the Medicines Approval report would be deferred to the February ARC when Dr Farquharson would be available to attend the meeting.

35.1.2 Following a brief debate the Committee agreed that in the event of an overall opinion of “Requires Improvement” or “Unsatisfactory” being given in an internal audit report, the responsible director would be invited to attend the ARC at the same time as the report is presented to the ARC. The Committee shall be looking to;
• Confirm that there is Management agreement on the issues
• Get an understanding as to why things have happened that led to the audit’s findings
• Receive assurance that there is commitment to meet the agreed deadlines for Management Actions.

35.1.3 The Committee noted the previously circulated Internal Audit Progress Report November 2012.

35.2 Data Security – Patient Identifiable Information (October 2012) – the previously circulated internal audit report on data security and the recommendations detailed within were noted. Mr Woods explained that the audit had focused on patients’ data being used for non-clinical purposes. He mentioned that induction and update training is provided for information governance, although training is not always completed or as regular as required. Also, various policies and procedures touch upon patient-identifiable information, with the volume and range of policies possibly contributing towards confusion. Mr Woods mentioned the board’s commitment to following the 6 principles of the Caldicott Report, and the audit found that applicants generally adhere to the assurances given in their Caldicott applications. However, Caldicott approval is not always being sought (25% of download instances). Lastly, Mr Woods reported that Waverley Gate is currently the only location with a designated Safe Haven for controlling the exchange of patient information with other organisations.

35.2.1 Mr Sherval highlighted:
• The issues that surrounded the Caldicott Guardian process and the level of work required to promote a positive culture of application and seeking advice.
• Work to reduce the volume of policies through a targeted approach, the development of technology and services to encourage best practice.

35.2.2 The Committee supported the management actions detailed within the report. Mr Sherval agreed to confirm with Dr McCallum that the timelines for agreed actions will be met. The Chair noted the need for relevant and appropriate policies to be workable, but that this did not excuse management responsibility to adhere to guidelines.

JS

Mr Sherval left the meeting.

35.3 Follow up of Management Actions – the Committee noted the previously circulated report that sets out progress in implementing Management Actions following internal audit reports.

35.3.1 Mr Woods highlighted that 11 final reports had been issued between April and October with those reports containing 32 Significant and 8 Important issues. Meanwhile, 23 Management Actions had been closed during the same period, although 20 of those 23 Management Actions (87%) had not been completed by their target dates. As at 31 October, Mr Woods reported that 67 Management Actions were outstanding of which 41 Management Actions (61%) have already passed their target dates.
35.3.2 Members considered the impact of the recent restructuring whereby the significant number of Management Actions for areas within University Hospitals Division had been reassigned to other directorates.

35.3.3 The Chair stated that it was unacceptable for there to be such a high level of outstanding actions. The effect of this was that the Board was accepting a wide range of risks, and was concerned that the Board did not have sight of these risks. He stated that the fundamental issue of agreed actions not being done by the agreed time needed to be addressed.

35.3.4 The Committee reflected on how to improve adherence to deadlines and ownership of the issues at an executive level. Members recognised emphasising the importance of positive dialogue between executive leads and Internal Audit during closure meetings as an important mechanism. Mrs Goldsmith felt this should be a robust discussion. The Chair noted that Internal Audit should not however come under undue pressure, and Mr Woods confirmed he was comfortable this was not the case, and he would not allow it.

35.3.5 The Chair noted the the failure to complete outstanding actions might be interpreted that managers do not take the issues seriously, and either or both the audit process or management focus is deficient. Following a detailed debate Mrs Goldsmith agreed to raise the subject with the Joint Management Team, and provide a management response to the Committee Chair within 4 weeks on the level of outstanding Management Actions, and how this will be addressed. It was also agreed that when Management Actions are sent out, the responsible Executive Director would be copied in.

36. **Counter Fraud**

36.1 **Counter Fraud Services Referrals and Operations – November 2012** – the Committee noted the previously circulated report summarising open and recently closed referrals to Counter Fraud Services. Mr Woods provided updates on the main cases. Members acknowledged the positive approach to tackling fraud within NHS Lothian.

37. **Corporate Governance**

37.1 **Training needs for Audit & Risk Committee Members** – The Committee agreed to defer this item to the next meeting.

37.2 **Update on Action Plan to Improve Awareness of and Compliance with Polices and Procedures** – the previously circulated report to advised the Committee of the updated action plan in response to the internal audit report on compliance with policies and procedures (March 2011) was received.
37.2.1 Mr Payne advised the Committee that on 6 November the Joint Management Team approved 7 Mandatory Policy packages for use in the organisation, and agreed to the establishment of a policy distribution centre.

37.2.2 The Committee noted the progress made to date.

37.3 Backlog Maintenance and Statutory Compliance - Mrs Goldsmith gave a detailed verbal update on backlog maintenance specifically highlighting the recent board paper on the matter, the commitment of £10 million over the next 18 months and the proposed employment of a project manager to oversee the works.

37.3.1 The Committee acknowledged that the issue of backlog maintenance had been quantified in terms of estimating how much it would cost to complete all the identified work. The Committee expressed concern that what is not explicit is the level of risk that the Board is effectively accepting with regard to legal compliance, by certain maintenance being deferred as part of the agreed programme of work.

37.3.2 It was agreed that the Committee would receive a briefing on the Board’s exposure to legal/ regulatory risks arising whilst maintenance work is not completed so that this could be quantified and presented to the Board.

37.4 Mapping of Activities to the Terms of Reference of the Audit Committee - the Committee reviewed the previously circulated report on the mapping of the activities to the Terms of reference, scrutinising each page to ensure that all areas of the terms of reference were routinely addressed.

37.4.1 The Committee agreed to accept the report subject to the inclusion of the proposed changes and subsequent updates for future meetings. Mr Payne agreed to take forward the necessary amendments to the report.

Mrs Goldsmith left the meeting.

38. Any Other Competent Business

38.1 Royal Hospital for Sick Children and Department of Clinical Neurosciences – The Committee agreed that the Finance and Resource Committee had responsibility for oversight of the Royal Hospital for Sick Children and the Department of Neurosciences Project. The Committee requested an assurance report from the Finance & Resources Committee on the risk management arrangements for the project.

38.2 Consolidation of Annual Accounts – the Committee discussed the consolidation of the Board’s and the Edinburgh and Lothian’s Foundation annual accounts. It was noted that the consolidation of the accounts would not have a material impact on the Board’s presentation of the annual accounts in terms of giving a true and fair view to the reader; any areas
requiring clarification would be detailed within the notes. Members agreed to await further technical advice regarding the consolidation of the accounts.

39. Date of Next Meeting

39.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 4 February 2013 at 9.00am in Waverley Gate, Edinburgh. Committee members are asked to attend by 8.45 for the scheduled pre briefing, and to note that a 30 minute closed session will take place at the end of the meeting, to be attended by Risk, Internal Audit, and External Audit.
Minutes of the Meeting of the Finance & Resources Committee held at 9.00am on Wednesday, 12 December 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (In the Chair); Mr P Johnston; Mr J Brettell; Professor J Iredale; Dr D Farquharson; Mrs S Goldsmith; Dr C J Winstanley; Mrs M Hornett, Dr A K McCallum; Ms K Blair and Professor A McMahon;

In Attendance: Mr C Graham (Minutes); Mr I Graham and Ms C Potter (until 11.30am).

Apologies for absence were received from Mr T Davison and Mr A Boyter.

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. Professor Iredale declared a non financial interest at item 50.4 as he is a University employee.

The Chair welcomed members to the first meeting of the new Finance and Resources Committee. He also welcomed Kay Blair into the Committee membership.

44. Minutes of the Previous Meeting

44.1 The previously circulated Minutes of the Finance and Performance Review Committee held on 10 October 2012 were approved.

45. Matters Arising

45.1 St Johns Hospital Burns Unit Relocation – Dr Farquharson updated the Committee on the ongoing work at the burns which had been due to start on the 10th December with enabling works in roof of the floor below the burns unit. The Committee noted that the timescale for the work to take 6 to 9 months to complete the burns unit work only. Dr Farquharson would provide further update to the next meeting.

DF

46. Terms of Reference

46.1 The Chair explained that he had felt a review of the terms of reference (TORs) for the new Committee appropriate. Mrs Goldsmith stated that the TORs were different in two regards, (a) they were much more focussed on property and asset management including Backlog Maintenance and (b) there was greater emphasis on
a longer term approach to reducing the Board’s cost base. It was acknowledged that one of the key issues for the Committee was moving to a risk based approach.

46.2 Mrs Goldsmith pointed out that the covering paper was asking for comment on the TORs and also posed some questions such as how through development of the Board’s clinical strategy and property strategy the Committee can ensure that the business cases are the right business cases and the Committee feels able to provide assurance and financial governance to the Audit & Risk Committee.

46.3 Dr Winstanley stated that the TORs were nearly there, he would wish to see more emphasis on how resources are prioritised and managed.

46.4 Mr Brettell stated that there required to be an annual picture of planned events with reserve for unplanned events. Business cases should be looked at in the context of planned spend. Professor Iredale welcomed the opportunity for the Committee to be involved with planning at an early stage, he added that it would be helpful to have an idea of a 5 year plan when making decisions on plans presented.

46.5 Ms Blair stated that it was important that the financial strategy was aligned to the workforce strategy. There was discussion on the membership and quorum of the Committee. It was agreed that Mrs Hornett should be an official member of the Committee and that the quorum should be changed to 5 (3 Non Executives and 2 Executives).

46.7 The Chair and Mrs Goldsmith agreed to reflect on these comments and would discuss this with Mrs Goldsmith outwith the meeting.

46.8 The Committee were happy for the TORs to go to the Board meeting for sign off, subject to the amendments to the quorum, membership and drafting points. The Chair would review the revised TORs on behalf of the Committee ahead of submission to the Board.

47. NHS Lothian Risk Registers

47.1 The Committee received the paper which was with the Committee for consideration for the first time.

47.2 The Committee noted that the Board had established a risk management steering group chaired by the Chief Executive and Dr Farquharson sat on this steering group as the lead for risk management. The Corporate Risk Register would be going to the next Board meeting and it was important that the Committee acknowledged its responsibilities in relation to the risk register.

47.3 Following discussion on the requirement for further work to be undertaken on the Corporate Risk Register, and each Committee’s specific responsibilities, the Committee noted the Risk Registers papers.
48 **Financial Performance**

48.1 Mid Year Review & Financial Position to 31st October 2012 - The committee noted that this paper has already been to Board. Mrs Goldsmith advised that the month 8 position had just been finalised and this continued to confirm break-even.

48.2 There was discussion on the reasons for the facilities management overspend. Mrs Goldsmith stated that a significant overspent was due to energy contract and price changes, this would be addressed by additional provision on a recurring basis into 2013/14. There was also overspent in the maintenance budget, capital and backlog programmes.

48.3 Ms Blair asked about the recurring shortfall outlined at section 3.10 in the report and how realistic would it be for work streams to address this. Mrs Goldsmith stated that there was a good track record of delivery but that this year had proved more challenging because of the capacity issues. An improvement was expected in productivity as the elective workload is being closely monitored. The Committee noted that all work streams have financial and project management support.

48.4 Ms Blair also asked about the performance indicators around productivity. Mrs Goldsmith stated that these were not well advanced and these would have to be reviewed to establish a baseline, against which future performance could be measured.

48.5 The Chair asked how the report recommendations could forecast a position of financial balance when NHS Lothian was borrowing money. Mrs Goldsmith acknowledged this and agreed to change this statement in the report.

48.6 The Chair added that productivity measures had fallen off the agenda in last few months and need to be picked up again. Dr Winstanley stated that there needed to be more understanding on workforce productivity and awareness of costs of procedures. There was a need for better awareness of costs ahead of integration.

48.7 The Chair suggested that finance and planning come back in due course with thoughts on how to take the next steps beyond activity.

48.8 Dr Farquharson added that NHS Lothian was a member of ‘Civil Eyes’ which is an organisation which works with clinicians and managers to better understand quality and productivity within health services. The Committee noted that there would be a meeting with ‘Civil Eyes’ in the new year to go over Lothian’s latest figures and look at per consultant productivity.

48.9 The Committee noted the report subject to the Financial Balance statement being altered for accuracy.

48.2 Draft Financial Plan 2013/14 – E&P Invest to Save - The Committee noted that this was the first high level summary of the 2013/14 plan.

48.2.2 The Committee noted that the report would come back to the next Committee meeting prior to being submitted to the February Board meeting. Dr Winstanley
suggested that when the paper comes to the board it would be helpful to indicate allocations for aligned budgets for health and social care partnerships. He also asked whether budgets for partnership would be aligned to NRAC. Mrs Goldsmith agreed to explore this further with Professor McMahon.

SG/AMcM

48.2.3 The Committee noted the first draft of the 2013/14 plan. This would also include action plans to address the strategic discussions Mrs Goldsmith and Professor McMahon would be having outwith the meeting.

49. **Capital and Property**

49.1 **Property and Asset Management Strategy Presentation** – Mr I Graham gave a presentation looking at the strategy and its four key elements
- Property
- EHealth
- Transportation
- Medical equipment

49.1.3 The presentation covered Meeting KPIs and benchmarks; Timescales (1-3 years and 5-10 years); Addressing priorities for future funding / business cases; areas measured against; estate condition; potential future estate; estate Masterplan model/drivers; asset management action line; saving opportunities from disposals; disposal versus capacity and ensuring ‘stakes in the ground’ were established.

49.1.4 There was discussion on the capacity challenge with the Royal Infirmary of Edinburgh and the infrastructure issues at the Western General Hospital. The plans for the Astley Ainslie site, the Princess Alexandra Eye Pavilion and the Lauriston Building were also discussed along with the proposals for the redevelopment of the Royal Edinburgh Hospital site.

49.1.5 The Chair thanked Mr I Graham for a useful presentation and summary which may be a topic for a future board member information session. The Committee noted the ongoing development of the strategy, with the first stage being to align appropriately with the Clinical Strategy.

49.2 **Capital Investment Programme 2012/13 and Business Case Update** - Mrs Goldsmith outlined the two parts of the paper (a) how the programme was progressing this year and (b) an update on business cases.

49.2.1 There was discussion on investment slippage in backlog maintenance and the good progress with the whole programme for medical equipment replacement. More slippage for smaller schemes had been reported to committee. The Committee noted that a revised capital programme had now been agreed with the Scottish Government and CRL slippage adjusted.

49.2.2 The Committee discussed the Royal Edinburgh Hospital reprovision business case and the proposition to replace all mental health facilities on the Royal Edinburgh Hospital site in first phase working with hubco. It was noted that the initial estimate for this was circa £60m.
49.2.3 Mrs Goldsmith reported that she had verbal confirmation from the Scottish Government that any slippage on the RHSC/DCN spent on backlog maintenance would be reimbursed to the Project.

49.2.4 The Committee noted the expenditure outlined in the report and the outcome of the mid year review of the capital programme.

49.3 NHS Lothian Estate: Backlog Maintenance Programme - Mrs Goldsmith reminded the Committee that the initial paper had come to the last meeting. This was to give the committee assurance that a programme board has been established, a programme director appointed, and that to date £8m of investment had been agreed,

49.3.1 The Committee noted the paper and the risks that would be retained by the Board. To note risk retaining by board

50. Risk Management for the Royal Hospital for Sick Children and Department of Clinical Neurosciences Re-provision Project

50.1 The Chair stated that this paper had been brought to the Committee to give a sense of the risk involved with the work that had gone on with the project. Mrs Goldsmith added that this was a good example of a group handling risk well and was for the Committee's information. The Committee hoped that this was the kind of benchmark it would receive as all major projects developed.

50.2 Mr Brettell stated that the risk register was incredible comprehensive and it was noted that the project team reviews the register quarterly and updates the project steering board on changes to risks or the addition of new risks. Mr I Graham added that this was the consistent approach to all major projects.

50.3 The Committee noted the paper for information and the Chair invited Mr Brettell to attend a project board meeting to observe if he wished.

50.4 It was also noted that the signing of the assay with the University of Edinburgh for enabling works was happening today. Mrs Goldsmith stated that the University had requested risk indemnity of £1m which had been cleared with the Scottish Government. Bidder’s day would take place on the 13 December.

51. Business Cases

51.1 Dental Decontamination - Dr McCallum reported that she had recently taken over this area of responsibility for delivery as well as strategy.

51.1.1 Dr McCallum outlined the proposed hub and spoke model with the HSDU being the main hub supported by new facilities at the Western General and St John’s Hospitals, along with some smaller community based decontamination facilities.

51.1.2 The Committee noted the requirement to have plan in place by the end of December 2012.
51.1.3 The Committee discussed the current utilisation of the HSDU and questioned whether this could be better utilised ahead of major investment in new ‘spoke’ facilities. Dr McCallum stated that this was not the case as if the unit operated about 50% capacity there would need to be a duplicate unit for disaster recovery purposes. There was also discussion on assurance and compliance issues.

51.1.4 Dr McCallum added that there were two main issues, (a) current facilities are monitored in terms of their lack of harm to patients so do not give a sustainable approach to risks (b) there is heavy reliance on the behaviour of staff on a day to day basis to minimise risk to patients, working with facilities that are not designed with current best practice in mind. This was not the best way to do business; facilities should be compliant and the decontamination process should enable more timely turnaround. Another risk was that with managing waiting times tightly and activity up there were greater demands on an unsustainable system.

51.1.5 The Committee agreed to move forward with the development of the business case subject to the capacity arguments being addressed and the business case setting out the risks and benefits more clearly.

51.2 **RIE Additional Beds** - The Chair asked Mrs Hornett to convince the Committee as to why to put more capital investment into more expensive to run beds at the RIE and not invest in revamping the Royal Victoria Hospital as a step down facility to get people out of the RIE. Mrs Hornett stated that while provision of step up/step down facilities were important, as is the continuing investment in social care, there remains a shortage of bed capacity on the Infirmary site. Given previous discussions about changing patterns of morbidity and demography this position is unlikely to change and so further beds are required to enable us to meet patient needs in a safe, dignified and timely way.

51.3 The Chair asked Mrs Hornett to convince the Committee as to why to put more capital investment into more expensive to run beds at the RIE and not invest in revamping the Royal Victoria Hospital as a step down facility to get people out of the RIE. Mrs Hornett stated that the biggest delays were with the City of Edinburgh Council arranging home care packages, however they have recently invested significant to improve this and there is the change fund to prevent readmission. The Board wants to keep people out of hospital if it is not the right place for them.

51.4 Dr Farquharson added that it was implicit that medical staff change the way they work, taking ownership patients and patient flow. The seven day presence of consultants on wards was also important otherwise we were just adding more beds. The Chair stated that there was need for clarity as to why there was a need to increase beds.

51.5 The Committee agreed to support the ongoing development of the business cases and looked forward to a further update on the Wards 109 and 209 business case at the next Committee meeting. It was also agreed to have the next meeting at the RIE so the Committee could undertake a site visit to the areas being talked about.
52. **Any Other Competent Business**

52.1 Committee Running Action Note – The Committee noted that the Running Action Note had been missed from the papers and would be circulated in future.

53. **Date of Next Meeting**

53.1 It was noted that the next meeting of the Committee would be held at 9.00am on Wednesday, 13 February 2013, in Board Room 1, Royal Infirmary of Edinburgh – the venue was changed as the Committee have requested a RIE site visit to review ongoing works in relation to the additional beds.

53.2 The meeting closed at 11.56am.
NHS LOTHIAN

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00am on Tuesday 4 December 2012.

Present:
Dr M Bryce (Chair); Mr A Joyce; Mr F Toner (9.25am); Dr R Williams and Mr R Wilson.

In Attendance:
Ms M Anderson; Ms J Bennett, Ms P Black (Item 39.5); Ms L Douglas (Item 39.2); Dr D Farquharson; Ms S Fife (Item 39.5); Mrs I Garden & Mr A Garden; Ms T Gillies; Mr C Graham (Minutes); Mrs M Hornett; Ms M Macfarlane; Mr E Olson (Item 33); Dr J Sherval (deputy for Dr McCallum) and Dr C Winstanley.

Apologies for absence were received from Dr A McCallum and Mr A Boyter.

CHAIR’S REMARKS

The Chair welcomed members to the meeting and asked those present to introduce themselves. The Chair apologised to the patient representatives who had not received copies of the papers ahead of the meeting and assured them that this would not happen again, whilst noting that there had been a change in the administrative arrangements for the Committee.

33. CARBAPENEM-RESISTANT ENTEROBACTERACEAE

The Chair welcomed Mr Olson to the meeting.

33.1 Mr Olson explained to the Committee, the work of the incident management team in relation to Carbapenem-resistant Enterobacteraceae (CRE). The presentation covered the current situation; what had been achieved so far, the role of the incident management team and when this ends; the strategy for control of CRE; the operational principle and issues for search and isolate; clinical risk assessment; screening for high risk units and general infection control

33.2 The Chair thanked Mr Olson for his presentation and pointed out to members that these were nasty and totally resistant organisms that were being dealt with. The Chair opened the floor to questions. Ms Bennett asked if the high risk groups identified would be those generally identified for other infections. Mr Olson confirmed that these would be the same risk groups and that day to day management was no different to standard infection control processes. Ms Macfarlane asked about risk to patient visitors. Mr Olson stated that risk was minimal.

33.3 Dr Williams asked about implications for primary care. Mr Olson explained that this had not yet been bottomed out and this would be part of the next phase, as current focus was on where the highest risk presented. GPs involved have been written to
but Mr Olson conceded that there was a steep learning curve in relation to CRE and patient information was currently being developed. Dr Williams stated that there could be a risk where people who may have been in hospital abroad return home and do not go into hospital here.

33.4 The Chair asked about communication implications for the general public and travellers. Mr Olson outlined that this was an emerging issue which needed to be tackled at national level. Dr Winstanley asked if there was a piece of work that could be undertaken through public health or health promotion in relation to providing targeted information to travellers at the airport. Dr Sherval suggested that such a piece of work would be for discussion with Health Promotion Scotland, he agreed to take this back for discussion with Dr McCallum who would provide an update back to the Committee.

AKM

The Chair thanked Mr Olson and he left the meeting.

34. PATIENT STORY

34.1 The Chair read out the poem received from an Intensive Home Treatment Team Service User. The Chair stated that it was hoped to have perspective directly from patients at the beginning of each meeting.

35. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF THE PREVIOUS MEETING: 2 OCTOBER 2012

35.1 The minutes of the previous meeting on 2 October 2012 were approved as a correct record subject to the following amendment:

- Paragraph 26.1.1 change “target was necessary” to ‘target was challenging but achievable’.

36. MATTERS ARISING – RUNNING ACTION NOTE

36.1 The Committee noted that most of the items listed on the Action Note were on the agenda for today’s meeting. Dr Sherval reported that in relation to the Dental health protection/infection control item, there was good progress with improvement and this item would be considered formally at the next Committee meeting.

AKM

37. EMERGING ISSUES

37.1 Royal Victoria Hospital (RVH) Wards Opening - Mrs Hornett reported that pressure caused by unprecedented activity in emergency and unscheduled care over the last few weeks had resulted in wards one and two at the RVH being refurbished and re-opened. The emergency and unscheduled care beds at the Royal Infirmary were currently at twice their capacity due to delayed discharges and with limited extra bed capacity options, the RVH had been the only option. Wards three and four at RVH
were also being worked on in case they are required to open to handle post Christmas activity.

37.2 Mrs Garden asked how many patients being admitted are suffering from cold related illnesses. Mrs Hornett clarified that all the patients being transferred to the RVH have received care and are waiting to either go home or to receive care packages. However cold related illnesses admissions are starting and norovirus is peaking earlier than expected. Mrs Garden added that this time of year also saw elderly people cutting back on heating due to fuel costs.

37.3 Mrs Hornett explained that in relation to staffing levels there had been issues regarding backfill; sickness and maternity leave. There had also been increased demand on the staff bank caused by the increase in elective activity to meet waiting times pressures. Fill rates for nursing gaps through the nurse bank were at 89% and some recent Allied Health Professionals recruitment had been helpful.

37.4 Dr Winstanley pointed out that whilst the Committee should be supportive of these arrangements to address the current situation, it was important that pressure was not lifted from City of Edinburgh Council about their responsibility to provide care packages for these people waiting to leave hospital. The Committee noted that a briefing session scheduled for today for council colleagues had been postponed due to lack of numbers attending. The Committee also noted that West Lothian Council had a long history of having zero delayed discharges. Mrs Hornett added that the meeting this afternoon not going ahead was disappointing. Currently in hospital there are 136 people who did not need to be there, a vast majority of these people were the responsibility of City of Edinburgh Council with a handful coming under East Lothian and Midlothan councils. The Chair stated that it was imperative to find solutions to the delayed discharge problem and that the committee would like updates on progress with this.

37.5 Dr Winstanley suggested that a letter from the Chair outlining the Committee’s concerns and desire for an early opportunity to engage be sent to Cllr Ricky Henderson. This suggested way forward was agreed by the Committee.

37.6 Mrs Garden raised a concern about people coming home on a Friday with no care packages being made available until the Monday. Mrs Hornett stated she would pick this up with Mrs Garden outwith the meeting.

38. **PERSON CENTRED CARE**

38.1 Nothing reported under this heading.

39. **SAFE CARE**

39.1 **Healthcare Associated Infection Update**

39.1.1 Dr Sherval went over the highlights in the report and thanked Fiona Cameron for producing the paper which was now in a familiar standard format. It was noted that
there was a downward shift against the Staphylococcus aureus Bacteraemia. Work was ongoing with Health Protection Scotland to achieve targets and the standard infection control actions such as hand washing were being promoted. The Committee noted that Dr McCallum had recently taken on the lead for decontamination issues, which includes the prison service as a new aspect which is currently hosted by East and Midlothian CHPs. The Committee supported the activities as outlined in the report.

39.2 Inpatient Fall Prevention Programme – Progress report

39.2.1 The Committee noted the paper reporting on progress towards achieving the falls target to reduce inpatient falls with harm by 20% by March 2013, which forms part of the Falls Prevention & Bone Health Strategy and Delivering Better Care Programme.

39.2.2 There was discussion on the care rounding approach, Ms Douglas stated that because patients are assessed and engaged with staff they are prompted to say to staff what they need, making care anticipatory rather than reactive. Mr Wilson asked if this made extra work for nursing staff. Mrs Hornett replied that once nursing staff use this approach they see it is structured and patient centred, there is no additional work; it is just better patient management. Ms Bennett added that using this approach at the new Royal Victoria Building had made for a much calmer environment with a fifty percent reduction in buzzers.

39.2.3 The Chair stated that it was important that all staff had computer access so they could view the Care Rounding DVD on the intranet. Mrs Hornett recognised that staff accessing computers was an ongoing issue.

39.2.4 Mrs Garden stated that she was delighted to note that since the Royal Victoria Building opened there had not been a rise in the number of falls as some may have expected with a single room environment. She added she was happy to see patients and their families having more involvement in planning.

39.3 Swab Incidents – Audit Compliance

39.3.1 The purpose of this report is to inform the Committee of the results of the audit undertaken across all NHS Lothian theatre groups to determine compliance with the Accountable Items Policy.

39.3.2 Dr Farquharson introduced the audit report which followed on from the verbal report early this year by Dr Simon Mackenzie, following two separate incidents of retained swabs which occurred in October 2011 and February 2012 in Main Theatres, WGH. The Committee noted that across all theatre groups there is an ongoing update and review of the Accountable Items Policy.

39.3.3 There was discussion on occasions when patients were treated in non NHS premises and which policy would take priority. Mr Wilson stated that he would like legal cover in terms of exposure to be checked. Ms Gillies added that there are different levels in terms of individual accountability for surgeons but there would be a service level agreement in place. It was noted that national procurement were developing a framework for the NHS using external providers.
39.3.4 Dr Winstanley suggested that the legal status be checked; Dr Farquharson agreed to look into this and report back to a future meeting.

39.4 Improving the Management and System Learning from Significant Adverse Events

39.4.1 Dr Farquharson introduced the paper and provided some context in relation to a recent BBC panorama programme. It was noted that all Boards provided baseline information in September and Health Improvement Scotland was carrying out reviews going forward. Lothian had not yet received a review date.

39.4.2 Ms Bennett stated that at the last meeting, the Committee asked for the action plan to have names and timescales added and for this to be a standing item with a progress report at every meeting. She added that it was clear that the health improvement Scotland process was to pick a minimum sample of four significant adverse events and look at how these are managed against current policies and procedures; identify areas for learning and interview staff involved in incidents. It was noted that the Clinical Governance and Risk team has carried out its own internal review and is aware of weaknesses in the system which have informed the improvement plan set out. Ms Bennett stated that there needs to be a culture change to see instant reporting as positive thing.

39.4.3 Dr Farquharson stated that the SAE Investigation Report & Improvement Plan at appendix 4 in the report gives assurance off robust mechanism in place. Mr Wilson asked how assurance was given that staff would not be subject to disciplinary action if they were required to be part of a review. It was noted that there was agreement with Human Resources that there was a need to investigate the incident before looking at staff capability in the rare incidents this was required at all.

39.4.4 There was discussion on staff having the option not to participate in a review. Mr Joyce stated that staff can be reluctant to be involved if they think their job is on the line, this had previously been similar with suicide reviews. It is important that a proper investigation into the incident is carried out and it is not a witch hunt.

39.4.5 There was also discussion on staff support and how easy it was to access this. Ms Bennett stated that there was a lot of information but not in one place or clearly signposted. Work was ongoing with the spiritual care team, occupational health and health and safety on this. The Chair suggested that in order to mainstream incident reporting it could become part of induction training.

39.4.6 It was noted that Lothian would receive six to eight weeks notice of its review. Ms Bennett agreed to bring updates back to the Committee in due course.

39.5 Implementation of the Liverpool Care Pathway (LCP) Within NHS Lothian University Hospitals and Community Health Partnerships

*The Chair welcomed Ms Black and Ms Fife to the meeting.*
39.5.1 Mrs Hornett introduced the paper updating the Committee regarding progress in implementing the LCP within NHS Lothian. Ms Black and Ms Fife provided highlights and an overview of the implementation process. The Committee noted that there had been recent press interest concerning the LCP.

39.5.2 There was discussion on the implementation of LCP; the move towards single system end of life care and the shift in balance away from hospitals as a place for end of life care, which in part of the Lothian Palliative Care Strategy. The support around quality improvement that was being provided by the Clinical Governance Support Team was noted by the Committee.

39.5.3 Involvement of patients and their families in decisions; discussions about goals of care and areas such as artificial nutrition along with the consent process were also discussed. Dr Winstanley asked about the audit trail for consent. Ms Black stated that the audit trail shows 30% people where fluids had been withdrawn do not die any earlier on the LCP.

39.5.4 Ms Macfarlane asked about the use by patients of advanced directives and living wills, Ms Fife stated that living wills and advanced directives had no impact on the LCP.

39.5.5 The Chair stated that there was a public communication/ public knowledge issue. Mrs Hornett added that there was anxiety and distress; however the LCP can make a positive difference when used properly. Mr Wilson asked if a legal view on the LCP had been sought, Mrs Hornett stated that as this was a pathway, it was unlikely that such a view was required as the LCP is a prompt or tool for clinicians to use along with their clinical judgement.

39.5.6 Ms Fife informed the Committee that an information leaflet was currently being reviewed which will clearly sets out what will happen when a patient is dying a follows the LCP, it was noted that the use of the leaflet would be supplementary to discussions with a patient’s family.

39.5.7 There was discussion on the Scottish Government requirement for NHS Lothian to implement the LCP and whether there would be any benefit to the patient in rebranding LCP as a Lothian care pathway.

39.5.8 Ms Black stated that communications were a huge issue and that work was to be done around this in discussion Scott Government, who were due to make a LCP announcement shortly. Dr Winstanley stated that there was a big deficit in relation to communicating LCP to the public in lay terms and that an internal and external communications plan was required. Cllr Toner added that the paper assumed that people know what LCP is and that a member of the public looking at the paper may not be clear about what LCP is, if someone were to search for LCP online they might pick up on the negative aspects currently relayed in the press.

39.5.9 The Committee acknowledged the progress with LCP and noted the LCP implementation. The Committee supported the developments around quality improvement and it was agreed that once the data was received, a final report,
briefing for Board members and an outlined communications approach would come to a future meeting, either February or April at the latest.

MH/SW

The Chair thanked Ms Black and Ms Fife and they left the meeting.

40. EFFECTIVE CARE

40.1 Quality Report

40.1.1 Dr Farquharson introduced the November 2012 Quality Report to the Committee.

40.1.2 The Committee noted the November 2012 Quality Dashboard, Dr Farquharson stated that future reports would include further narrative for explanation. There was discussion on early detection of cancer; smoking cessation; colorectal, breast and cervical screening programmes and incident causes such as falls, violence and aggression. It was noted that there was more work to be done on surgical and medical readmission rates.

40.1.3 Mr Joyce asked about the violence and aggression figures shown for East and Midlothian. Ms Bennett stated that these figures were illustrative of the services hosted by East and Midlothian. Ms Bennett stated that she would provide a further breakdown or footnote in future reports.

40.1.4 The Committee accepted the Quality Report for November

40.2 Medical Profiles

40.2.1 Dr Farquharson introduced the report and outlined to the Committee specialties where NHS Lothian was performing well against other health boards in Scotland, e.g. lower mortality rates and length of stay in many areas.

40.2.2 Dr Farquharson also covered areas where NHS Lothian had not done so well and was behind average, such as Acute Medicine, St John’s Hospital; Emergency Medicine; Unplanned Readmission rates; Respiratory and Gastrointestinal Medicine. With regard to respiratory Ms Macfarlane, stated that aspects of coughs causing physical disability had been looked at by Hull Cough Clinic and out of area referral had been raised at the recent NHS Lothian Annual Review. Dr Farquharson agreed to discuss this work with the clinical director respiratory medicine.

40.2.3 Ms Gillies informed the Committee that there was discussion at national level as to how to use the data the medical profiles report provides and why it takes so long to get the data. It was noted that this data was more speciality based than scorecard data and that there was slightly different definitions between the medical profiles and hospital scorecard.

40.3 Renal Registry

40.3.1 Dr Farquharson introduced the report informing the Committee of the key results against key indicators relevant to NHS Lothian and NHS Borders reported in the
Scottish Renal Registry Report 2011. It was acknowledged that this was a very technical report but that it was important not to relegate it to exceptional reporting.

40.3.2 There was discussion on renal replacement therapy; the increase in survival rates; the staffing and challenges at the renal unit; age profiled consultants and succession planning. Ms Gillies stated that an additional consultant was expected to start in January 2013. Home dialysis was also discussed along with Lothian’s organ donation registration rate. Ms Macfarlane asked about Healthcare Associated Infection (HAI) risks in relation to blood pressure cuffs and how this was dealt with. Dr Sherval stated he would take that away and pass on to relevant colleagues to report back.

40.3.3 The Committee found the register to be quite helpful although it was felt that it could have been more succinct and presented better in terms of conclusions. The Committee felt it may be useful to have similar registers for other areas. The Committee noted the renal registry.

40.4 Improving Care for Older People in Acute Hospitals Healthcare Improvement Scotland Inspections Older Peoples Inspection of Care Action Plan

40.4.1 Mrs Hornett reported that NHS Lothian had undergone its first unannounced inspection in the Royal Infirmary of Edinburgh at the end of August. The report received at the beginning of October had highlighted areas of good practice and also highlighted examples of very poor care. The Committee noted that work was already underway on the vulnerable people’s action plan and that there was an action plan in place for the Royal Infirmary to address the shortfalls in the report. There would be regular reporting back to the Committee. The Committee accepted the report’s recommendations.

40.5 Complaints, Concerns, Compliments and Enquiries Monthly Performance Report – Quarter 2, July to September 2012

40.5.1 The Committee received the performance report. It was noted that responsibility for complaints, concerns, compliments and enquiries was now with the Director of Communications and Public Affairs. In his absence Mrs Hornett spoke to the report. It was noted that the acknowledgment and response rates had improved but there was no change in the most common causes of complaints. Dr Williams asked if there had been a change in policy with clinician to clinician communication now going through complaints team. Mrs Hornett stated that this was to do with the recent introduction of the patient rights act guidance.

41. HEALTHCARE GOVERNANCE RISK REGISTER

41.1 Dr Farquharson introduced the report setting out the Committee’s risks on the Corporate Risk Register to inform assurance requirements. The Committee noted the establishment of a NHS Lothian Risk Management Steering Group. Dr Farquharson stated that the group, chaired by the Chief Executive had met for the first time last month.

41.2 Cllr Toner asked if the action plan for the risk – ‘Sustainability of Paediatric and Neonatal Services at St John’s Hospital’ Frank could be provided. Dr Farquharson
stated that this was still work in progress but that he would pick this up with Cllr Toner outwith the meeting.

DF/FT

41.3 The Committee noted that the risk register was a work in progress and would be added to the agenda as a standing item.

41.4 Ms Bennett stated that many of the risks are interlinked staff and financial governance and that there is a huge amount of risk registers at operational level, these reflect the corporate risks. Ms Bennett asked if the Committee would find it useful to have a view of the NHS Lothian risk registers in totality. The Chair stated that whilst an overview is useful the Committee did need to have sight of the detail so the Committee could be sighted on high risks before the red flag stage. The Committee agreed to be guided by Ms Bennett at future meetings where the top risks could be discussed.

42. STATEMENT OF ASSURANCE NEED

42.1 Dr Farquharson introduced the report setting out the external review of the Healthcare Governance Committee’s (HCG) Statement of Assurance Need. Mr Wilson stated that this had an important link to the previous risk register paper and suggested that this be added to the next meeting agenda for fuller discussion. Dr Winstanley added that this was a good start and suggested that for the next meeting papers could include a paragraph on what assurance is sought. Ms Bennett stated that the terms of reference needed to be updated to take account of changes to the committee structure.

43. OTHER MINUTES: EXCEPTION REPORTING ONLY

43.1 The Committee noted the following sets of minutes:

- Clinical Management Group: 11/09/12; 09/10/12
- Health and Safety Committee: 25/09/12
- Area Drugs and Therapeutic Committee: 05/10/12
- Lothian Infection Control Committee: 27/08/12
- Organ Donation Committee: 30/10/12

44. EXCEPTION REPORTING ONLY

44.1 The Committee approved the following items:

- SIGN Guidelines Impact Assessment - Progress Report
- Public Protection Update and Annual Report

45. ANY OTHER BUSINESS

45. There was none.
DATE OF NEXT MEETING

- Tuesday 5 February 2013 to be held from 9am – 12:00noon in Meeting Room 7 at Waverley Gate.

2013 Dates

- 5 February 2013
- 2 April 2013
- 4 June 2013
- 6 August 2013
- 1 October 2013
- 3 December 2013
Welcome and Apologies

Apologies noted from: Graham Alexander, Judith Gaskell, Alison McNeilage, Tony Segal

David opened with announcing that this was Iain Whyte’s last meeting as his term of office ends on 30 September 2012.

David presented Ian with a gift expressing the Committee’s gratitude. Ian thanked the Group and indicated he had enjoyed his involvement in the Committee and acknowledged all the work the committee had undertaken.

Introductions were made to new appointments to the committee:-

Mike Ash, Non-Executive Lothian NHS (committee chair designate)
Jon Turvill, Clinical Director of East Lothian CHP
Rob Packham, Interim AHP Manager for East & Midlothian CHP
Alison MacDonald, Chief Nurse for East and Midlothian CHP

NHS Lothian Clinical Strategy update
Alex McMahon talked to the paper “Our Health, Our Future”. He highlighted areas for change and improvement. Areas discussed were the National vision, and, strategic aims (5 in total) and the process to be adopted. The Appendices were also referred to:-
  1. Future state unscheduled elderly care model.
  2. Future state planned care model
  3. Engagement with Stakeholders.

Ann McCarthy enquired re the new model of care envisaged for East Lothian. DAS explained they were looking at re-provision of ELCH, what it can provide locally and how this will feature in the strategy. Murray Leys advised that timeframes require to be considered as this could influence how this progresses.

Alex McMahon advised that training/resources would be incorporated within the body of work still ongoing.

David Heaney advised that sustainability will come from the outcomes of the Change Fund resources which are focused primarily on the elderly in the community.

Alex McMahon confirmed that safe staffing levels are being reviewed across the board (Ann McCarthy pointed to pressures in maternity). Murray Leys informed the Group this issue requires to be considered in relation to the individual communities and the shift from secondary care into primary care.

2.0 Minutes of the Previous Meeting
Ronnie Hill was not in attendance.
Counsellor Grant was present,
Thereafter the Minutes were agreed as accurate.

3.0 Action Note Previous Meeting

Integration Consultation Feedback:-
DAS explained that there had been an assumption that East and Midlothian would provide joint feedback to the consultation. However CHPs feedback for the draft was that this was not an agreed position and a decision was taken to send in a separate response from each area but these were a shared health and social response.

The EL Sub Committee supported the feedback response.

Ann McCarthy advised that PPF members had been encouraged to send in responses from a joint and individual perspective.

Jill asked how Lothian Health would fit into such a partnership. IW advised this still required to be worked through. There also remains questions around how services not integrated would be managed. DAS suggested route maps may be employed and ML suggested that while things are working well at present the aim is to look at long-term opportunities for improvement. LH confirmed finance is supportive of ML’s vision.

Decisions

The report was noted

4.0 Items for Decision

4.1 Lanfine Unit Redesigns Feedback
Ciara Byrne attended to speak to the redesign paper. A stakeholder event is being planned for November to discuss options. Relocation of the unit to AAH
in advance of the AAH re-provision to the Royal Edinburgh Hospital site is being considered. AMcA queried if local representation is to be involved, Ciaira could not be sure but agreed to feedback this to the project board. DAS inquired if respite would be built in. Robert Packham also inquired what the connection is between Lanfine and community neuro patients. Ciaira said she would ensure these were taken back to the project team. Feedback expected following the stakeholder event.

4.2 Belhaven Hospital Minor Injuries Service

DAS brought a paper on the Minor Injuries Service at Belhaven Hospital and Care Home and talked through the detail there were significant concerns regarding the low number of patients going through the Minor Injuries service during the day. This results in the deskillling of personnel as the volumes cannot support their continued professional development. Viable alternatives exist at Edington Hospital, GP Practices and Roodlands (out of hours). Therefore a proposal to cease this service at the end of September was discussed and supported by the committee. This will not affect other Belhaven services. Partnership are supportive of this, however it was noted that Councillor Michael Veitch does not. Councillor Grant indicated that he and Councillor Hampshire and McLennan concurred with the report. Communication plan to be agreed with the Clinical Nurse Manager.

Decisions

The report was agreed.

5.0 Items for Discussion

No items

6.0 General Managers Report

DAS provided an update on items featuring in his report:


He also reported on the official opening of the Musselburgh Primary Care Centre.

The paper proposed that cancelling the bus service from Haddington to Bonnyrigg should cease when Lammerlaw reopens as journeys were minimal against the cost of retaining the service. Ann asked about the GP cover for Lammerlaw and why this was required. DAS explained the reasons and governance for this.

Decision

The report was agreed

6.0.1 UHD update:

DAS reported on behalf of UHD:

Priorities are:

- Elective Waiting Times
- Unscheduled Care
• Financial balance

Orthopaedic Rehabilitation beds are being considered in the frailty plan for the future and for the new community hospital.

6.0.2 Performance Report:-
FMcJ explained the background of the report. The measures are placed into 4 areas:- Governance, Finance, Service Quality and Efficiencies. Fraser McJannett is keen to receive feedback. IW thanked DAS and FM for putting the report together in a scorecard format. Additional Partnership outcomes to be built in. David Heaney will propose measures. Ann McCarthy referred to high levels of occupancy. IW referring to sickness/absence which is high in East Lothian. Absence Panels are scheduled for next week.
Ann McCarthy highlighted that bank use in Midlothian is high but being advised this is due to Learning Disability issues which have now been addressed (now 19 new staff in post). This might result in removing some data from individual reports for these reports in future. Joint outcomes will feature for the future. IW asked how this is cascaded and DAS advising he is confident this is being cascaded through management lines. Alison highlighted how the less quantifiable issues at ward level are being strengthened.

Decisions

This format was supported for the future by the Committee.

6.1. Staff Governance Report:-

Covered above within the statistics within the performance report

6.2 Finance Report:-
EL - £252,000 underspent. This is due mainly to the prescribing budget underspend based on falls in some drug prices.
Core & Hosted in balance
LRP – on target
GMS – is now Primary Medical Services (PMS)
PMS expenditure - In line to break even
September report will be focussed for EL only which will be easier to interpret. Ann asked about “golden hello’s” and being advised these are payments to new partners joining a practice in Lothian
David asked about the 60, 20, and 10. 10 split historically used to divide allocations between Edinburgh, East and Mid and West Lothian - Lynne gave assurance regarding these splits. Consideration of this is ongoing within NRAC
David Heaney will share the council paper to support demographic growth for East Lothian.

Decision

The report was noted

6.3 Clinical Director’s Report:-
Jon updated the Committee as to his background.
GP in Cockenzie for 16 years, Out of Hours GP, Lead for Long Term Conditions
Access to care within his Practice has been an issue which resulted in an increase in attendance at acute hospital. New “appointment” system being piloted which will hopefully address the above issue.

Jon will provide more detail within following reports to the committee.

Decision

The report was noted

6.4. Chief Nurse Report:-

Alison McDonald's report covered the following key issues:-

Report on Child Protection issues is due out in October;
Releasing time to Care initiative;
The day hospital engaging in better care programme;
Lammerlaw Ward – still dependent on medical staffing but hopeful for opening on 3rd October 2012;
Review of Health Visitor Service – tomorrow is the first workshop for all staff
No significant infection outbreaks
Hand washing compliance good.
PQI replaced PEAT audits – action plan for Edington was received today. Will report at future meetings;
Older People Acute Care Plan will be incorporated into the nursing report

Decision

The report was noted

6.5 AHP Manager’s Report:-

Rob Packham advised he is new to working in East Lothian and is currently AHP Manager for University
It has been agreed he will support East and Midlothian until December.
Rob is keen to build on connections i.e. Speech and Language Therapy and Paediatrics
The service is meeting LRP with a slight underspend;
Equity of provision across the system is being reviewed
7 day working is in the pipeline for therapy services to support hospital discharges
Received a telehealth award within Falls work
Has met with partnership to achieve satisfactory representation;

Decision

The report was noted

6.6 LUCS:-

The report from LUCS was covered including:-

Contacts have increased this year;
Shift cover remains a difficulty;
Sickness and absence is being addressed;
Overspent due to medical sickness, the Jubilee & legionnaires disease outbreak
New quality measures being introduced.  
Requested the Committee to endorse the Annual Report.

Decisions

The report was noted

6.7 Primary Care Contractors Organisations:-

DAS reported two papers for noting

7.0 Carers Forum
Tony not in attendance; no update available.

8.0 Public Partnership Forum
They requested an invitation for PPF members to the GP forums in the future. JT

9.0 Community Health Partnership Committee
Re-invite pharmacy, optometrists, dentists etc. Also voluntary sector rep. DAS agreed to action this. DAS

10. AOCB
No items raised
NHS LOTHIAN
EAST LOTHIAN COMMUNITY HEALTH PARTNERSHIP

Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday, 1 November 2012, in John Muir House, Haddington

Present: Michael Ash (in the chair)
David Small, General Manager (DS)
Moyra Burns, Health Promotion
Murray Leys, Head of Adult Social Care, East Lothian Council
Ann McCarthy, PPF Representative (AM)
Gill Colston, PPF Representative (GC)
Sally Westwick, Interim Assistant General Manager (SW)
Alison MacDonald Chief Nurse (AMcD)
Donald Grant, East Lothian Council
David Heaney, Strategy & Policy, East Lothian Council (DH)
Tony Segal, Carers of East Lothian

In Attendance: Miriam Anderson (Minutes) (MHA)

1.0 Welcome and Apologies

Apologies noted from: Jon Turvill, Fiona Mitchell, Robert Packham, Sharon Saunders

David opened and welcomed all to the meeting. It was suggested it would be helpful to have name tags for future meetings.

MA gave a brief overview of his background and highlighted some areas of work for the Account Commission for Scotland and also involved in the review of Community Health Partnerships and subsequent report.

MA also highlighted to members that verbal reports at future meeting should only be the exception therefore he requests that written reports be received timeously in order that they are sent with the papers for the meetings.

2.0 Minutes of Previous Meeting

Minutes of meeting on 6 September 2012:-
1.1 ML – how does this fit with the Clinical Strategy Framework – DS confirmed this is the same and ML asked if the same language can be used. ML asking how we can feed into this piece of work as it mentions integration between secondary PCM and social care.

With the amendment above minutes are a correct record and true reflection.

3.0 Action Note Previous Meeting

To be brought forward for February. Roodlands came out as the preeminent option for re-provision. MA held this is an important point. GC said there will be further input from members of this committee including the PPF. Ann reminded this has been discussed many times before and other options were preferable then. Ann is not confident that all that is being considered is appropriate. MA will ensure that information will be brought to future meetings. Strategic conversations are also being had within CHPs as large changes in
service delivery i.e. minor injuries, scanning etc. Mike will continue to bring
draft papers and proposals through this meeting.

Gill Colston highlighted conversations re integration

Change Fund Update

Duncan back in the New Year. Paper back in December

Health & Social Care Integration Update

Paper back in January

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

4.0 Items for Decision

None.

5.0 Items for Discussion

5.1 Change Fund update – DH

Funding remains the same until year 2014. Half of the fund is invested in
50/50 split between health and social.

20% is to be invested in the third sector. A detailed review of all projects is
required. Steering Group has now reduced to 8 members as projects are
ongoing. Actions have been agreed within the group in order to continue to
update the position. 4 project have already ended, funding will cease for a
further 7 projects in year 2013. The remaining 35 will continue and further
consolidate implementation over the next year. Systems are being developed
for performance and exit strategies for the remaining projects

DH reported that a plan will be required to be developed to take to the board.
MA asked for a paper back in February 2012 summarising this.

SW asked if identifying the shift in the balance of care can be evidenced. DH
advised measure and calculation of the preventative admissions is not being
collected, however he understood that Carol Lumsden and Jon Turvill are
working on this and may be something that can be seen within their piece of
work.

5.2 Health and Social Care Integration

Item deferred to end of meeting for detailed discussion.

DS and ML reported that we are still awaiting Government legislation, and
therefore many assumptions are being made. There is still at present much
uncertainty. Developing proposals are ongoing at present and much work is
taking place behind the scenes in order to move to a Shadow Board status in
advance of legislation

Much discussion took place and all members had the opportunity to ask in an
open and frank way any questions that came to mind, including what the
implications for this committee and membership was.

MA suggested that detailed record of this discussion was not required for the
record but thanked all for taking part in what will be the first of many future
discussions around integration.

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.

Delayed Discharge position good. ML highlighted that there was £1.9m over committed. There are challenges in recruitment into home care services which are difficult. Murray highlighted how staff are continuing to work and together to hold this good position and it should be noted.

Gullane Medical Centre & Day Centre- issues over the site have now been resolved. AM highlighted that she is not hopeful as this has stated in the past and still no ground work commenced.

MA asked that once a firm date is known this will be circulated to the committee members.

Edenhall Closure - Esk Centre - awaiting building warrant for internal works to toilets, a further dealy may result in the move date of late November being effected.

Tranent - date not yet confirmed, awaiting planning permission

Lammerlaw – reopening on 14th November. GPs aligned to provide day cover and evening and weekends will be provided by the Out of Hours Service.

Edington - Option paper requires to be drafted at some point. Meeting on 14th November which may inform this. Chairman due to visit in December 2012.

MA requested a copy of the East and Midlothians Risk Register.

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.

Leavers percentage is running at 5% this can be largely due to the Prison Service as there has been a large turnover since joining NHS Lothian. MA suggested that this seems high and therefore maybe the prison stats should be separated out.

AM also suggested this could be the same for out or hours as this will skew figures also David suggested he would try to extract hosted services but it is challenging to play around with the data when it comes to the CHP.

Sickness absence panel held recently. AMcD is working with HR and Partnership to provide training to ensure that early intervention is managed
robustly at local area as this is seen to be an area that required focus. Update
to be given at next committee. DG asked how this is reviewed in respect of
what is the trigger percentage is, AMcD explained the absence traffic light
system for absence management.
SW said there are issues similar within this in the hosted services. MA believes
there will be rewards for this early intervention work in the future.

Decisions
The report was noted.

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

The CHP is reporting at mid year an under spend of £107k most of this is within
prescribing.

There is overspend in nursing in hospitals and unmet efficiencies to date.

Prescribing under spend is from two things change in generic pricing approx
£2m impact. LH expanded a bit on this to describe it as drugs that came off
patent this equates to a 5.2 m under spend in total. This will go to areas of
overspend across the system i.e. flu costs, jubilee cost impact etc

MA asked if this is recurring. LH replied no as drug generic pricing can change
year on year.

Mid year review has predicted that all CHPs will break even assuming that flu
costs will be underwritten by the Director of Finance.

The CHP is confident that this is a fair reflection.

ML highlighted how this will be managed in the integration with local authority.
Interesting challenges ahead were noted but LH reported that finance are part
of the workstreams being established to review finance integration/issues.

Decisions
The report was noted.

Clinical Director’s Report
The Sub-Committee considered a report which had been circulated in advance
of the meeting.

Roodlands Hospital
Transport issues were highlighted within the report and concerns raised.
Delays returning patients’ back to Roodlands after attendance at other Lothian
Hospitals.

Inadequate radiology cover is creating issues. Being investigated.

The Lammerlaw item was covered in GM report but plans to open in
Novembers with GP cover.
The pilot Patient Access at Harbours GP is now in its sixth week. Early
indicators are the patients are appreciative of quicker access but GP are struggling with the demand at times.

AM highlighted that she is not aware of the current issues but has known there have been problems waiting on ambulances in the past.

Decisions

The report was noted.

Chief Nurse Report

The Sub-Committee considered a report which was tabled at the meeting with apologies from AMcD for lateness in not getting it out with the papers.

Health Visitor review of role and case loads still ongoing. GP representation are to be invited to future review meetings.

Releasing time to care project has concluded. A staff member from domestic services is currently going through training programme and this is the first non clinical person in Lothian. MA asked for further detail on hand wash compliance to be identified within reports and discussion on the impact to be had at the meetings in future.

Mental health nursing leads have now been appointed and in post. ML asked that the outstanding mental health review could now commence. DS agreed to discuss how and where this piece of work now sits.

Formal congratulations to the east lothian psychological therapies team was extended for their achievement in being shortlisted for the NHS Lothian Celebrating Success award. An invite to this meeting has to be to be extended to them.

Lammerlaw team have been able to do a lot of team building whilst this ward has been closed. MA and members would like visit once opened.

Unannounced visit to RIE action pan of 28 items identified. AMcD has now had site of the report and are currently using this to inform work in our own areas/wards.

ML - Community Mental Health Team. A review is to be undertaken imminently. David agreed this is the right time to carry this out and supported this happening. Also REH phase one is 90 beds a reduction of approx 20 across Lothian. ML highlighted that he would like to be involved in discussions around any reduction in beds as this has a community impact for joint services.

TS highlighted that when the review is taken forward that the third sector are involved in order to support any case for changes and what that impact may be for them.

DS is unsure if conversations/consultations have happened within East and Midlothian for the REH RE-provision

Murray highlighted his concerns regarding pan Lothian issues.

Decisions

The report was noted.
A HP report

The Sub-Committee considered a verbal report from DS in the absence of the AHP Manager

David highlighted that AHP service is working on a plan to implement 7 days working for allied health professional across lothian.

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

There has been an increase in activity over August and September. The Prof to Prof telephone line demand is also increasing and currently the management are looking to see if the evidence and outcomes can be used to shift the balance of care and potential for funding shift too.

Sickness absence issues are currently being managed

Overspend - the jubilee and legionaries caused pressures on funding which finance are aware of. Some of the generic pricing benefits may assist this position.

Festive period cover in the planning stage. Pharmacy opening - a challenge as only two open on two days each week.

MA picked up on complaints and asked if there is there a system. SW highlighted that all areas followed the Lothian agreed system and process.

MA highlighted an audit Scotland website on finance which may be interesting to others. ?????????????????????Web address

Health Promotion

Apologies for being late and not submitting a paper in advance from Moyra Burns

For future will bring a dashboard and submit reports on current and relevant issues for East Lothian.

Health Promotion do have a pan Lothian role and have relationships with all areas.

Sickness/absence not good in service at present

SMS were runners up for a reward and MB asked if consideration for invite could be noted.

Looking at children and young peoples’ frameworks within council and our own areas to review this.

Maternal infant nutritional support is ongoing
Primary Care Contractors Organisation

DS had no items to highlight. LH advised the Scottish contract will be different and the uplift agreed to overall. Change to quality and outcomes framework will require a lot of work for the GPS in the future. Dental will move to cash limited which is a significant change. Pharmacy contract changes for next year reimbursement changes which may change the old 50/20/10/10/10 split, which would have benefits for both Mid and East Lothian. Opticians’ changes may enable prescribing locally.

MA agreed to support this change in formula split and present it at the board sometime.

Decisions

The report was noted.

7.0 Carers Forum

Fund for unpaid carers approved for 700k for Lothian and this equates to £70k for East Lothian. Tony is working with community planners to support rural and hard to reach areas.

Tony reported that East Lothian is a good model for other areas as we generally do very well in respect of support and involvement.

MA asked if there are meetings of carers as he would like to come along to any forum. Tony said they don’t have regular forums as such as they try to reach carers in different ways i.e. domiciliary outreach homes and centres, ML and colleagues are on board with this type of approach.

8.0 Public Partnership Forum

Items under discussion are:
- Ambulance service
- Homeopathy
- Access for carers and disabled people
- How involvement of communities can happen at an earlier stage.

MA said he would come along to a future PPF meeting to introduce himself.

AM shared an unapproved record of a Belhaven meeting, DG suggested this was an inaccurate reflection regarding comments from councillors as not all three agreed. DH advised the joint planning process being has being reviewed for some time now. A survey monkey was conducted and options will be presented at a local meeting next week.

9.0 Community Health Partnership Committee Appointments

No new appointments

10.0 AOCB

None

11 Date of next meeting

It was agreed that the next meeting would take place on 20th December 2012 at 2.00 pm in the Adam Room, John Muir House, ELC, Haddington
1. **Welcome/ Declarations of Interest/ Apologies**

Mrs Allan welcomed those present and invited introductions. Apologies were noted as above and Mrs Allan extended best wishes to Jim Kendal. There were no declarations of interest.

A change to the agenda was made – Item 8, Patient Access Pilot, was rescheduled to follow immediately after item 3, Matters Arising.

2. **Minutes of the Previous Meeting held on 1st September 2012**

The minutes were approved with no amendments.
3. **Matters Arising Not Covered on the Agenda**

   a) Colin Briggs informed the group that progress with updating Edinburgh CHP website has been limited. Given the volume of changes required within the website, it is has been decided a complete redesign is required which would result in the current website being taken down in the interim. The new design would incorporate Capital Projects. Papers from meetings will continue to be published on the internet whilst the website is being redesigned. Ella Simpson offered to supply links to voluntary websites to improve communication links. Colin Briggs to provide update on progress.

   Action: CB

   b) Colin Briggs provided an update on Primary Care Services in North West Edinburgh. Namely a meeting has been requested by East Craigs Medical Centre to consider how patient demand can be met from population growth. Capital Projects are seeking approval for Muirhouse Medical Centre. Colin Briggs to report on progress at next meeting in December.

   Action: CB

4. **Item 8 : Patient Access Pilot:**
   **Presentation by Dr Peter Cairns, Clinical Lead Wester Hailes Medical Centre and Iain Smith, Health Access Co-ordinator.**

   Dr Cairns presented Wester Hailes Medical Centre’s newly adopted Patient Access system. He explained that the new system was a move away from traditional appointments being offered to patients over the phone and instead was an ‘engagement’ system whereby the patient gave a brief description of their complaint and the receptionist would add the patient to the GP’s worklist. The GP prioritises their own worklist and directs their patients to the most appropriate appointment – which may be another healthcare professional or maybe the GP. Alternatively the work may be dealt with without an appointment if suitable (e.g. follow up for results). Dr Cairns reported that the system was working extremely well although had only been running for two weeks. There had been no patients in the waiting room on Monday morning which was previously a very busy time and no patients had failed to show for their appointment (DNA). Wester Hailes Medical Practice had paid a modest fee to a private company for use of the Access system.

   John Davidson asked if the receptionists had received training. Dr Cairns advised that the reception staff were trained and their initial feedback was very positive as now they were able to offer patients a timely solution.

   Angela Lindsay noted that through-patient survey experience, had found 70% of patients would like to book through a digital channel. Dr Cairns explained that the concept of their new patient access system was to prevent patients from booking in advance without an understanding of the problem – although patients can still pre-book appointments for non-urgent demand when the condition is known.

   Peter Gabbitas invited Dr Cairns to present at a planned Edinburgh CHP GP Engagement event being held in November.

   Colin Briggs expressed his support for the system and indicated that he would like to expand its use across Edinburgh CHP.

5. **Chair’s Report**

   Mrs Allan provided an update of her induction which included meeting all the management team members, visiting nine CHP managed facilities (including the Willow Project and Ellen’s Glen) and chairing an Orthodontic appeal
meeting and the launch of the Stroke Workbook. Mrs Allan thanked everyone involved for being so generous with their time during this busy period.

6. **Integration of Health & Social Care**

Peter Gabbitas discussed his paper produced to set out proposed interim governance arrangements (paper 5) for partnership and shadow partnership. He stated that the aim is to work in a consensus way rather than a voting system. The paper has been approved by both the NHS Lothian Board and by the Strategy Group in Edinburgh Council.

Voting members will include 7 senior Health Board representatives – 4 of whom will be non-executive Directors (and will include Mrs Shulah Allan) and 7 elected members. Elected members will include the Convenor and Vice Convenor of the Council’s Health Social Care and Housing Committee, 2 other councillors from the coalition and an additional 3 councillors – one from each opposing party.

Non-voting members present in an advisory capacity will be from 3 main groups: Patients/Clients, Carers/3rd Sector and Professional Advisory and will include Dr Ian MacKay (Clinical Director) and Lynda Cowie (Chief Nurse).

Peter Gabbitas informed that the interim arrangements would be in place until legislative enactment is complete.

Jim Brown questioned if the consultation period was complete. Peter Gabbitas confirmed that the consultation period ended on 11th September 2012. The aim is for Civil Servants to take forward the results to the Minister between November and December.

John Davidson questioned if other areas had formed different governance designs. Peter Gabbitas responded that East and Midlothian have a different design based on councillor numbers.

Colin Briggs noted that Angela Lindsay and Lynda Cowie were working to ensure every profession have a voice and is represented through selection/election process.

Mrs Allan noted that an important task is to ensure that the voice of carers and patients is inclusive.

Ricky Henderson advised that a governance report has been approved by Edinburgh Council yesterday. He noted the opportunity to set up a structure that would deliver the message of Healthy Living.

Ella Simpson advised that consultation was held with the 3rd sector. She raised concerns that partners in housing were missing from representation. Ella Simpson also voiced opinion that the structure should allow honest involvement with voluntary sector.

Ricky Henderson welcomed Ella’s comments and confirmed that the Voluntary Sector are vital partners. Housing feedback was noted by Ricky Henderson.

Peter Gabbitas commented on the relationship between children and their transition into adulthood and housing being extremely important.

Seb Fischer welcomed the fact that carers had been considered and felt that representation is more important than voting rights.

Peter Gabbitas confirmed that patient/client engagement is in progress and is aiming for an inclusive approach. He also noted that GPs are key to the partnership but already 24 are being considered which meets the maximum group size.

Peter Gabbitas outlined the timeframe:

- Discussion ongoing with first meeting scheduled with Edinburgh Council in November. It is proposed that the shadow will replace the Vice Government.
• During the period between now and end of November, Health services will be deciding who will be represented.

• Between December 2012 – March 2013 Acute services will be confirmed. Melanie Hornet accepts responsibility for half of the acute sector. Unscheduled Care will be working with Peter Gabbitas.

• It is envisaged that in Edinburgh, the new Health and Social Care Partnership will be established from 1 April 2013 and will direct further integration development up to and beyond 1 April 2014.

Ian MacKay is working on the next paper which will be circulated at the following sub-committee meeting.

Performance – Presentation on performance to end of August and emerging management team approach – Colin Briggs and Gareth Colin (copy of presentation attached)

• Corporate: Sickness rates are currently at 4.25% down since July 4.28%. The previous 3 months sickness rates are lower than average. Short term sick rates were 1.77% whilst 2.48% for long term sickness. 3.5% is the aspirational target. It was clarified that long term sickness was 4 weeks or more.

• Turnover of staff in Edinburgh CHP was at 0.8% for August. Currently there are just under 2,500 staff employed by Edinburgh CHP. Colin Briggs accepted that an annual staff turnover figure would be more useful than a monthly figure.

• Staff Personal Development Plans (PDP) were recorded at being 23.7% complete through eKSF. Colin Briggs invited comments from Angela Lindsay who manages one of the largest staff groups – Allied Health Professionals. Angela Lindsay commented that there was 100% compliance for all staff – evidenced through recent audit, however there are issues with the way this data is logged onto eKSF and various time lags that the system records based on a staff members start date. This can provide misleading data. Sheena Muir commented that this was also the case for her staff groups – eKSF reported some elements as being not complete when in fact 99% compliance had been achieved. Colin Briggs noted the reporting system eKSF was providing misleading data.

• Complaints: were reported as being total = 7 with 14% breaching the response standard being 80% of responses should be within 20 days and should be the type of response we would want to receive ourselves. Mrs Allan questioned if patients were satisfied with their complaints outcomes. Colin Briggs explained that the process involves a team based at Waverly Gate sending complaints onto Edinburgh CHP head office who then disseminate onto the appropriate department. Frequently complaints are sent back to Waverly Gate if they clearly do not meet an articulate standard. He clarified that patients can engage the Ombudsman should patients be dissatisfied with the outcome of their complaint – however patients are first offered an opportunity to meet a CHP representative to discuss their complaint first.

• Finance – An underspend of £761,000 was noted. Additional beds remain open in the Astley Ainslie and Corstorphine Hospitals. These beds were open under an agreement with the rest of NHS Lothian that they were necessary to support safe care for emergency admissions into Lothian’s acute hospitals. Mrs Hollis and Mr Briggs explained that there is an expectation that funding will be made available to meet the pressure from
open beds. Prescribing was raised as an area that does not fall into standard reporting as it takes 2 months to process, therefore results are staggered. At month 5 there was £365,000 underspend (7.5% variance). 56% of planned prescribing has been achieved. It was commented that GPs in Edinburgh have the lowest national spend being £134 on prescriptions per year compared to the average £179. The good work of GPs within Edinburgh CHP in relation to prescribing spend was recognised. Lynne Hollis commented that some contributing factors to the prescribing spend were contributed by the introduction of a Scottish Tariff for some drugs which delivered a £2 million saving. Half of the saving will go back into Pharmacy services with the other half contributing general savings. Another factor impacting the saving was that a high volume of patents were ending enabling generic drugs to be used in substitute which were much more cost effective – typically 10% of the patent price. However Lynne Hollis noted that the cost of Whooping Cough and increased flu vaccination volumes will add pressure to the future budget. Fiona McCreedy recognised the benefits of fixed pricing within pharmacy. The overspend in nursing was accounted for by the cost of delivering complex care to some patients whilst the SMART Centre contributes to overspend by providing regional and national driving assessments in addition to local driving assessments. Additionally there is increased pressure from wheelchair costs. Sheena Muir is monitoring the costs closely and is also working to reduce staff absences. Sheena Muir noted delayed discharges were 58 in total – being complex care patients in the Robert Fergusson Unit who have behaviourial problems resulting post brain injury. These patients are all from outwith Edinburgh CHP.

- **Quality Performance:** Hospital Acquired infection had no cases reported within Edinburgh CHP for MRSA/MSSA. 7 incidents of CDiff were reported being a consistent trend of the last few months.

- **Access (waiting times)** Mr Briggs explained that there is a national standard for waiting times for access to elective treatment, which was that no patient should wait longer than 18 weeks from referral to treatment. At present 98.5% compliance. The Vasectomy service are due to report next month. The Driving Assessment Service typically has a cohort of people who chose to wait for an appointment at a satellite service based closer to their homes. Edinburgh CHP is the only place in Scotland to run a national service. Colin Briggs will seek an update and report back at next meeting.

- **Angela Lindsay** reported that although not illustrated in the slides, the Domiciliary Physiotherapy Service waiting times are typical and average the same as last year. It is a very high volume service with over 25,000 referrals within a year. There has recently been a new service introduced to provide remote contacts through telehealth and via telephone. For musculoskeletal cases, there was typically 2 follow up appointments required for every new patient. Recently have amalgamated to a single system which has resulted in a merged waiting time. Some patients opt to wait longer to be seen by a more local service – impacts waiting time. A 4 week access target is being introduced with an aim of being 90% compliant by end of 2014.

- **Keep Well** Ciara Byrne reported that despite a reduction in budget and staff, the service still delivered 1963 cases above their target. An agreement with GPs has been achieved to extract data quarterly from practice data. Currently in the process of building a data set for Weight Management and Smoking. Colin Briggs noted that the Keep Well work links to the Reducing Health Inequalities target and is identifying Chronic Disease prevalence through its Keep Well clinics. Mrs Allan invited Ciara
Byrne to return to the December Sub Committee meeting to present and update on Keep Well in further detail.

As closing points, Colin Briggs advised that Gareth Clincscale is currently looking at information flow within the CHP and encouraging staff to think outside the box. He hopes to align performance indicators to objectives and seeks further detail to provide the dataset better. Colin Briggs was keen to hear views on the presentation format and content. He invited those who wished to provide feedback and/or discussion on content to contact him directly or via Gareth. Initially John Davidson commented that the content was a bit too long but helpful. Mrs Allan requested that accountability was evidenced. Lynne Hollis commented that already there was a lot of data being presented, however would welcome PMS contract data. Ella Simpson noted that annual reporting would provide a clearer way of comparing trends – based on financial year end. Ricky Henderson suggested that more service user data ought to be captured and reported on.

8. **CHP Capital Projects Update**

Mr Briggs introduced the paper (paper 7) provided by Mr Whitton, being a summary of the various primary care projects underway. Maggie Gray provided highlights:

- The procurement options and approval process is set out in report and includes HUB and Capital Projects.

- **The West End Medical Practice** relocation into the grounds of the Anglican Cathedral. Complex legal issue with title deeds. Work programmed to start November 2012.

- **The Wester Hailes Healthy Living Centre** Pedestrian access remains an outstanding issue and the relocation of mental health services.

- **Firrhill Partnership Centre**: Feasibility study has identified further option which would involve Firrhill Medical Practice having to move to new centre. Being progressed.

- Three Hub projects are being ‘bundled’ collectively to enable more efficient management. A project steering group will be set up for this ‘bundle’. Please refer to paper 7.1 for draft dates.

- **Firrhill and North West Edinburgh Partnership Centre**: Colin Briggs invited discussion.

- Peter Gabbitas noted that the commitment to take up 550sq metre office option was subject to feasibility study. Children’s and Families services is a priority for consideration as the new centre will be built on that existing site.

- Ella Simpson asked if Flexibility of space in relation to the design of the building was being taken into account. Colin Briggs responded that guidance was being followed from the Scottish Government’s architects’ guidelines. Colin Briggs also noted that Older Peoples Mental Health Service could be facilitated by utilising the current Firrhill Medical Practice – providing more outdoor space/garden.
Peter Gabbitas noted that Ratho Medical Practice has been added to the Finance Performance Review. Ricky Henderson declared an interest as elected councillor for Ratho. He welcomed Colin Briggs consideration for the Ratho community.

Colin Briggs raised the concern that population growth needs to be considered for the North West Edinburgh Partnership Centre. Permission was sought to begin the tender process. Granted by Mrs Allan.

Sheena Muir provided update on Astley Ainslie Hospital – Balfour Pavilion Ward 1 out of commission following a recent fire. Plan to relocate Care of the Elderly – 67 beds across 3 wards. Clinicians would prefer a 3 phase approach however, financially a 2 phase approach being adopted. Mrs Allan enquired as to what engagement with stakeholders had taken place. Colin Briggs responded that currently none as yet due to the very limited length of stay each patient encounters in this ward – communication with each patient to follow once timeframe is known. Assurance that communication will be patient centred.

Mrs Allan opened the floor to questions:

Norman Work raised the topic of 300 new houses being built on water board site at Fairmilehead (planning permission granted) and his concerns regarding the impact this growth in population would have on local GP practices. Specifically, Mr Work sought to establish the official mechanism for informing Edinburgh CHP. Colin Briggs responded by assuring Mr Works that Edinburgh CHP monitors planning permission applications. Maggie Gray also advises that on some occasions the GP practices themselves contact Edinburgh CHP.

Decisions
The report was noted.

9. **Any Other Competent Business**

None raised.

10. **Date and Time of Next Meeting**
The next meeting of the Edinburgh CHP Sub-Committee is scheduled for Wednesday 5th December 2012 at 1 pm in Meeting Room 7/8 in Waverley Gate.
1. **Welcome/Declaration of Interest/Apologies**

Shulah Allan (SA) welcomed those present and invited introductions.

There were no declarations of interest.

Apologies were noted as above.

2. **Minutes of Previous Meeting held on 3 October 2012**

The minutes were approved with no amendments.

It was noted that Voluntary Organisations and Public Partnership Forum Reps have not received copies of minutes for Primary Care Forward Group or Primary Care Joint Management Group for several months. The meeting secretary was asked to address this.

**Action – Anne Crandles**
Jim Brown (JB) also stated that he had not received ECHP Performance Management minutes. SA suggested that it might be better to use the performance report that had been produced for this meeting.

Peter Gabbitas (PG) offered to share the Shadow Health and Social Care Partnership minutes with the membership.

3. Matters Arising
Colin Briggs (CB) reported that he and Dr Robin Balfour (Clinical Lead, North East Edinburgh) had met with the practice team at Parkgrove Medical Practice, branch surgery of East Craigs Medical Practice. This had been a positive meeting and was a step towards progressing the provision of primary care in North West Edinburgh.

4. Dallas – Presentation
Angela Lindsay (AL) gave an informative presentation on DALLAS and the Scottish programme, “Living it Up”, which is about re-designing services and keeping older people healthy. It is anticipated that there will be 55,000 users by May 2015. West Lothian, Highland, Grampian, Forth Valley and Lothian Health Boards are also participating in this programme.

Lisa Stewart (LS) described how the team has sought user engagement, e.g. canvassing people in Ocean Terminal and at the RIE. The main issues raised were accessing better information, i.e. how to find services, products, trusted information with links (e.g. NHS 24) and how to make better connections with services. LS explained that the programme will support people, especially older people, to use telehealth and provided examples of tools used to do this including a digital postcard used in Grampian, a video clip from the “Living it Up” website and a pulse oximeter. LS added that training and education would be given to care home staff. It was noted that some funding has been held back for Telehealth.

AL reported that a Lothian digital health and care centre is about to be announced. She described the wide range of initiatives that have been implemented and the healthcare professionals involved in these, e.g. IMPACT nursing teams, MSK triage service and hospital discharge avatars. She concluded that the scope of this work is only limited by imagination but added that people would need help to forget old ideas.

5. Performance Report
CB and Gareth Clinkscale (GC) presented an overview of ECHP’s performance. PG noted an increased emphasis on performance management within Edinburgh CHP. SA acknowledged this work, stating that the new format allows the Performance Management Group to consider detail and trends and to ask questions.

GC talked to the December 2012 Report (copy attached). The associated discussions are noted below:
- Lynne Hollis (LH) commented that although the financial position looks healthy this is, in part, due to unfilled vacancies. The difficulties in recruiting to certain posts, e.g. community nurses, were acknowledged.
- Sheena Muir (SM) explained that Wards 1 & 2 at the Royal Victoria Hospital have been re-opened for delayed discharges.
- Whilst sickness levels have increased to 4.58%, this is mostly long term sickness absence. CB pointed out that sickness level for Edinburgh CHP is 3rd best overall in NHS Lothian.
- The use of AHP bank staff has increased. AL pointed out that the use of bank and,
latterly, agency staff is due to core gaps in rehab services and the previous use of zero hour contracts. Working towards being back on track.

- The Vasectomy Service is currently working with a backlog. Additional outpatient appointments have been offered to address this and it is envisaged that this should be resolved by Jan/Feb 2013.
- Although the Wheelchair Service is exempt from the 18 week target (service provision not a treatment) there is a need to be careful not to ‘over-perform’ and to ensure that there is a system for reviewing clinical priorities.
- LH commented that the prescribing position is partly due to new generics, drugs coming off patent, many drugs coming in at a cheaper price and tariff prices going down. A key point is to recognise GP performance, i.e. Edinburgh has the lowest spend per head in Scotland. SA noted that there had been a really interesting presentation on prescribing at the last Performance Management meeting. A prescribing report had been tabled at a recent PPF meeting and it had been good that David White had been there to allay concern regarding prescribing in both hospital and general practice settings. LH added that polypharmacy is an ongoing theme and an internal audit of prescribing in NHS Lothian is due to start soon.

GC concluded by stating that he would welcome further feedback and suggestions.

6. Integration
PG reported that the first meeting of the Shadow Health and Social Care Committee had taken place. The main focus of the meeting was the remit of the Committee, its role, procedures, behaviours and political will. The arrangements for chair and vice chair and the professional advisory group were agreed. Whilst there would be a representative for every group, invites to attend would be made as and when appropriate e.g. Ella Simpson (ES) is to be invited to attend to discuss how best to engage with the third sector.

Michelle Miller (MM) is currently engaging with carers and users to plan a set of criteria. MM to attend the next PPF meeting in January 2013. It was noted that Seb Fischer (SF) from VOCAL has not had any involvement to date and is unaware of the process.

At a national level, Jim Forrest (Director of Health and Social Care, West Lothian), PG and representatives from NHS Highland will present to Ministerial Steering Group. PG will also attend the Delivery Group for Older People. A document summarising the main issues will be produced shortly. A response, which would provide a signal of intent, is anticipated early in the New Year.

PG explained that Edinburgh CHP would continue to host Sexual Health, SMART, Neurological Rehab services. New hosted services for Edinburgh will be Specialist Learning Disabilities and Specialist Addiction Services – these will have a centralised core with a devolved model for West Lothian ad East and Mid. Mental Health services, including REAS, will be managed by Tim Montgomery. David Small is leading on the reprovision of REH and will continue to do so through to the outlying business case stage (to be completed by 31 March 2013). Discussions continue regarding Prison Healthcare Services, Health Promotion and Complex Care. SA commented that she has meet with Alison McCallum to discuss Health Promotion and a statement is to be made for this group.

There was a discussion re Health Inequalities. PG observed that currently this service sits in multiple areas which can become very difficult. Councillor Ricky Henderson (RH) is looking at managerial structures. CB stated that there is diffuse management with no professional oversight and there is a need to have sensibly aligned structures. He
DRAFT

added that working out the various links between the relevant agencies would take time. SA promised to keep Health Inequalities on the agenda. Action – Shulah Allan

A draft agreement that can be signed by both parties is being worked on. This will cover budgets, differential uplifts and targets, underspends and overspends, development, communication, training and joint performance management systems. It was noted that MM has joined ECHP’s Performance Management Group.

7.  **GP Engagement**

CB reported that the GP Engagement event on 30/11/12 has been successful with over 70 Lothian practices represented. There were presentations on Integration, the Patient Access appointment system, management of older people in North West Edinburgh and improved clinical pathways (Care of the Elderly) for primary and secondary care. The event concluded with a workshop on the Scottish GP contract. Edinburgh CHP is working with the LMC to run a further event in six months time.

8.  **Capital Projects**

Maggie Gray (MG) gave an update on the following capital projects:

- Wester Hailes Healthy Living Centre is on target to finish early. A final decision on early acceptance is required by January 2013 in order to avoid double running costs. The only outstanding item is the underpass and thereby access to the new centre. CEC in negotiations with the shopping centre owners.

- Firrhill Partnership Centre/North West Edinburgh Partnership Centre /Blackburn, West Lothian. Undergoing review by Scottish Futures Trust – new projects request to Hubco at end of Jan 2013. The current draft timetable is start on site in Sept 2014; therefore need to look to draw in timetable. The Scottish Futures Trust to facilitate workshop for NHS Lothian and City of Edinburgh Council to look at the master plan for Muirhouse. The meeting with patients from Craiglockhart Surgery had been positive with most concerns resolved.

- The Initial Agreement for the reprovision of Ratho Surgery was approved in October 2012. There is an extensive approval process, including the ECHP Sub Committee, to go through. The next step is to develop a business case to be presented at NHS Lothian’s Finance & Performance Review in February 2013. As some of the meeting dates are out of alignment and in order to meet the 28/12/12 deadline, MG suggested that ECHP Sub Committee agree the document via email. This was agreed to. MG highlighted that there had been a fire at the proposed Ratho site which had caused damage to outbuildings. Security has since been stepped up.

- The preferred contractor has been selected for the West End Medical Practice project. Site work will start in January 2013 with completion early in 2014. Legal arrangements need to be agreed.

LH reported that in 2013/14 capital expenditure will not be devolved and all projects will go through and be reported on by the partnership. PG commented that there has been no discussion of this issue yet, noting that the partnership cannot own assets and that VAT and capital can only be decided at national level.

SA observed that the Mental Health services currently delivered from Cambridge Street will move to Wester Hailes when the new centre opens and that patients have raised concerns about travelling to Wester Hailes. SA added that David White has indicated that interim arrangements have been made for this patient group.

The reprovision of services from the AAH site to REH was discussed. This is
progressing rapidly with a revised timeline for 2014, rather than 2016. SM explained that the priority is likely to be all units in MacKinnon House which may include the Robert Ferguson Unit. SM is waiting on formal feedback. Funding is available to decorate and create some family space. Additionally, simple cosmetic changes at Ellen’s Glen that help with challenging behaviours are being carried out.

SA had recently visited the Jardine Clinic and observed work that was making a huge difference. CB commented that Tim Davison (Chief Executive, NHS Lothian) had been a manager in REH 20 years ago and now on his return to Lothian sees little change and is therefore committed to making changes. SA stated that it was good to see money being used in better ways for better outcomes.

9. Keep Well
Ciara Burns (CBy) gave a comprehensive overview of the Keep Well service. The Scottish Government had envisaged that this project would contribute to a reduction in health inequalities and that this could be built into normal practice. The target groups were 40-64 year olds in the 15% most deprived data zones which equated to 25,000 people in Lothian and 17,000 in Edinburgh, plus other vulnerable groups and those in prison. Certain patient groups, e.g. strokes and MIs, were excluded.

The project started in 2007 with 14 practices using a standardised model and the related HEAT target. This has grown to 106 practices and a team of 11 nursing staff, with most work (70%) concentrated in 22 practices. Each patient is offered a 40 minute nurse-led appointment with clinical and mental health screening and a review of lifestyle factors. The nurse uses motivational interviewing techniques. From this a score indicating the risk of having a heart attack in the next 10 years can be applied. The practice team follows up on any issues that are detected.

Patients are recalled every 5 years and are never taken off the Keep Well list, although patients tend to move onto a disease register which takes them out of the Keep Well project criteria. Two invitations, written in Easi-Read, are sent to patients over a 90 day period. The project team also uses NHS 24 to make calls in evenings.

The team worked with an external company, BlueBay, to resolve data governance and IT issues. 17,000 people were seen, 7% of whom were at a high risk of MI or stroke. Although more women than men were seen, more men were in the high risk category. Overall the project found 300 patients with hypertension and 100 diabetics. Project has seen improvement in BP, diet and activity levels. The team is working with GPs re prescribing statins and makes use of health coaches, Smoking Cessation and Weight Management services. CB commented that Steven McBurnie and Ian McKay are looking at statin prescribing. LH suggested that this might be an issue for the Medicines Management Team but C By stated that there was not a lot of cost involved.

Future priorities include physical activity with Health Scotland, diabetes risk scores, statin patient groups, smoking cessation and annual review uptake. Community services are also to be offered Keep Well.

SA asked if Keep Well could be used to measure Health Inequalities. GC and CBy have started to look at measuring the changes in risk factors. CBy pointed out that the data is reported quarterly to the Scottish Government and that the real impact will be in Public Health data in 5 years time.
10. **Withdrawal of GP Service, Minto Street**

CB announced that the Southern Medical Group will close its branch surgery in Minto Street on 31 January 2013. The two practices see the same patients (list size is 1700) in two different sites that are not very far apart. The practice has involved the local community in this proposal. Eight patients including 1 MSP attended the two consultations meetings. As there are no objections to this proposal and there is no legal way of preventing this from happening CB asked that the ECHP Sub Committee note this action.

11. **Children’s Inspection**

A pilot inspection of children’s services that includes schools, child protection and Social Work is underway in Lothian. This is a lot of work for Lynda Cowie who will give a report on the integrated inspection at the next Edinburgh CHP Sub Committee meeting.

**Action – Lynda Cowie**

12. **PPF – Joint Meeting**

The joint PPF meeting heard an update on Integration and a report from the Voluntary Organisations. The PPF is anxious to see that the VOs are thoroughly involved in the new partnership. PG has given an assurance that this will be the case.

13. **Chair’s Report**

SA reported that she has participated in and/or visited the following:

- Edinburgh Partnership Group’s Health Inequalities workshop.
- Homelessness event
- Dental Appeals
- New Shadow Partnership
- **Celebrating Success Awards** – which recognised the following staff:
  - Willowbrae
  - John Steyn
  - Orthotic Redesign
  - Candice McArthur – runner up, staff employee of year

- **Daily Record Health Awards** - which included the following Lothian winners:
  - Family Nurse Partnership - a couple of graduates from the project to attend next Edinburgh CHP Sub Committee.
  - Mental Health Nurse – Nurse of the year

- SA also noted that ECHP has achieved Healthy Working Lives – Bronze Award
- Welfare Reform meeting – Kate Burton and Lesley Johnston to attend a future meeting
- Cabinet Secretary/NHS Lothian meeting at Murrayfield. Patient representatives had made good points.
- Patients’ Council AGM (speaker)
- PPF Meeting.

13. **AOCB**

It was suggested that a smaller room should be booked for future meetings.

14. **DONM**

The meeting is scheduled for Wednesday 6th February 2013 in Meeting Room 7, Waverley Gate
1.0 Apologies and Welcome

Apologies were noted as above.

A welcome and introduction was made to Alison McDonald, newly appointed Chief Nurse for East and Midlothian CHP. Alison gave a brief resume of her background in Edinburgh CHP and she said she is looking forward to the challenges this new post offers.
2.0 Minutes of the Previous Meeting held 31.05.12
The minutes were agreed as being a true and accurate record of the meeting subject to the following change:

Carer Report
Paragraph 3 should read Short Break Bureau.

3.0 Matters Arising / Action Plan
Action Log was updated.

4.0 Items for Decision
No items for decision

5.0 Items for Discussion

5.1 Progress Report Update – Midlothian Partnership Change Fund Work streams
TW updated the Committee.

The Change Fund was launched by Scottish Government in November 2010 to assist Health and Social Care Partnerships to achieve the Reshaping Care for Older People Agenda. The key themes of the agenda are; reducing the number Care Home Places, reducing the number of hospital admissions by providing care and support to people in their own homes or a homely setting, building a sustainable service for the long term to deal with the demographic changes and the number of individuals living with dementia.

Progress in 2011/12

- An Innovation Fund was created to enable local providers and voluntary organisations to pilot new ways of working. The 5 Innovation Fund projects are delivering good outcomes for both carers and the cared for person.
- Vocal In-reach and carers education workers have supported carers in the hospital and the community
- The Telecare project has delivered a significant increase in the numbers of individuals receiving both the basic and enhanced Telecare package.
- Highbank assessment and Intermediate care beds are enabling earlier hospital discharge and preventing some admissions to hospital,
- The hospital In-reach assessment workers are ensuring the zero 6 week target is maintained whilst shadowing the proposed 4 week delayed discharge target.

Community Planning hold risk registers for all partnerships and the Adult Health and Community Care register will include any risks in relation to the Older Peoples Action Plan for 2011-15 and how these will be managed.

There has been regular involvement of a wide range of partners in the
implementation of the 2011-12 plan and development of the 2012-13 plans. These include regular meetings of providers groups such as care home managers; care at home managers; and day service providers. The Older People’s Planning Group has representatives from a range of agencies including users and carers whilst the Overarching Older People’s Management Group has Third Sector, Independent Sector and Carer representation.

The workstreams of the 2011-12 and 2012-13 plans also reflect the feedback and input of older people and their carers through the Older People’s Strategy. Approximately 1,000 people have had the opportunity be involved in the development of the Strategy, with a further consultation event planned for October 26th 2012.

TW attached an appendix to his paper highlighting all the different work streams ongoing at present.

DAS highlighted to the Committee that there had been significant other investment via Long Term conditions and resource transfer funding streams.

EE reported that he still had concerns regarding the extended 7 days working for practitioners to support the reduction in readmissions to the NRIE at weekends and evenings.

DAS suggested there will be opportunities for increased support via the Frailty Programme and 7 day week working within primary care.

EE highlighted the excellent delayed discharge numbers and wondered if this could be linked to the above programmes implementation. TW suggested that via JIT discussions this may be able to be demonstrated.

SE reported that she believes that at times transport difficulties may lead to patients being taken to hospital rather than to another primary care site for treatment.

HR reported that the Rapid Response Service within Midlothian, enables local support for patients with access to assessment, re-ablement and looks set to get stronger with the co-location of health and social care staff at the Highbank site. HR also reported that he and Carol Lumsden are developing a learning event to deliver to GPs.

EE wanted it noted the hard work and the challenges in delivering this model.

5.2 Integration of Health and Social Care in Scotland – Consultation Response

DAS reported that following an agreement two separate responses were submitted, however, these were joint Health and Social Care responses.

Legislation will require us to be integrated formally by March 2014, this may require some shadow arrangements in advance. As detailed before the scope is potentially broad.

DAS highlighted that there is still much work to do in respect of organizing
the governance, structure and senior committee and board arrangements. This is a work in progress.

DAS reported that there have been some working group meetings and that more detailed work is now needed i.e. Finance, ER. There is also a 3 way meeting with the Chief Executive Officers and leaders scheduled for the 18th October which is to discuss a shadow arrangement.

JG reported that the Carer Forum had responded separately via public consultation. She also highlighted that they are concerned that the future boards/committees may not have a seat on it for them.

GW reported that the Voluntary Services had also submitted a return to the consultation.

EE thanks DAS and Council Partners for their contributions to collating the responses. He also noted his concern regarding hosted services if East and Mid health split.

He did note however that the willingness and contribution from Carers and Voluntary Services has been invaluable.

5.3 Falls Pathway

Fallen Uninjured Person
Roz Eccles reported that this is progressing well and they are almost at the point of identifying a Single Point of Contact for East and Midlothian. SE asked when this would be as it had been along time awaited. Roz said this is particularly difficult as it is dependant on staffing in post but anticipates this would be within the month.

Care Home Telecare Project
Roz highlighted the positive impact this was having in home in respect of knowledge and training.

RP also wanted it noted that Roz Eccles and Morag Barrow had been nominated for a UK award and are travelling to London soon for a ceremony.

Fall Awareness Week
RE highlighted that this took place in June 2012. There were stalls manned in Kings Park with a theme of ‘boost your bones’.

Physio on the Go
This is a proactive piece of work in care homes, day centres, lunch clubs etc. Information is given out on how to reduce and prevent the risk of falls.

Exercise and Education
OTs and Physios are running a 7 week course in falls prevention and aimed at sheltered housing but open to non residents also.

5.4 Physical Disability Action Plan

TW reported the purpose of this plan was to address the needs of disabled people, including those with long term conditions and those with sensory impairment. He said that this work involved and included input from all
parts of the sector i.e. transport, council, health and education. The following items were identified through the public consultation including a number of health related issues and recommendations.

Amongst these were:-

- The need for quality time and support from GP’s and quicker access to appointments.
- Improved disabled parking at GP surgeries and hospitals.
- Transport to appointments can be difficult and there may be value in developing a volunteer transport support system.
- The desire for a more localised clinic model, condition specific, satellite clinics. This might include portable specialist clinics on specific topics and conditions in local areas.
- The need to improve communication between health departments for individuals seeing lots of different health professionals.
- Access to good information to enable people to take responsibility for their own conditions.

SW highlighted that she is heavily involved in this work and is the health point of contact for this.

MG said it is very difficult and sometimes there is a struggle with labels when it should just be for access to the most appropriate service.

EE suggested that we should seek help in supporting the misuse of car parking spaces for the disabled.

TW reported on the action plan that was attached with the papers and said this would be progressed and further updates could be brought to this meeting.

6.0 Performance Reports

General Manager’s Report

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

Delayed Discharges

Continued good performance was noted.

Integration Agenda

As detailed under separate agenda item

Premises

It is encouraging that a likely location for the reprovision of Malta House has been identified at AAH. EE was unsure that this location was appropriate for patients to travel for day service. DAS said this has been
discussed with service users and it is felt that with support for directions this could be managed well.

**Homeopathy Review**

Consultation stakeholders group have 4 public meeting planned.

Responses to the public consultation should be encouraged by all.

**Decisions**

The report was noted

**6.0.1 East and Midlothian CHP – Performance Report**

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

DAS highlights as below some of the advantages and purpose of a performance scorecard for the CHP:-

A wide variety of measures can be used to monitor CHP Performance. The sub-committee receives regular reports and updates on many of these (absence management, financial management, delayed discharges etc) but to date it has been difficult to provide the Committee with a complete overview of CHP Performance.

To address this, a ‘performance scorecard’ has been developed. This scorecard synthesises key performance measures into one document and will provide sub-committee members with the opportunity to have a complete overview of CHP performance.

Where it is appropriate, measures will be given a ‘Red, Amber, Green (RAG) rating.

- Green implies that a measure is ‘on track’
- Amber that there is a ‘minor deviation from trajectory’
- Red implies that performance is ‘off track’.

In addition to this, an arrow is used to indicate whether there has been any improvement. An upward arrow indicates improved performance, a sideways arrow that performance has been maintained and a downward arrow, a decrease in performance. For example, a downward arrow in an area with a ‘Red’ rating suggests that this area is particularly challenged.

**DAS reported that this is the first iteration of the scorecard. As such the Committee’s feedback on the format and scope of the scorecard would be welcomed**

EE suggested he thought this was positive and helpful and invited the committee for comments. He also suggested that it is important to really know what we do with the information when we get it and how it will be used to improve on performance.
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.

DAS reported that turnover was high. He also reported that sickness absence remains higher than acceptable.

DAS reported that he recently convened a sickness absence panel, HR and Thomas Miller, Lead Partnership met together with him to review some 50 cases. It was noted that in the main all cases were being managed appropriately and those of concern had been taken up with the relevant manager.

TMcL highlighted the Healthy working Lives agenda and how it has a positive impact on staff moral which can lead to improved attendance.

Decisions

The report was noted.

6.2 Finance Report

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

Lynne advised that there is a significant change for Prescribing this year with a lot of drugs moving off patent. This will assist in helping us achieve the LRP for Prescribing.

Lynne highlighted a break-even position for Midlothian, Core Services had a small underspend, there was a slight overspend in SMS and LD, within prescribing. Some of the savings within prescribing will be offset and some reinvested into Primary Care pressures, approx £400k

SE highlighted waste medicines again and HR reported that work is ongoing within initiatives between practices and pharmacies.

The increase in property costs is being picked up via Head of Estates.

Uplifts via NRAC monies are being actioned by DAS and LH. There will be a need to shift balance of care to enhance district nursing resources.

6.2.1 PMS Expenditure by CHP

LH talked to this paper and highlighted for future this paper would be shortened and more area focussed.

EE asked why we pay superannuation for locums. LH said this was a
national agreement.

Decisions

The reports were noted.

6.3 Clinical Director Report

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

HR included a report for Seasonal Flu Vaccinations 2011/12. He asked the committee to note that Midlothian had a very high uptake of over 65 year olds for this vaccination.

Prescribing Budget Report 2012/13 this reports shows that Midlothian was the least CHP over spent and continues to do very well.

He reported that there have been no important clinical developments or governance issues worthy of the committee’s attention in the most recent period.

HR reported that he hopes to bring the CHP prescribing action plan and the Lothian Primary Care Impact report 2012 to the next meeting.

MG said it was challenging getting carer’s access to the flu vac as a matter of course. Julie agreed this.

HR said GPs are recording this information but carers would require to identify themselves on occasions.

Flu notices to be made available at all GP Reception areas.

Decisions

The report was noted.

6.4 Chief Nurse Report

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

Alison highlighted key points :-

Child Protection
Adult Protection
HAI for Midlothian

Healthcare Technician programme assessment had taken place and outcomes waited.

MCH – Community garden is ready to open and reports are very positive
HV Review has commenced and the first workshop is about to take place. A plan is expected early December 2012.

Prison review of nursing outcome expected next week

Launch of new HAI manual is ongoing and audit and compliance programme being implemented.

Decisions

The verbal report was noted.

6.5 AHP Manager Report

Rob Packam, Interim AHP Manager introduced himself with a quick resume of his background. His report highlighted the following:-

Occupational Therapy services were struggling to recruit experienced OTs into their teams. Internal recruitment making it challenging to attract new personnel.

An underspend at present as a result of long term vacancies.

AHP will continue to support the Frailty Programme and implementation

AHP services are looking at a model for 7 day working in East and Midlothian with a view to implementing by January 2013.

Brian Brockie, Physiotherapy Head of Service is going to lead on E-health issues for AHPs.

RP reported that work continues within R&D, partnership and other areas of new ways of working, compliance, complaints etc.

EE suggested that he is keen to see barriers between Primary Care and Secondary care broken down and welcomed RP’s approach to integration of the two and his experience within Secondary care.

Decisions

The update was noted.

6.6 Hosted Services
The Sub Committee considered reports which had been circulated in advance of the meeting.

6.6.1 – Health Promoting Hospital

MS introduced Tracy McLeod, Health Promotion Specialist, who leads the Healthy Working Lives agenda in Midlothian.

Tracy tabled a paper on Midlothian Health Promoting Hospital and talked through the following key issues:-

The JHIP Plan 2012-13 included a commitment to support staff, patients, visitors and volunteers to embed approaches that promote health and wellbeing at the hospital.

Tracy McLeod, has co-ordinated and supported this work. A multi-agency Steering Group was established and agreed to work to achieve the following long term outcomes:

Midlothian Community Hospital promotes health and wellbeing for patients, staff and visitors.

Key outputs with resulting outcomes have included:

Partnerships developed that will help to sustain health promotion activity.

- Steering Group led by the Health Promotion Service included representatives from both NHS and community organisations.
- Volunteers have also been recruited – 5 from the NHS volunteer centre, 3 from Ageing Well and 2 from Therapet dogs. They lead activities including diversion therapy, a knitting group, Toot 4 Fruit delivery and new age curling.

Increased opportunities for people to improve their health and wellbeing.

- Toot for Fruit van providing delivery of fresh fruit and vegetables weekly.
- Hospital gym made available to staff with a three fold increase in use.

Canteen provides healthy living options and an opportunity to socialise.

Improved access to health promotion information that will increase knowledge to allow for health behaviour change.

- Achievement of Silver Healthy Working Lives award for staff – includes health information and activities.
- Community information and activities promoted.
- Variety of formats used: television screens with panels for health messages, posters, leaflets, DVSs, community directories and direct contact.

Also further development of hospital environment to promote health and wellbeing.
Cyrenian's led a consultation and mapping exercise regarding the development of the grounds. This has resulted in paved walk ways, benches and a garden hut. A sign is being designed by a local college for the entrance and local community groups are helping to put in fencing and raised beds. The garden has been designed to be easily accessible. There is a garden coordinator who is working with individuals and community groups and it is now open for relaxation, growing and physical activity. The official opening by Dr Charles Winstanley and the Lord Provost takes place on the 5 October at 2pm.

- £500 NHS Foundation Grant awarded for gardening equipment this year.

6.6.2 Learning Disability Service Strategy

Sally talked to the paper and was happy to take any comments.

EE asked us to keep up the pressure and encouragement for the ‘moving on strategy’ for complex patients and also regarding the reprovision of inpatient areas within the REH programme.

Decisions

The report was noted.

6.7 Primary Care Contractors Organisation

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

Decisions

The reports were noted.

7.0 Carers Forum

JG gave a verbal report to support attached Carers Action Midlothian minutes.

Julie reported that the surgeries for support to carers are being progressed.

Julie highlighted that she would be keen to retain membership of these committees in the future

Decisions

The report was noted
8.0 **Public Partnership Forum**

SE gave a verbal update on behalf of the Public Partnership Forum.

She reported on death of a previous PPF member who had in the past contributed much to the work of the PPF for Midlothian.

SE also reported that the PPF had submitted a response to the Integration consultation and encouraged return for the Homeopathy Review.

The action planning for Stroke Care continues and it is expected a plan will be in place by Nov. the group will then meet twice yearly to update and review. It is hoped that as part of the outcomes saved beds bays will be captured.

SE asked if the issue of transport had moved forward in any way to improve access to community health services. TW agreed to look into this.

SE also asked for clarity around the waiting time issues. EE replied that this is extremely challenging and there is a lot of work to do in order to get this into a reasonable position. DAS added that he would see if there is a press release that can be shared with the local advertiser to inform local public.

GW asked when Catherine Evans was to return from maternity leave, it was highlighted that this is confirmed as November.

**Decisions**

The update was noted.

9.0 **Community Health Partnership Committee Appointments**

Mike Ash has been confirmed as Joint Chair of Midlothian and East Lothian Sub Committees

10.0 **AOCB**

GW reported that the Older Peoples directory is being launched next week

DAS asked members to stay behind and join the tea party for Eddie Egan in the lounge afterwards.

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

Thursday 6th December 2012 at 14:00 in the Council Chambers, Midlothian House, Buccleuch Street, Dalkeith
CHAIRMAN’S REPORT

1. Internal

1.1 MSP Briefing

On 7 December I chaired a well attended quarterly MSP briefing. It covered wide ranging operational issues.

1.2 Visits

On 5th December I visited the Royal Edinburgh Hospital with fellow Non-Executive Directors. We were briefed on site re-provision plans and visited wards.

1.3 Consort

On 22 January I attended a meeting of the joint NHS Lothian/Consort Board which I co-chair.

1.4 Community Gardens

I chaired the quarterly meeting of the Community Gardens Steering Group on 18 December. We heard about progress of a second community garden now established in the grounds of the new Midlothian Community Hospital. This joins the established Royal Edinburgh garden, and will be followed by a garden at Belhaven in East Lothian now in its early stages of construction.

1.5 Office Team

On 12 December I joined Elaine Watters and Douglas Weir for a farewell lunch for Janette Calder who has retired from the NHS. Janette provided vital support to the Corporate Services Manager and additional support to the Chair and Chief Executive. When you are next in Waverley Gate please welcome Georgia Campbell who replaces her.

2. External

2.1 On 29 November I attended a meeting of the Food for Life steering group. With Edinburgh Council and Edinburgh University, NHS Lothian is part of pilot that will test the health, environmental, and economic effect of locally procured food over a two year period from 1st April 2013. Our test site will be St John’s Hospital.
2.2 Friends Foundation

On 4 December I attended a City of Edinburgh Council reception to mark twenty years of the Sick Kids Friends Foundation. During this period the Foundation has raised an impressive £18M towards facilities, services, and equipment not normally covered by NHS funds. NHS Lothian will be working closely with the Friends on facilities in the re-provided hospital.

Charles Winstanley
Chairman
11 January 2013
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for January 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 9. 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. This report focuses on cancer.

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.

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 Exception Reporting – Quality Dashboard

3.7.1 Hospital Scorecard data continues to show that NHS Lothian has a higher rate of medical and surgical readmissions and length of stay than the Scottish rate. Further work is being undertaken to analyse this data and integrate into work already being progressed through medical profiles. Discussions have taken place with ISD about the hospital scorecard readmissions data. As a result of the discussions they are providing more detailed data so that we can attempt to pinpoint where within our system the rates are highest. This has involved ISD doing work to align the methodologies for the scorecard and medical profiles. The first cut of these data were received before Christmas; further analyses have been requested and are awaited.

3.7.2 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.

3.7.3 Meeting the HEAT target for Staph. Aureus Bacteraemia remains a challenge (see graph 13) and is described in more detail in the Healthcare Associated Infections paper.

3.7.4 In October 2012, there was an increase in falls with harm (see graph 18). We examined the location of these falls in relation to the Care Rounding Spread Plan. The Board should note that the vast majority of falls in this month were from areas in the initial planning phase or at early implementation phase of Care Rounding. To sustain improvements in falls harm reduction, a rapid spread plan has been put in place.

3.8 At the November 2012 Board, a paper set out a 5-year programme update for the Scottish Patient Safety Programme (SPSP) and it was agreed that NHS Lothian’s mortality reduction and harm reduction driver diagram and improvement plan (2012-15) would be made available at the next Board (see Appendix 2).
3.9 Clinical Effectiveness Measure – Cancer

3.9.1 Cancer effectiveness measures are as follows:

1. Mortality rates
2. Smoking cessation outcomes
3. Colorectal Cancer Screening Uptake
4. Breast Cancer Screening Uptake
5. Cervical Screening Uptake
6. Primary Care review of patients newly diagnosed with cancer

3.9.2 Earlier Detection of cancer (DCE) is a policy priority for NHS Scotland. The focus of DCE is reducing the socioeconomic and ethnic variation in stage at presentation. The expected outcome is improved one and five year survival, to be achieved by diagnosing a greater proportion of cancers at stage 1 of the disease. NHS Lothian has established a Detect Cancer Early programme to deliver the outcomes required of the Board by 2015. NHS Boards are required to increase by 25% the proportion of stage 1 cancers detected in lung, breast and colorectal cancers, which are the focus of the national Detect Cancer Early programme. Measurement for the programme is currently being finalised by the Scottish Government Health Department. The baseline position for NHS Lothian has now been supplied by Information Services Division Scotland, and improvement from this baseline will be reflected in the Local Delivery Plan.

3.10 Mortality rates

3.10.1 Table 1 shows the mortality in Lothian and in Scotland over the period 2007-2011 for all cancers (excluding non-melanoma skin cancer) and for the four most common cancers: lung, colorectal, breast and prostate cancer.

3.10.2 In each case the rate of deaths standardised to the European population (to take account of differences in the populations) are presented, as are the Standardised Mortality Ratios (SMRs). The SMRs show the rate of deaths in relation to the Scottish mortality rate; if the SMR is less than 100, then the mortality rate is less than the Scottish rate; if it is more than 100 it is greater than the Scottish rate.

3.10.3 For all cancers, the mortality rate in Lothian is lower than in Scotland. For breast cancer the mortality rate is lower than the Scottish rate and for lung, colorectal and prostate cancer the mortality rates are not significantly different. Mortality rates for 2007-11 are also presented by Scottish Index of Multiple Deprivation (SIMD) (Figure 1). This shows that Lothian’s profile is similar to Scotland with a higher mortality in the most deprived groups. This reinforces the importance of targeting resources towards prevention and early detection and reducing inequalities in access to evidence based interventions.
### Table 1: European Age Standardised Mortality Rates and Standardised Mortality Ratios from all cancers and four types of cancer for Lothian and for Scotland for 2007-2011

<table>
<thead>
<tr>
<th></th>
<th>All excluding non-melanoma skin cancer</th>
<th>Lung cancer (excluding mesothelioma)</th>
<th>Colorectal Cancer</th>
<th>Breast Cancer</th>
<th>Prostate Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lothian</td>
<td>Scotland</td>
<td>Lothian</td>
<td>Scotland</td>
<td>Lothian</td>
</tr>
<tr>
<td>EASR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lothian</td>
<td>198.2</td>
<td>204.1</td>
<td>55.5</td>
<td>55.8</td>
<td>19.6</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>194.3</td>
<td>202.6</td>
<td>53.4</td>
<td>55.0</td>
<td>18.4</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>202.1</td>
<td>205.6</td>
<td>57.6</td>
<td>56.6</td>
<td>20.9</td>
</tr>
<tr>
<td>SMR</td>
<td>97.4</td>
<td>100.0</td>
<td>99.3</td>
<td>100.0</td>
<td>97.2</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>95.6</td>
<td>95.8</td>
<td>91.5</td>
<td>82.5</td>
<td>91.5</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>99.3</td>
<td>103.0</td>
<td>103.1</td>
<td>95.8</td>
<td>95.8</td>
</tr>
</tbody>
</table>


**EASR:** age-standardised mortality rate per 100,000 person-years at risk (European standard population)

**CI:** Confidence Interval

**SMR:** Standardised Mortality Ratio

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### Figure 1: Age-standardised cancer mortality rate per 100,000 population: 2007 – 2011

Data extracted November 2012.

Source: General Register Office for Scotland (GROS) (mortality and populations)

ICD-10 Codes: C00-C97 excluding C44.

SIMD 2009 deprivation quintile.

2011 data is provisional.

**EASR:** age-standardised mortality rate per 100,000 person-years at risk (European standard population)
3.11 Smoking Cessation

3.11.1 There are Scottish Government targets both for the overall number of successful quit attempts and the successful quit attempts by those in the most deprived groups. These run from April 2011 to March 2014.

3.11.2 Table 2 shows that Lothian is, to date, exceeding the milestones required to meet both of these targets. To continue on this trajectory, NHS Lothian will continue with its strategy of providing brief intervention training to encourage referrals to the service and continuing to explore other innovative approaches.

<table>
<thead>
<tr>
<th>Total Successful Outcomes</th>
<th>Successful Outcomes (%) in Inequalities Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian 6,765</td>
<td>3,381 (61%)</td>
</tr>
<tr>
<td>Milestone for period 5,630</td>
<td>4,144 (60%)</td>
</tr>
</tbody>
</table>

Data extracted from National database on 23/10/12

3.12 Colorectal cancer screening

3.12.1 The data in Table 3 shows the uptake rates for colorectal cancer screening. The uptake level in Lothian is improving but remains slightly lower than that across Scotland. Figure 2 shows that the pattern of uptake by deprivation quintile nationally is also reflected in NHS Lothian, with lower uptake in the most deprived groups.

<table>
<thead>
<tr>
<th>% Uptake 2008-2010</th>
<th>% Uptake 2009-2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
<td>Scotland</td>
</tr>
<tr>
<td>Male</td>
<td>44.8</td>
</tr>
<tr>
<td>Female</td>
<td>53.4</td>
</tr>
<tr>
<td>Both</td>
<td>49.2</td>
</tr>
</tbody>
</table>

The number of eligible people invited for screening over 2009-2011 was 235,379 (114,610 male)

Source: Information Services Division., NHS National Services Scotland – Bowel Screening Programme: Key Performance Indicators Reports

3.12.2 The Detect Cancer Early programme is due to launch the bowel cancer awareness segment of their social marketing campaign in February 2013. This will promote the bowel screening programme and a key element will be to involve primary care more closely in encouraging uptake.
3.13 Breast Screening

3.13.1 Data shows that during the most recent three years 2008/09-2010/11, overall uptake in NHS Lothian has remained stable at 72% (Table 4).

Table 4: Percentage uptake of Breast Screening by NHS Board (three year rolling average), females aged 50-70 years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
<td>72.6</td>
<td>72.8</td>
<td>71.9</td>
<td>72.0</td>
<td>71.8</td>
</tr>
<tr>
<td>Scotland</td>
<td>75.4</td>
<td>75.2</td>
<td>74.9</td>
<td>74.9</td>
<td>74.9</td>
</tr>
</tbody>
</table>

Data source: http://www.isdscotland.org/Health-Topics/Cancer/Publications/2012-04-24/Uptake_by_NHS_Board

3.13.2 This figure is above the QIS standard of 70% and below the Scottish average of 75%. Figures are similar for NHS Lothian, NHS Lanarkshire and NHS Glasgow & Clyde where the majority of appointments are offered at a static centre. Uptake tends to be higher in Boards where the majority of screening is undertaken by mobile units. The balance of mobile to fixed mammography is currently the subject of a national review which is due to report in January 2013.

3.13.3 Work is ongoing between primary care, health promotion, community development and cancer charities to promote the benefits of screening and also to provide staff with training and information to ensure a higher, positive profile of the programme at primary care level. As a consequence of this effort overall uptake rates remain consistent. Furthermore, for the prevalent screening round (women new to screening) uptake rates vary by less than 1% year on year (70%) and for the
incident screening round (women attending screening on a regular basis) uptake rates remain high (88%).

3.13.4 In Lothian, uptake levels vary across deprivation categories from 79% (least deprived) to 58% (most deprived). This pattern is reflected across Scotland. Work is ongoing as part of the Detect Cancer Early Programme to pilot a range of interventions jointly with bowel screening to improve uptake.

3.14 Cervical Screening

3.14.1 Table 5 shows the cervical screening uptake rates by age group compared with the overall Scottish rates. Uptake rates in women over 35 years are consistently higher than Scottish rates.

Table 5: Percentage uptake of Cervical Screening by NHS Board females aged 20-60 who had a smear taken within previous 5.5 years

<table>
<thead>
<tr>
<th>Age Band</th>
<th>NHS Lothian 2010/11</th>
<th>NHS Lothian 2011/12</th>
<th>Scotland 2010/11</th>
<th>Scotland 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>51.7</td>
<td>51.2</td>
<td>56.6</td>
<td>56.3</td>
</tr>
<tr>
<td>25-29</td>
<td>68.1</td>
<td>66.5</td>
<td>74.3</td>
<td>74.0</td>
</tr>
<tr>
<td>30-34</td>
<td>77.5</td>
<td>76.2</td>
<td>80.2</td>
<td>79.8</td>
</tr>
<tr>
<td>35-39</td>
<td>84.2</td>
<td>83.3</td>
<td>83.9</td>
<td>83.5</td>
</tr>
<tr>
<td>40-44</td>
<td>87.2</td>
<td>86.7</td>
<td>85.6</td>
<td>85.4</td>
</tr>
<tr>
<td>45-49</td>
<td>88.2</td>
<td>87.6</td>
<td>85.9</td>
<td>85.6</td>
</tr>
<tr>
<td>50-54</td>
<td>87.1</td>
<td>86.3</td>
<td>84.4</td>
<td>84.0</td>
</tr>
<tr>
<td>55-59</td>
<td>85.6</td>
<td>84.9</td>
<td>82.1</td>
<td>81.4</td>
</tr>
<tr>
<td>Overall</td>
<td>77.7</td>
<td>76.7</td>
<td>79.1</td>
<td>78.7</td>
</tr>
</tbody>
</table>

Source: SCCRS/ISD(D)4 for 2011-12

Minimum standard of 80% is currently subject to national review

3.14.2 Women aged less than 35 years have lower uptake rates for a range of reasons including confusion about the overall health message in relation to cervical screening. The Scottish Cervical Call Recall System (SCCRS) mailers and supporting health promotion materials have been recently revised in part to address this. In December 2012, the UK-wide Screening Committee recommended some changes to the screening programme for different age groups. The Scottish Government has indicated that these will be implemented in full by 2015; this is likely to have an impact on the uptake rates.

3.14.3 Over the last 25 years the cervical screening programme has been very successful in reducing the incidence of cervical cancer. However, there is growing consensus amongst health professionals in Scotland that disease rates have now plateaued. Consequently, interest is focusing on the evaluation of the clinical and cost effectiveness of HPV testing as part of the screening programme. Age standardised incidence rates for Lothian have declined from 18.0 per 100,000 persons at risk in 1988 to 7.5 per 100,000 persons at risk in 2010.¹ These rates correspond to a decline in annual cervical cancer registrations from 71 to 39. An anonymised local audit of all invasive cancers takes place to support this work.

¹ Source: http://www.isdscotland.org/Health-Topics/Cancer/Publications/2012-04-24/i_cancer_female_genital_organs.xls
3.15 Primary care review of patients newly diagnosed with cancer

3.15.1 GPs and practice nurses in Lothian care for around 16,000 patients who have been diagnosed with some form of cancer (excluding non-melanotic skin cancer). Of these, approximately 17% have been diagnosed in the previous 18 months, and are eligible for a review under the Quality and Outcomes Framework (QOF). The QOF indicator requires that these patients are reviewed in primary care within six months of the practice receiving confirmation of the diagnosis. The rationale for this is that the review should identify the patient’s individual health and support needs, and ensure coordination of care between sectors. In 2011/12, Lothian primary care teams reviewed 2,617/2,723 (96%) of eligible patients.
**Quality Dashboard November 2012** *(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. 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.

<table>
<thead>
<tr>
<th>Quality Ambition: Person-centred</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Measures</strong></td>
<td><strong>Number of complaints</strong></td>
</tr>
<tr>
<td>20-day Complaints Response Rate *</td>
<td></td>
</tr>
<tr>
<td>3-day Complaints Response Rate *</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Ambition: Safe</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Measures</strong></td>
<td><strong>Hospital Standardised Mortality Ratios for RIE, WGH &amp; St. John’s</strong></td>
</tr>
<tr>
<td>Incident Management Key Performance Indicator *</td>
<td>Incidents with harm</td>
</tr>
<tr>
<td>Hand Hygiene Compliance *</td>
<td>Adverse Event Rate</td>
</tr>
<tr>
<td>Peripheral Vascular Catheter Compliance *</td>
<td>C. Difficile Rate *</td>
</tr>
<tr>
<td>Early Warning Score Compliance *</td>
<td>Staph. Aureus Bacteraemia Rate *</td>
</tr>
<tr>
<td>Medicine Reconciliation Compliance *</td>
<td>Number of Cardiac/Respiratory Patients 2222 Calls *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Ambition: Effective</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Measures</strong></td>
<td><strong>Inpatient Falls with Harm</strong></td>
</tr>
<tr>
<td>Falls Prevention Compliance *</td>
<td>Inpatient Pressure Ulcers Grade 2 or above *</td>
</tr>
<tr>
<td>Pressure Ulcer Compliance *</td>
<td>Nursing Medication Administration Incidents *</td>
</tr>
<tr>
<td>Admission to stroke unit on day or day after admission*</td>
<td></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>

<table>
<thead>
<tr>
<th>Additional Quality Measures</th>
<th><strong>Hospital Scorecard: April 2011-March 2012 (Next release December 2012)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td><strong>Lothian Rate (Per 1000 admissions)</strong></td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>21.12</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>41.88</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>50.03</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>111.56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Lothian</strong></th>
<th><strong>Scotland</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>0.90</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>0.97</td>
</tr>
</tbody>
</table>

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2 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 show slight reductions (2 sites) or a slight increase (1 site).
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>Title: 20-day Complaints Response Rate (Graph 1)</th>
<th>Title: Number of Complaints (Graph 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Number of complaints responses within 20 days</td>
<td>Numerator: Total number of complaints</td>
</tr>
<tr>
<td>Denominator: Number of all complaints responses</td>
<td>Goal: Reduction in number of complaints</td>
</tr>
<tr>
<td>Goal: 85% of complaints responded to within 20 days</td>
<td></td>
</tr>
</tbody>
</table>

**Process Measure**
20-Day Response Target across NHS Lothian, Quarterly (Apr 2009-Sept 2012)

**Data Source: Datix**

**Outcome Measure**
Formal Complaints per quarter across NHS Lothian (Apr 2009-Sept 2012)

**Data Source: Datix**

<table>
<thead>
<tr>
<th>Title: 3-day Complaints Response Rate (Graph 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Number of complaints responses within 20 days</td>
</tr>
<tr>
<td>Denominator: Number of all complaints responses</td>
</tr>
<tr>
<td>Goal: 100% formal acknowledgement within 3 working days</td>
</tr>
</tbody>
</table>

**Process Measure**
3-Day Response Target across NHS Lothian, Quarterly (Apr 2011-Sept 2012)

**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 – June 2012** *(Graph 4)*

**Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – June 2012** *(Graph 5)*

**Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2012** *(Graph 6)*

Data Source: ISD (Quarterly)

### Safe: Reduction in Incidents with Harm and improved Incident Management
Title: Incident Management Key Performance Indicators (KPIs) (Graph 7)

Numerator: Percentage of incidents with major harm or death and/or graded as very high or high risk, fully closed within 60 working days of being reported.

Denominator: Number of incidents with major harm or death and/or graded as very high/high.

Goal: Compliance target – 100%

Title: Incidents with harm (Graph 8)

Numerator: Number of incidents associated with serious harm reported per month in NHS Lothian (Apr 2010-Mar 2012)

Goal: There are specific goals for reductions in Falls, Pressure Ulcers & Medication Incidents. See separate graphs for progress against these.

Title: Adverse Event Rate (NHS Lothian Acute Hospitals) (Graph 9)

Numerator: The number of adverse events (AE) in a monthly random sample of closed case notes (deaths and live discharges)

Denominator: The total number of patient days (PD) in the month for the randomly drawn patients in the sample.

Goal: 30% reduction in Adverse Events from a 2007 baseline by 2012
Safe: Reduction in Healthcare Associated Infections

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent compliance with hand hygiene (NHS Lothian Acute Hospitals) (Graph 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>The total number of opportunities in the sample where appropriate hand hygiene was conducted</td>
</tr>
<tr>
<td>Denominator:</td>
<td>The total number of opportunities in the sample. N=6,600 per month</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Title:</th>
<th>C. difficile associated disease rate against HEAT Target 2011-12 (Graph 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Total number of patients over 65 with C.DIFFICILE toxin positive stool sample (CDI)</td>
</tr>
<tr>
<td>Goal:</td>
<td>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 Nov 2012 – 0.34</td>
</tr>
</tbody>
</table>

Process Measure

Outcome Measure

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

Data Source: Health Protection Scotland

Data Source: Local Audits (QIDS)
**Safe: Compliance with Peripheral Vascular Bundles**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent compliance with PVC Bundle (NHS Lothian Acute Hospitals)</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>

**Process Measure**

Source Data: Local Audits (QIDS)

**Outcome Measure**

Progress against HEAT Target for S.aureus Bacteraemia (SAB)

Data Source: Health Protection Scotland
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 (Graph 15)

Numerator: Arrest – Number of 2222 calls which were for a cardiac or respiratory arrest
Medical Emergency – calls which were not 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 Arrests from February 2012 baseline within 2 years from baseline

Source Data: Local Audits (QIDS)

Source Data: Local Audits (Resuscitation Officer Database)
<table>
<thead>
<tr>
<th>Month</th>
<th>Safe: Improvement in Medicines Reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Title:</strong> Percent of patients with medication reconciliation performed (NHS Lothian Acute Hospitals) (Pilot Site=One Ward) (Graph 16)</td>
</tr>
<tr>
<td></td>
<td><strong>Numerator:</strong> Total number of patients with medication reconciliation performed</td>
</tr>
<tr>
<td></td>
<td><strong>Denominator:</strong> Total number of patients reviewed. n=15 per month</td>
</tr>
<tr>
<td></td>
<td><strong>Goal:</strong> 95% Compliance</td>
</tr>
</tbody>
</table>

**Process Measure**

- Compliance with Medicines Reconciliation

**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.

Effective: Reduction in in-patient Falls - Delivering Better Care

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent compliance with Falls Prevention CQI (NHS Lothian Acute Hospitals)  (Graph 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>No. of patients fully compliant</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total no. of patients reviewed per month n=964</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title:</th>
<th>Patient Falls with Harm  (Graph 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of falls reported with harm, moderate, major/ death</td>
</tr>
<tr>
<td>Goal:</td>
<td>20% reduction in inpatients falls and associated harm by March 2013.</td>
</tr>
</tbody>
</table>

Process Measure

<table>
<thead>
<tr>
<th>Month</th>
<th>Count of falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-12</td>
<td>20</td>
</tr>
<tr>
<td>May-12</td>
<td>18</td>
</tr>
<tr>
<td>Jun-12</td>
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<td>Jul-12</td>
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<td>Aug-12</td>
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<td>Sep-12</td>
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<td>Oct-12</td>
<td>8</td>
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<td>Nov-12</td>
<td>6</td>
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<tr>
<td>Dec-12</td>
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<td>Jan-13</td>
<td>2</td>
</tr>
<tr>
<td>Feb-13</td>
<td>0</td>
</tr>
<tr>
<td>Mar-13</td>
<td>2</td>
</tr>
<tr>
<td>Apr-13</td>
<td>4</td>
</tr>
<tr>
<td>May-13</td>
<td>6</td>
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<td>Jun-13</td>
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<td>46</td>
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<tr>
<td>Feb-15</td>
<td>48</td>
</tr>
<tr>
<td>Mar-15</td>
<td>50</td>
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</tbody>
</table>

Outcome Measure

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

<table>
<thead>
<tr>
<th>Count of reported patient falls with harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Median</td>
</tr>
<tr>
<td>Extended Median</td>
</tr>
<tr>
<td>Target Median</td>
</tr>
</tbody>
</table>

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

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

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)

Process Measure

Outcome Measure

Count of avoidable pressure ulcers (Grade 2 and above) developed in NHS Lothian hospitals reported on Datix

Data Source: QiDS

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

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

**Title:** Admission to Stroke Unit within 1 day of admission  
**Graph 22**

- **Numerator:** Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
- **Denominator:** 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

- **Goal:** By March 2013 90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

**Process Measure**

- **HEAT target** Percentage of stroke patients admitted to acute stroke unit within one day of admission

<table>
<thead>
<tr>
<th>Time period</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-10</td>
<td>60%</td>
</tr>
<tr>
<td>Dec-10</td>
<td>70%</td>
</tr>
<tr>
<td>Feb-11</td>
<td>80%</td>
</tr>
<tr>
<td>Apr-11</td>
<td>90%</td>
</tr>
<tr>
<td>Jun-11</td>
<td>95%</td>
</tr>
<tr>
<td>Aug-11</td>
<td>98%</td>
</tr>
<tr>
<td>Oct-11</td>
<td>91%</td>
</tr>
<tr>
<td>Dec-11</td>
<td>92%</td>
</tr>
<tr>
<td>Feb-12</td>
<td>90%</td>
</tr>
<tr>
<td>Apr-12</td>
<td>95%</td>
</tr>
<tr>
<td>Jun-12</td>
<td>98%</td>
</tr>
<tr>
<td>Aug-12</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Data Source:** ISD

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

- **Numerator:** Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission
- **Denominator:** Number of patients admitted with initial diagnosis of stroke

- **Goal:** 100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

**Process Measure**

- **Percentage of stroke patients with swallow screen on day of admission**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-10</td>
<td>30%</td>
</tr>
<tr>
<td>Dec-10</td>
<td>35%</td>
</tr>
<tr>
<td>Feb-11</td>
<td>40%</td>
</tr>
<tr>
<td>Apr-11</td>
<td>45%</td>
</tr>
<tr>
<td>Jun-11</td>
<td>50%</td>
</tr>
<tr>
<td>Aug-11</td>
<td>55%</td>
</tr>
<tr>
<td>Oct-11</td>
<td>60%</td>
</tr>
<tr>
<td>Dec-11</td>
<td>65%</td>
</tr>
<tr>
<td>Feb-12</td>
<td>70%</td>
</tr>
<tr>
<td>Apr-12</td>
<td>75%</td>
</tr>
<tr>
<td>Jun-12</td>
<td>80%</td>
</tr>
<tr>
<td>Aug-12</td>
<td>85%</td>
</tr>
</tbody>
</table>

**Data Source:** ISD

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

- **Numerator:** Number of admitted patients with initial diagnosis stroke that have a brain scan on the day of admission
- **Denominator:** Number of patients admitted with initial diagnosis of stroke

- **Goal:** 80% of patients with initial diagnosis of stroke should receive a brain scan on day of admission

**Process Measure**

- **Percentage of stroke patients with brain scan on day of admission**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-10</td>
<td>10%</td>
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<tr>
<td>Dec-10</td>
<td>15%</td>
</tr>
<tr>
<td>Feb-11</td>
<td>20%</td>
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<tr>
<td>Apr-11</td>
<td>25%</td>
</tr>
<tr>
<td>Jun-11</td>
<td>30%</td>
</tr>
<tr>
<td>Aug-11</td>
<td>35%</td>
</tr>
<tr>
<td>Oct-11</td>
<td>40%</td>
</tr>
<tr>
<td>Dec-11</td>
<td>45%</td>
</tr>
<tr>
<td>Feb-12</td>
<td>50%</td>
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<tr>
<td>Apr-12</td>
<td>55%</td>
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<tr>
<td>Jun-12</td>
<td>60%</td>
</tr>
<tr>
<td>Aug-12</td>
<td>65%</td>
</tr>
</tbody>
</table>

**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.

Jo Bennett
Clinical Governance & Risk Manager
10 January 2013
jo.bennett@nhslothian.scot.nhs.uk

Dr Elizabeth Bream
Consultant in Public Health
10 January 2013
Elizabeth.bream@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Supporting Technical Appendix
Appendix 2: NHS Lothian Mortality & Harm Prevention Driver Diagram and Improvement Plan
Hospital Standardised Mortality Ratio (HSMR)
HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level ‘warnings’ for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

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


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

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

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

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)
NHS Lothian Mortality Reduction and Harm Prevention Driver Diagram & Improvement Plan (2012-15)

- Reduce mortality by 20% from 2007 baseline as measured by HSMR by December 2015
- Routine and systematic learning from mortality which is used to inform improvement programmes
- Learning from adverse events and Mortality reviews
- Learning from metrics
- Learning from others
- GTT Adverse event, Mortality** prescribing errors, case note reviews and SAE’s, cardiac arrest reviews
- HSMR
- Dashboards, ward scorecards, QoI, Dalx
- Other boards, IHI, SPSP, HIS, HEI, OPAH scrutiny
- Implement evidence based interventions to reduce mortality
- Timely identification & response to deteriorating patients
- Sepsis & VTE identification and management
- Improve end of life care
- Effective communication
- Effective patient centred care
- Deteriorating patient work stream to reduce cardiac arrests
- Implementation of care rounding
- Standardising documentation
- Implementation of structured ward rounds
- Education programmes
- Implement sepsis and VTE bundles
- Monitor LCP
- Develop EOLC standards
- Test the Amber bundle
- Structured ward rounds
- Review DNA CPR as part of cardiac arrest reviews
- Use of SBAR in handovers & escalation with feedback
- Use of simulation training with feedback and teamwork
- Safety briefings, ward at a glance
- Standardised documentation
- Reduction in harm from falls, PU, infections, VTE, medication admin & prescribing errors, and complaints and litigation

HSMR – Hospital Standardised Mortality Rate
IHI – Institute for Healthcare Improvement
HIS – Healthcare Improvement Scotland
HEI – Healthcare Environment Inspectorate
OPAH – Older People in Acute Hospitals
VTE – Venous Thromboembolism
LCP – Liverpool Care Pathway
EOLC – End of Life Care
DNA CPR – Do Not Attempt CPR
SBAR – Situation, Background, Assessment, Recommendations
SAE – Significant Adverse Event
GTT – Global Trigger Tool
SEWS – Scottish Early Warning Score
NHS LOTHIAN IMPROVEMENT PLAN TO REDUCE MORTALITY AND PREVENT HARM 2012-15

The improvement plan has been split into: -
- Interventions to Reduce Mortality and Harm Actions
- Routine and Systematic Learning our data

Interventions to Reduce and Monitor Mortality and Harm (prioritised and identified from HSMR Casenote Review and Boards on Board Action Plan)

<table>
<thead>
<tr>
<th>No.</th>
<th>Issue to be resolved</th>
<th>Specific actions</th>
<th>Start date</th>
<th>Responsible Officer and Group</th>
<th>Date for completion</th>
<th>How monitored</th>
<th>Progress at Dec 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Timely identification and response to deteriorating patients</td>
<td>1.1 Roll out the deteriorating patient work stream and learning from the pilot areas at SJH to all other acute sites. The aim is to ensure that the local identification and response to patient deterioration is reliable regardless of time of day and day of week. The response for boarders as a high risk group is integral to this intervention.</td>
<td>7/1/2013</td>
<td>Julie McLaughlin Deteriorating Pt Education group</td>
<td>March 2014</td>
<td>Deteriorating Pt Education group Deteriorating pt Steering group CMG</td>
<td>Education sessions Phase One Urology and General Surgery WGH Second Phase Orthopaedics 28th Jan Third phase Medical &amp; Surgical Assessment 25th Feb</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2 Early Warning Score to be updated in light of learning from SAEs and the cardiac arrest audit. The new chart to include the criteria &amp; Sepsis 6, more information about neuro observations and a new response chart.</td>
<td>21/6/2012</td>
<td>Annette Henderson Deteriorating Pt Education group</td>
<td>15/12/2012</td>
<td>QIDS Reports, Datix, GTT reviews, Cardiac arrest dashboard</td>
<td>Pilots have been successful and anecdotal reports of better sepsis recognition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.3 Testing of response stickers to document response to SEWS breach and escalation</td>
<td>7/1/2013</td>
<td>Julie McLaughlin</td>
<td>Jan 2013</td>
<td>Deteriorating Pt Education Group</td>
<td>Tested and effective in some other boards</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td>1.7 Education and training: Foundation training and resuscitation training has been</td>
<td>1/12/2012</td>
<td>Colin Murray Resuscitation Officer</td>
<td>In place and ongoing</td>
<td>PG Education All Foundation Doctors have had training on SEWS,</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Issue to be resolved</td>
<td>Specific actions</td>
<td>Start date</td>
<td>Responsible Officer and Group</td>
<td>Date for completion</td>
<td>How monitored</td>
<td>Progress at Dec 2012</td>
</tr>
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<td>---------------------</td>
<td>----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>updated to include identification and management of the unwell or deteriorating patient. Feedback from cardiac arrest scenarios and simulation is used in a number of practical ways to support training</td>
<td>Simon Edgar AMD Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>escalation, use of SBAR for handover. All staff have mandatory updates from ROs</td>
</tr>
<tr>
<td>1.8</td>
<td>A review of unplanned cases transferred to high dependency/ICU will take place</td>
<td>N Maran AMD Safety Ross Paterson</td>
<td>1/12/2013</td>
<td></td>
<td>June 2013</td>
<td>Deteriorating Pt Steering Group</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sepsis identification and management (SPSP)</td>
<td>1.4 Sepsis work stream to progress testing in pilot sites to reduce avoidable harm in collaboration with deteriorating patient work stream</td>
<td>1/12/2013</td>
<td>Ross Paterson Cons Intensives' SPSP Fellow</td>
<td>2015</td>
<td>SPSP Deteriorating Pt Steering Group CMG Infection Control Comm</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>End of Life Care</td>
<td>3.1 Pilot the AMBER bundle for end of life care</td>
<td>1/3/2013</td>
<td>P Brooks-Young</td>
<td>No end date set</td>
<td>EOLC Steering Group</td>
<td>Identified as a pilot site for national project</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2 Continue education and monitoring around improved end of life care and Liverpool Care Pathway</td>
<td></td>
<td>P Brooks-Young</td>
<td>Ongoing</td>
<td>EOLC Steering Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3 Develop EOLC bundle for testing in pilot wards</td>
<td>1/11/2012</td>
<td>Christina Lilley</td>
<td>TBC</td>
<td>EOLC Steering Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.4 Repeat 3x2 IHI Mortality Review in 2013 to see whether the number of patients admitted for EOLC has continued to reduce over time.</td>
<td>17/4/2013</td>
<td>A Henderson SPSP Mgr</td>
<td>July 2013</td>
<td>SPSP EOLC Steering Group</td>
<td>Reduction from baseline demonstrated 2 years ago</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5 Review appropriate use of DNA CPR through cardiac arrest audit</td>
<td>1/6/2012</td>
<td>Jo Bennett</td>
<td>Ongoing</td>
<td>Deteriorating Pt Steering Group &amp; CMG</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Effective Communication</td>
<td>4.1 Audit and review responses of medical staff to concerns about ill or deteriorating patients including participation in anticipatory care through the implementation of the</td>
<td>7/1/2013</td>
<td>Julie McLaughlin Deteriorating pt Education group</td>
<td>Testing phase</td>
<td>Deteriorating Pt Steering Group CMG</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Issue to be resolved</td>
<td>Specific actions</td>
<td>Start date</td>
<td>Responsible Officer and Group</td>
<td>Date for completion</td>
<td>How monitored</td>
<td>Progress at Dec 2012</td>
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</tr>
<tr>
<td></td>
<td>structured ward round</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Identify poor communication issues and address these as part of deteriorating patient work stream and education</td>
<td>7/1/2013</td>
<td>Julie McLaughlin Simon Edgar</td>
<td>Ongoing</td>
<td>Deteriorating Pt Steering Group CMG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Reinforce the use of communication tools such as SBAR, safety briefs.</td>
<td>7/1/2013</td>
<td>Julie McLaughlin Simon Edgar</td>
<td>Ongoing</td>
<td>Deteriorating Pt Education Group</td>
<td>All foundation doctors have had education in use of SBAR in handovers and its built into practice and documentation for all staff.</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Improve the quality of communication with patients by educating all staff about caring conversations as part of the introduction of care rounding and using the observational tool to measure the quality</td>
<td>7/1/2013</td>
<td>Jane Muirhead Joyce</td>
<td>Ongoing</td>
<td>Care Rounding Group OPAH DBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>The spread of care rounding to all clinical areas in order to reduce falls, pressure ulcers, improve nutrition and hydration and improve patient experience</td>
<td>1/1/2012</td>
<td>Jane Muirhead Nancy Burns Lindsey Milroy Moira Weedall Ruth Roper</td>
<td>December 2013</td>
<td>Care Rounding Group DBC OPAH</td>
<td>There has been a reduction in falls in NHS Lothian with harm contributing to rollout plan</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Meet the targets set for VTE</td>
<td>1/1/2012</td>
<td>Graham Nimmo</td>
<td>Dec 2015</td>
<td>SPSP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Continue targeted improvement work to reduce adverse events in prescribing and administration of medication</td>
<td>1/10/2011</td>
<td>Sarah Ballard-Smith Carolyn Swift</td>
<td>March 2013</td>
<td>DBC</td>
<td>Data shows improvement</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Increase the number of clinical areas compliant with medicine reconciliation to reduce adverse events in prescribing and administration of medication</td>
<td>1/1/2008</td>
<td>N Maran AMD Carolyn Swift</td>
<td>March 2015</td>
<td>SPSP CMG</td>
<td>Increase in compliance in pilot areas and spread to other areas</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Issue to be resolved</td>
<td>Specific actions</td>
<td>Start date</td>
<td>Responsible Officer and Group</td>
<td>Date for completion</td>
<td>How monitored</td>
<td>Progress at Dec 2012</td>
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</tr>
<tr>
<td></td>
<td>5.5 General Practice to measure improvement in compliance with warfarin management as part of QOF</td>
<td>Sept 2012</td>
<td></td>
<td>Dr Gordon Black GP</td>
<td>Ongoing</td>
<td>SIPC Steering Group HCG Cmtee</td>
<td>More than 90 practices participating in this project</td>
</tr>
</tbody>
</table>
**Routine and systematic learning from mortality which is used to inform clinical actions**

<table>
<thead>
<tr>
<th>No.</th>
<th>Issue to be resolved</th>
<th>Specific actions</th>
<th>Start Date</th>
<th>Responsible Officer and Group</th>
<th>Date for completion</th>
<th>How monitored</th>
<th>Progress at Dec 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Learning from case note reviews</td>
<td>1.1 SPSP GTT undertaken on 20 patients per month per acute hospital (total of 100) to identify adverse events. This random sample also includes deceased patients</td>
<td>1/10/2007</td>
<td>A Henderson SPSP Mgr</td>
<td>Ongoing</td>
<td>CMG HCG Cmtee</td>
<td>Process will be reviewed in light of national harm free care initiative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2 Develop the pilot on clinical coding as part of the GTT review providing feedback and best practice to the clinical teams</td>
<td>1/2/2013</td>
<td>Dr Liz Bream Public Health A Henderson SPSP Mgr</td>
<td>Ongoing</td>
<td>CMG HCG Cmtee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.3 Improve the sharing of learning from GTT adverse event reviews with clinical teams and feed into other learning e.g. from Datix and action plans</td>
<td>1/1/2013</td>
<td>A Henderson SPSP Mgr</td>
<td>Ongoing</td>
<td>CMG HCG Cmtee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4 Test the use of the GTT reviews with Cardiology as a method of reviewing notes and learning about harm</td>
<td>1/2/2013</td>
<td>A Henderson Mr Prasad Trish Daily</td>
<td>Ongoing</td>
<td>Cardiothoracic QIT CMG</td>
<td>Agreed commitment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5 Repeat the IHI Mortality review to identify changes and learning</td>
<td>1/5/2013</td>
<td>A Henderson SPSP Mgr</td>
<td>1/7/2013</td>
<td>CMG HCG Cmtee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.6 Acute Division to report on learning from systematic multi-disciplinary mortality reviews</td>
<td>2/2/2012</td>
<td>Tracey Gillies AMD Nikki Maran</td>
<td>Ongoing</td>
<td>CMG HCG Cmtee</td>
<td>All directorates have regular M&amp;M meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.7 Systematic mortality reviews to be a standing item on the divisional Clinical Governance agenda with regular reports to the Board Healthcare Governance Committee</td>
<td>2/3/2013</td>
<td>Tracey Gillies AMD</td>
<td>June 2012 onwards</td>
<td>CMG HCG Cmtee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.8 Learning points from future mortality reviews, GTT AE reviews, SAE to be identified and added to this HSMR action plan for implementation and monitoring where appropriate</td>
<td>1/3/2013</td>
<td>J Bennett CG &amp; RM A Henderson</td>
<td>Review initiated. Date TBC</td>
<td>CMG HCG Cmtee</td>
<td>Review initiated</td>
</tr>
<tr>
<td>2.</td>
<td>Learning from adverse events</td>
<td>2.1 Process for the learning from SAE is being revised in line with learning from</td>
<td>1/10/2012</td>
<td>J Bennett</td>
<td></td>
<td>CMG HCG</td>
<td></td>
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<td>Date for completion</td>
<td>How monitored</td>
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<td>J Bennett CG&amp;RM</td>
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<td>CMG HCG Cmtee Board</td>
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<tr>
<td></td>
<td>Learning from metrics SPSP and CQI</td>
<td>4.1 Use of Board, other dashboards and ward scorecard &amp; QIDS to monitor, learn from SPSP, rounding, HAI and other data and action as appropriate and ensure board are aware of and cited on risks</td>
<td>2010</td>
<td>J Bennett CG&amp;RM</td>
<td>In place, ongoing</td>
<td>CMG HCG Cmtee Board</td>
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<tr>
<td></td>
<td>Improve content and accuracy of Discharge Letter to improve coding</td>
<td>6.1 Best practice at SJH consists of standardised discharge template letters for specific conditions and includes med rec information with feedback from GPs.</td>
<td>21/12/2012</td>
<td>Catriona Rostron Chief Nurse</td>
<td>Ongoing</td>
<td>CMG HCG Cmtee</td>
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<tr>
<td></td>
<td>Learning from others - National SPSP and HIS</td>
<td>7.1 Learn from national SPSP programme and HIS through participation in events and development of capacity and capability e.g. IAs, Fellows, SIS, and external scrutiny</td>
<td>2007</td>
<td>Dr Nikki Maran A Henderson</td>
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Ayrshire and Arran report

30
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, as recommended by Antimicrobial Management Team.
- Support the ongoing work with Meticillin Resistant *Staphylococcus aureus* screening programme by promoting compliance with Clinical Risk Assessment and swabbing.
- Support ongoing work with mandatory surveillance.
- Recognise the need for ongoing work to maintain standards in anticipation of Healthcare Environment Inspectorate visits.

3 Discussion of Key Issues
3.1 *Staphylococcus aureus* Bacteraemia: there were 28 episodes of *Staphylococcus aureus* Bacteraemia in December 2012 (5 Meticillin Resistant *Staphylococcus aureus*, 23 Meticillin Sensitive *Staphylococcus aureus*), compared to 20 in November 2012 (2 Meticillin Resistant *Staphylococcus aureus*, 18 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013, with a current rate of 0.32 (updated to December 2012). In order to achieve the target, NHS Lothian has to average no more than 17 episodes per month for the twelve month period, with a current average of 21 episodes per month.

3.2 *Clostridium difficile* Infection: there were 23 episodes of *Clostridium difficile* Infection in patients aged 65 or over in December 2012, compared to 19 in November 2012. NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.39 cases or fewer per 1000 total occupied bed days by March 2013, with a current rate of 0.34 (updated to December 2012). In order to achieve the target, NHS Lothian has to average no more than 27 episodes per month for the twelve month period, with a current average of 23 episodes per month.
3.3 Norovirus outbreaks: Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to service. Since November 2012 there have been 225 patients identified as norovirus positive across all acute sites.

3.4 The 22nd bi-monthly national hand hygiene audit report was published by Health Protection Scotland on 28/11/2012. This indicates NHS Lothian is achieving hand hygiene compliance of 96%, which exceeds the national compliance of 95%. The table shows a breakdown of staff groups, comparing both national and local compliance.

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Delivery of hand hygiene education and training continues, with a focus on improving and sustaining hand hygiene compliance throughout all staff groups. The escalation policy for non-compliance with hand hygiene was approved by NHS Lothian Partnership Forum on 13/11/2012. The policy is currently being communicated through appropriate forums and implementation is in progress.

3.5 The new Meticillin Resistant *Staphylococcus aureus* screening Key Performance Indicators have been agreed and a pilot of data collection and submission completed from 5-26/11/2012. The compliance levels have been set at a minimum of 90% for Clinical Risk Assessment and swabbing. The surveillance team continues to measure compliance via three weekly snapshot audits of the ward areas in scope to assess this compliance. The compliance levels vary across the organisation and it will take significant work to ensure the required levels are met on a consistent basis.

3.6 The Healthcare Environment Inspectorate: the Healthcare Associated Infection Self Assessment with associated evidence was submitted on 14/12/2012.

3.7 Incident updates for December 2012: Infection Prevention and Control have been involved in investigating several incidents, including: incident of Hepatitis A; equipment decontamination; increased norovirus levels; ongoing work relating to ingress of insects to theatre facilities.

3.8 Antimicrobial Management Team:

3.8.1 Alert antibiotic policy pilot-study: this policy supports the appropriate use of selected broad-spectrum antibiotic agents (termed ‘alert antibiotics’) in order that development of antibacterial resistance is reduced. The pilot commenced in February 2012 in the Royal Infirmary Edinburgh. The Clinical Management Group have authorised this to permanent status within the Royal Infirmary Edinburgh and in addition extended the alert policy to the Western General Hospital and St John’s Hospital.

3.8.2 Antibiotic Prescribing Indicators: the target level for compliance with the guidelines and documentation of 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. St Johns Hospital is achieving 70% for Prescribing Indicators and 100% for documentation compliance. Surgical Prophylaxis remains at 100% compliance 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.
- Increased numbers of Healthcare Associated Infections leads to adverse patient harm, as well as failure to comply with Health Efficiency Access Treatment targets.
- There is the potential for the Healthcare Environment Inspectorate to find adverse areas of cleanliness or standards of practice. This would undermine the organisation’s commitment to a healthier, safer healthcare environment and could lead to adverse publicity for NHS Lothian and loss of public/patient confidence.

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.
List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
SAB There were 28 SAB recorded during December 2012 (5 MRSA & 23 MSSA). The lowest number recorded in the last 12 month period is 15 (August 2012).

CDI There were 34 CDI recorded in December 2012, 23 were in aged 65 & over. February 2012 recorded the lowest number in the last 12 month period with 20 cases.

SAB HEAT Target Currently, NHS Lothian is not on trajectory to achieve the set target of 0.26 or less cases per 1000 AOBDS by March 2013.

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

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

Hand Hygiene Monitoring Compliance

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

MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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Total Staphylococcus aureus Bacteraemia (SAB) Cases

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Quarterly Rolling Year *Clostridium difficile* Infection Cases per 1000 Total Occupied Bed Days for HEAT Target Measurement

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Quarterly Rolling Year *Staphylococcus aureus* Bacteraemia Cases for HEAT Target Measurement

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

*Clostridium difficile* Infection (CDI)
There were 9 CDI recorded during December 2012.

This is the new Report Card Format introduced by Scottish Government July 2011
**Western General Hospital**

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

**Clostridium difficile** Infection (CDI)
There were 15 CDI recorded during December 2012.

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**St John's Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during December 2012.

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

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Liberton Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during December 2012.

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

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

### Hand Hygiene Monitoring Compliance

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Staphylococcus aureus Bacteraemia (SAB)
There was 1 SAB recorded during December 2012.

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

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.

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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MSSA Bacteraemia Cases

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**Royal Victoria Hospital**

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

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

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

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

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

**Clostridium difficile** Infection (CDI)
There were no CDI recorded during December 2012.
**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 December 2012 there were 18 SAB recorded.

*Clostridium difficile Infection (CDI)*
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice's. During December 2012 there were 8 CDI recorded.

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

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
ESTABLISHMENT OF THE SHADOW BOARD OF THE MIDLOTHIAN HEALTH & SOCIAL CARE PARTNERSHIP

1 Purpose of the Report

This report is to inform and seek approval for the proposed arrangements for the establishment of a shadow board of the Midlothian Health and Social Care Partnership. This is in response to Scottish Government’s proposals for the integration of health and social care services.

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

2 Recommendations

2.1 The Board is recommended to:

i) Agree to the proposed arrangements for the shadow board’s remit, membership and governance as outlined in this report.

ii) Agree to receive a further report confirming that the necessary arrangements are in place, taking account of the Government’s published proposals as necessary.

iii) Support the proposal to seek the support of the Midlothian Community Planning Partnership for the shadow board to assume community planning responsibilities for adult health and care.

iv) Note that these proposals may be subject to change depending on the detail of government legislation.

v) Note that these proposals have been agreed by Midlothian Council on 8th January 2013

3 Discussion of Key Issues

3.1 Scottish Government plans to legislate for the establishment of Health and Social Care Partnerships. Initially there will be a requirement to jointly oversee adult services although there will be local discretion as to whether to extend the scope of the Partnership. Following the Government’s major consultation exercise during 2012 it has yet to publish its final proposals.
3.2 It is anticipated that the legislation will not be enacted until April 2014 at the earliest. However current legislation is already permissive and NHS Boards and Councils are being encouraged to design and implement new arrangements in advance of the legislative changes.

3.3 Following a series of meetings involving Non Executive Directors, Elected Members, Chief Executives and Senior Officers from both NHS Lothian and Midlothian Council it was agreed to recommend the establishment of a shadow board from 1 April 2013.

3.4 Proposals regarding membership and remit are outlined in Appendix 1. For the first year, whilst in shadow status, the Chairperson will be selected from NHS Lothian members whilst the Vice Chair will be the portfolio holder for Community Care in Midlothian Council. These positions will alternate annually.

3.5 It is intended that during the initial stages of the board the scope of services within the HSCP remit will be all Community Care services. Whilst there are no immediate plans to include children’s services this will be subject to ongoing discussion.

3.6 In recognition of the scale of anticipated change, the early establishment of robust governance arrangements will be a key task for the shadow board. These arrangements, including proposals for delegated authority, will be subject to further consideration and approval by NHS Lothian Board and Midlothian Council.

3.6 At the meeting of Non Executive Directors, Elected Members, Non Executives and Chief Executives in November 2012 it was agreed that discussions would be held on management arrangements to support the shadow board. These discussions are at an advanced stage and further regular reports will be provided on this issue.

3.7 The move towards integration of health care and social care is welcomed and will contribute significantly to improving outcomes for our populations. However, for services to remain sustainable more attention is needed to ensure that service users are able to access the full range of preventative and inclusive services in their communities. It is recommended, therefore, that tangible steps are taken to locate the Health and Social Care Partnership Board firmly within the Community Planning context. It is proposed that a recommendation be made to the Midlothian Community Planning Partnership that the function of the Adult Health and Care and Housing Group be delegated to the new Health and Social Care Partnership shadow board.

4 Key Risks

4.1 There is a potential risk that the Scottish Government’s proposals to establish Health and Social Care Partnerships will lead to an over-emphasis on structural change. The details of the proposed remit of the Shadow Board outlined in Appendix 1 is intended to ensure that, during the shadow period, the primary focus is on improving outcomes for service users and carers.
4.2 In addition, the governance arrangements being developed before and during shadow board status will allow all risks to be identified at an early stage and appropriate mitigating action implemented.

5 Risk Register

5.1 All CHPs are considering a common definition of risk in this area to appear on CHP risk registers. A robust process of regular review 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.

6 Impact on Health Inequalities

6.1 The creation of a Partnership between health and social care will enhance the capacity to address health inequalities. The emphasis on ‘localism’ will make it more likely that health inequalities occurring within particular communities will be actively considered and addressed.

7 Impact on Inequalities

7.1 The Government’s Consultation Report “Integration of Adult Health and Social Care in Scotland” (May 2012) includes their detailed partial EQIA. Locally this will be undertaken specifically as part of the shadow board work programme

8 Involving People

8.1 A comprehensive staff engagement programme in Midlothian CHP and Midlothian Council was put in place initially to inform and seek the views of staff in response to the Government’s Consultation Report. This exercise has since been replicated within both agencies as a means of ongoing staff involvement and will form part of a continuing and joint communication and engagement programme.

8.2 In recognition of their crucial role, plans are in early development to host dedicated engagement and involvement workshops in March 2013 with Third and Independent sector colleagues, Carers and with the Public Partnership Forum.

9 Resource Implications

It will be the task of the shadow board to develop budget proposals, including a joint financial framework, and these will require full consideration by both Midlothian Council and NHS Lothian in due course.

There are no immediate resource implications arising from this proposal to establish a shadow board.

David Small
General Manager, East and Midlothian CHPs
14 January 2013
David.Small@nhslothian.scot.nhs.uk
List of Appendices

Appendix 1: Role, Remit and Membership of the shadow HSCP Board for Midlothian
ROLE, REMIT AND MEMBERSHIP OF THE SHADOW HSCP BOARD FOR MIDLOTHIAN

Remit
Agreement is being sought from Midlothian Council and from NHS Lothian to establish a shadow board from 1st April 2013 whose remit will include:

- **Strategy:** Ensuring effective management of key strategic changes in the field of community care.
- **Formal HSCP:** Developing plans for the establishment of a formal HSCP including structural and financial arrangements.
- **User Involvement:** Developing a stronger, more coherent approach to the involvement of users/patients, carers and the broader community.
- **Related Partnership Bodies:** Maintaining an overview of existing related partnerships including MELDAP and the Adult Protection Committee.
- **Partnership Working:** Overseeing the development of strong partnership arrangements with East Lothian Council, other Local Authorities and the broader Community Planning Partnership.
- **Health Services:** Ensuring effective partnership working is further developed with those health services not directly within the remit of the HSCP including, but not exclusively, hosted services and acute sector.
- **Performance:** Monitoring the performance of the Partnership against key indicators.
- **Community Planning:** Developing arrangements so that the HSCP operates as the ‘Adult Health and Care’ thematic community planning group.

Work Plan
The shadow board will ensure high level governance over:

- Joint commissioning strategies for all community care groups
- Older People - Transformation Plan and Dementia Redesign
- Mental Health - A Sense of Belonging
- Learning Disability - Development of new PIP and Joint Strategy
- Physical Disability - 2012-15 Action Plan
- Carers Strategy - 2012-15
- Hospital - Review of services provided by the Midlothian Community Hospital
- 24/7 Services - Development of comprehensive integrated services
Membership of the shadow board:

- It is proposed to have 8 voting members:
  
  4 Council elected members (agreed at the Midlothian Council meeting of January 8\textsuperscript{th} 2013 as Councillors Catherine Johnstone, Bob Constable, Derek Milligan and Brian Pottinger) and 4 non-executive NHS Lothian members, one of whom will be a Partnership Representative.

- The third sector will be represented and consideration is also being given currently to specifically having a carers’ representative sitting in attendance in addition.

- Officers in attendance will include the jointly accountable officer, clinical leads from health and social work, integration leads from health and the council and, in addition, include housing representation.

- It is recognised that strong, inclusive and effective professional engagement for both NHS and Council staff and independent contractors will be required and consideration is currently being given as to how to maximise this within a supporting planning structure.

Meeting Arrangements

The Board will meet 6 weekly and report regularly to the CHP sub committee and to the Council, as well as seeking formal ratification of any major decisions taken by the board during the shadow period. For any issues outside the delegated authority of the CHP the Board will report to NHS Lothian Board.
NHS LOTHIAN

Board Meeting
23 January 2013

Medical Director

CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to summarise NHS Lothian’s risk management system and present the draft top 10 risks on the NHS Lothian Corporate Risk Register.

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 NHS Lothian’s risk management system.

2.2 Discuss the current draft top 10 risks on the NHS Lothian Corporate Risk Register (Appendix 1).

3 Discussion of Key Issues


3.2 Risk Management Architecture - Diagram 1 below sets out the architecture of NHS Lothian risk registers which are brought together into one corporate risk register under the new Risk Management Steering Group (RMSG).
3.2.1 The key function of the RMSG is to develop, refine, review and assess the implementation of NHS Lothian’s Risk Policy and Procedure in support of the Board in collaboration with the Governance committees of the Board. The RMSG reviews the corporate risk register to ensure it is fit for purpose and identifies assurance mechanisms. It reports via the Joint Management Team (JMT) to the Board.

3.2.2 The Audit & Risk Committee also reviews the register from RMSG and undertakes its own assurance process on behalf of the Board which may include detailed examination of the risk system and individual risks.

3.2.3 NHS Lothian uses Datix to ensure a consistent robust system-based solution for all areas of the organisation to review, capture, record and monitor risks consistently. This system has been subject to an external review (August 2012) by Datix and confirmed as ‘Good’ with a number of areas highlighted as good practice.
3.3 **Risk Register alignment with Management and Control process** - The summary of the top 10 Corporate Risks is set out in Appendix 1 and its assurance requirements are set out in its final column. Risks are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used is based on the same risk scoring matrix.

3.3.1 All the items in the Corporate Risk Register have been previously noted in various papers to the Board as indicated on the register in the title column. A report showing risks scores over time for all key risks is utilised by JMT to track progress and includes alignment with corporate objectives to evidence risks associated with key objectives.

3.3.2 Internal Audit uses the Corporate Risk Register to inform internal audit workplan.

4 **Key Risks**

4.1 The Board is not sighted on NHS Lothian key risks in order to determine the nature and extent of risk exposure for NHS Lothian.

5 **Risk Register**

5.1 Not applicable.

6 **Impact on Inequality, Including Health Inequalities**

6.1 The findings the Equality Diversity Impact Assessment are that although the production of the Corporate Risk Register updates do not have any direct impact on health inequalities, each of the component risk areas within the document contain elements of the processes established to deliver NHS Lothian’s corporate objectives in this area. The risk policy that supports the development and maintenance of the risk register has been Equality & Diversity Impact Assessed.

7 **Involving People**

7.1 No change to policy or service change.

8 **Resource Implications**

8.1 The resource implications are related to the control of individual risks within the register.

Jo Bennett
Clinical Governance & Risk Manager
14 January 2013
Jo.bennett@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: Top 10 Corporate Risks
## Top 10 Corporate Risks

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| 3189 | 10. Financial Balance | Maintenance Backlog | Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk. | • The backlog maintenance sum has been reported at circa. £140 million. The Property Asset Management Strategy (PAMS) describes how this figure will be reduced by disposals and Reprovision Programme. F & R have agreed to fund an initial £10 million expenditure on the high and significant risks over the next 18 months.  
• A procurement and implementation strategy will be approved in early November 2012, which will describe how this figure will be safely expended. An update of the PAMS for next year will log the affect upon the backlog maintenance and compliance figure.  
• A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance.  
• A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years. | Reviewed Oct 2012 - Controls updated. Risk grade/rating remain unchanged. | Adequate but ineffective; control is properly designed but not being implemented properly | High 16 | Medium 4 | Director of Human Resources & Organisational Development | Finance & Resources Committee |
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| 1085 | 6. Programme of Governance and Efficiency | Public Protection (Child, Adult, MAPPA) | There is a risk of harm to individuals and to the Organisation’s reputation because of increasing complexity of cases, reduced capacity of medical and nursing specialist services and the limitations of the existing IM&T infrastructure. This has the potential to be a contributing factor in the occurrence of harm to a patient, public or member of staff. This may lead to adverse outcome for the organisation. | • As a result of the review of Public Protection arrangements a revised structure has been implemented ensuring designated leads for child and adult protection are in place reporting directly by the Designated Nurse for Public Protection to the Executive Director for Public Protection (Public Protection Framework attached).  
• The Public Protection arrangements are supported by range of robust policies, procedures and guidelines both interagency and health.  
• A comprehensive Public Protection training strategy is in place. The governance arrangements for public protection are monitored by the Executive Lead through the relevant public protection action groups.  
• There are interagency structures in place across Lothian to ensure effective partnership working at operational and strategic level.  
• Processes are in place with health and interagency to investigate significant incidents and disseminate learning. | Reviewed Oct 2012 - risk re-graded from Very High level to High (risk rating 15)  
• The Designated Doctor for Child Protection will be retiring in May 2013. Plans are in progress to recruit a Designated Doctor to fill this vacancy. The recruitment process is currently being progressed to advert. Funding has been secured to increase the capacity for this post from 2 session to 5 sessions weekly.  
• The NHS Lothian MAPPA Group has been reconvened chaired by the Nurse Director. The Designated Nurse for Public Protection has taken on the role of MAPPA Lead for NHS Lothian. Work is underway to develop an Operational Post for MAPPA. Guidance on information sharing within the NHS relating to offenders managed under the MAPPA arrangements is in progress. | Uncertain; impact of controls not known at this time and more work required to identify current situation | High 15 | Medium 9 | Nurse Director | Healthcare Governance Committee |
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| 1086 | 6. Programme of Governance and Efficiency | Litigation exposure | There is a risk of: High cost claims relating to both patient and staff experience. Risk of adverse publicity relating to initial incidents and time taken to resolve claims. Risk of ineffective learning leading to repeat incidents. | • Currently developing NHS Lothian policy for Litigation.  
• Operational SOPs have been developed for the recording, investigation and reporting of claims.  
• Work ongoing with Clinical Governance Team and UHD Corporate Nursing colleagues to develop a process for sharing lessons learned from claims, and follow-up of action plans - planned pilot process in WCDN being set-up. | Reviewed Sep 2012 - risk grade/rating remain unchanged.  
• Work being progressed with Clinical Governance Team to develop standard process for sharing of lessons learned from incidents and claims in Lothian.  
• Work with UHD Corporate Nursing team to develop a standard process for ensuring that action plans developed in response to incidents and claims are completed.  
• Ownership of risk moved from the Medical Director to Nurse Director. | Satisfactory; controls adequately designed to manage risk and working as intended | High 12 | Low 2 | Nurse Director | Finance & Resources Committee |
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| 1103| 7. Appropriate Staff Arrangements in place | Sustainability of Paediatric and Neonatal services at St. John’s Hospital | There is a risk that serious staffing challenges in medical paediatrics across the South East of Scotland will lead to inability to staff the middle grade rota at St. John’s for every shift with someone who has the necessary competencies to cover paediatric service and neonatal service, leading to patient safety risks. The control measures in place may affect financial balance and outpatient waiting times (excludes Community Child Health Department and Respite Care). | - Weekly Planning Group meetings.  
- Additional efforts to recruit consultant paediatricians to permanent posts at St John’s.  
- The employment of NHS Lothian medical and nursing staff as internal locums at enhanced rates of pay as per the relevant Terms and Conditions of Service.  
- The employment of agency medical staff when required and available to support the middle grade paediatric rota at St John’s.  
- Internal communication with the staff affected at St John’s about the action being taken to sustain the service.  
- A programme of communication and business continuity planning with the Scottish Ambulance Service (SAS) and NHS 24.  
- Business continuity planning involving the Royal Hospital for Sick Children (RHSC), neonatal and obstetric services at the Royal Infirmary of Edinburgh (RIE), the Lothian Unscheduled Care Service (LUCS) and West Lothian Community Health and Care Partnership. | Reviewed Sep 2012 - risk grade/rating remain unchanged.  
- UHD BC which examines rota compliance is being developed and the risk register will be informed by this work. In discussion with SG, in-patient paediatric ward closed for 3 weeks to ensure patient safety maintained. In-patient activity now restored to normal and ongoing discussions with SG looking at a sustainable model of care using ANNM’s and APNP’s. 3 consultant neonatologists and 3 consultant paediatricians have been appointed, and from August paediatric trainees have been allocated to St John’s. | Adequate but ineffective; control is properly designed but not being implemented properly | High 16 | Low 2 | Healthcare Governance Committee | Medical Director |
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| 3211| 2. Waiting Times Targets | Achievement of National Waiting Times Targets | There is a risk of: Not achieving national waiting times targets (stages within the 18 weeks RTT pathway; 31/62 Cancer waiting times) for a number of reasons: Lack of core capacity in a number of specialties; Internal capacity not being utilised effectively; Risk of overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money. Risk of adverse publicity relating to failure to meet waiting times targets. |  - The Chief Executive chairs a fortnightly waiting times meeting monitoring the delivery of in-patient/day case and out-patient activity to reduce the backlog. There is monitoring of the financial impact of the recovery plans. The performance against the Treatment Time Guarantee is monitored.  
- Development and implementation of a consistent approach to capacity planning is progressing with QuEST support.  
- Development of skills for demand and capacity planning and management across various staff groups in the organisation. Develop the use of real time demand and capacity management on medical and surgical wards to support effective capacity management and proactive admission and discharge planning.  
- Development and implementation of booking processes which supports good waiting list management; and use of the 6-4-2-1 theatre scheduling system to make better use of theatre capacity.  
- Commissioned support for purchase of external capacity to ensure Value for Money. | Updated Jan 2013 |

Updated

- The waiting times paper is presented monthly to the Board providing a progress report on reducing the backlog, and on increasing internal capacity to meet demand.

Adequacy of controls: Satisfactory; controls adequately designed to manage risk and working as intended

Residual Risk Grade: High 12

Risk level (Target): Low 1

Risk Owner: Medical Director

Assurance: Finance & Resources Committee
<table>
<thead>
<tr>
<th>ID</th>
<th>NHSL Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Residual Risk Grade</th>
<th>Risk level (target)</th>
<th>Risk Owner</th>
<th>Assurance</th>
</tr>
</thead>
</table>
| 2964 | 10. Financial Balance | The Board does not achieve its financial targets each year on a sustainable basis. | The Board does not achieve its financial targets each year on a sustainable basis. There is a UK-wide reduction in public sector budgets, which in turn has significantly reduced the projected level of growth available to the NHS Board in the next few years. The Board is already in a challenging position, and receives an allocation less than the NRAC formula prescribes. The cost base is subject to inflationary factors which always exceed general rises in funding, which therefore makes efficiency savings a continuous necessity. | • The Board approves budgets at the start of the financial year.  
• Financial governance policies & procedures, such as SFIS and Scheme of Delegation are in place.  
• System of delegated budgetary control is in place.  
• A system of control to identify and monitor the delivery of LRP savings is in place.  
• A system of risk management is in place, and financial management risks are a formal category. These risks appear on risk registers throughout the organisation.  
• The Board is subject to external and internal audit, and there is a follow-up system in place to monitor the implementation of audit recommendations.  
• The Board has a formal committee structure, and a management structure to monitor performance.  
• The Director of Finance presents monthly finance reports to the Joint Management Team each month, as well as reporting to the Finance & Resources Committee and the Board.  
• The Director of Finance provides a formal review of the forecast year end financial outturn following month 3, month 6 and month 9 results, which incorporate a detailed analysis and consideration of all aspects of the financial position. | Reviewed Sep 2012 - reassess following Mid Year Financial Review from High level (risk rating 15) to High (risk rating 10)  
• The Director of Finance presents monthly finance reports to the Executive Management Team each month; and to the F&PR and NHS Board on a bi-monthly basis. The Director of Finance provides a formal review of the forecast year end financial outturn following month 3, month 6 and month 9 results, which incorporate a detailed analysis and consideration of all aspects of the financial position. | Adequate but ineffective; control is properly designed but not being implemented properly | High 10 | Low 2 | Director of Finance | Finance & Resources Committee |
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<tr>
<th>ID</th>
<th>NHSL Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Residual Risk</th>
<th>Grade</th>
<th>Risk level</th>
<th>Risk Owner</th>
<th>Assurance</th>
</tr>
</thead>
</table>
| 3203 | 12. HEAT Targets and Standards | Unscheduled Care (Please note risk 3211 Waiting Times Targets (including 4 hour target), as inter-relationship and dependency between these two risk) | Performance against the delivery of Unscheduled Care is primarily measured by the 4 hour Emergency Care Standard. Performance against this standard is a measure of the effectiveness of performance against the whole healthcare system. It reflects the effectiveness of patient flow through the system. Poor performance is evidenced by the number of breaches of the 4 hour standard, levels of overcrowding within Emergency Departments, the number of patients boarding, the need for elective cancellations due to capacity pressures, the number of delayed transfers of care (either from acute to sub-acute or to non-hospital). It is understood that poor performance against these measures will have a direct and adverse impact on patient care. Whole system working involves GPs, SAS, Local Authorities, NHS24, LUCS, primary care and secondary care. | The Unscheduled Care Group is responsible for developing and implementing the unscheduled care strategy. The Group is co-chaired by the Director of Nursing and the Director of Health & Social Care. The Group has developed a range of proposals which are being implemented including:  
- The development of new medical assessment models to improve senior consultant presence in the evening and weekends.  
- The development of models of care for older people to support admission avoidance and earlier discharge from hospital  
- The development of increased capacity in social care services to reduce the number of patients with a delayed transfer of care for social reasons (including an additional 4,610 hours per week care at home for older people in the first nine months, a 12% increase) The weekly discharge target has now increased from 63 people per week to 72 people per week  
- Effective Joint Working with Councils to progress the Integration agenda  
- Investment in additional bed capacity (RIE ward 104, WGH ward 25, re-opening of RMH ward 1 and 2, Costorphine)  
- Planned development of additional capacity on RIE site for assessment and ward bed capacity in line with demand  
- Work on redesign to improve processes (e.g. admission avoidance with OPAT, development of ambulatory care pathways, more rapid pull of patients to wards)  
- Investment in senior supervisory nursing staff: to support improved discharge planning including earlier in the day discharges to support patient flow.  
- Investment in staffing within Emergency Departments  
- Focus on those patients waiting for packages of care of less than 14 hours; care at home as well as those on the rehabilitation list who could be supported at home. In addition we continue to focus on the reduction in the length of time to process complex cases, including guardianship applications.  
- The performance metrics in place through the Change Fund plans will be used to determine the impact and effectiveness of the interventions and will be reported through JMT and CH(CP) Sub-committees. The Delayed Discharge team within NHS Lothian will closely monitor delays over 2012/13 to ensure they remain on trajectory and provide analysis to support any proposed changes required to address performance through JMT and the Board. | Reviewed Jan 2013 – risk details, grade/rating have increased due to performance over December/January. | Inadequate, control is not designed to manage the risk and further controls & measures required to manage the risk | High 10 | Low 1 | Medical Director & Director of Health & Social Care | Finance & Resources Committee | 11
<table>
<thead>
<tr>
<th>ID</th>
<th>NHSLothian Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Residual Risk Grade</th>
<th>Risk level</th>
<th>Risk Owner</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1076</td>
<td>12. HEAT Targets and Standards</td>
<td>Healthcare Associated Infection</td>
<td>Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation publicly impacting on the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment. NHS Lothian has an Infection Prevention &amp; Control team in place. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid &amp; East and West Lothian) established to cover both acute and community settings. UHD and CHP Infection Prevention and Control Committees are well established and report to board through LICAC. IT based system in place to facilitate IPCN to monitor incidences of HAI within their clinical remits and to monitor for trends and patterns. SPSP have provided a collection of tools to support good practice to minimise potential for patient. IPCNs work collaboratively with clinical teams and bed management to provide advice and guidance on isolation and restriction of patient movements to balance the risk of transmission and impact on patient flow. IPCNs communicate directly with clinical services, escalating as appropriate. SAB and CDI rates reported weekly and monthly through IPCT reports SMT/JMT papers. All incidences of SAB &amp; CDI investigated, clusters of 2 or more investigated for links SBARs are provided. Systems are in place to escalate investigation. HAI Matrix utilised to identify reporting level HAIIRT. Communications provide support to manage public release of information as required. Packages of audits are in place to monitor standards. HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro. There is a Decontamination Strategy Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment.</td>
<td>Reviewed Oct 2012 – risk grade/rating remain unchanged</td>
<td>Satisfactory; controls adequately designed to manage risk and working as intended</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Director of Public Health</td>
<td>Healthcare Governance Committee</td>
<td></td>
</tr>
<tr>
<td>ID</td>
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<td>Title</td>
<td>Description</td>
<td>Controls in place</td>
<td>Updates</td>
<td>Adequacy of controls</td>
<td>Residual Risk Grade</td>
<td>Risk level (Target)</td>
<td>Risk Owner</td>
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</table>
| 1100 | 3. Staff Governance Policies | Staff Occupational Health and Safety | Inherent hazards to staff health and safety from the provision of healthcare. There exists a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being. | • Robust Occupational Health Services.  
  • Closed loop Health & safety management system in place.  
  • Robust H&S Committee structure. H&S policies and procedures in place.  
  • Competent specialist H&S advice in place. | Reviewed Sep 2012 – risk grade/rating remain unchanged  
Review of the risk management policy and the issue of a risk register procedure designed to provide guidance and ensure consistency of approach in operational risk management. | Adequate but ineffective; control is properly designed but not being implemented properly | Medium 9 | Low 2 | Director of Human Resources & Organisational Development | Staff Governance Committee |
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<tr>
<th>ID</th>
<th>NHSL Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
</tr>
</thead>
</table>
| 1267 | 9. Capital Programme     | The Board's Capital Plan cannot be delivered                         | There is a UK-wide reduction in public sector budgets, which in turn has significantly reduced the level of available capital funding. Revised national arrangements have been introduced through CEL 32 (2010): Arrangements for the Management of NHS Scotland Capital Resources after 2010/11. Amongst other things, the Board’s delegated limit has been reduced from £10m to £5m. The Board therefore has less capital funding, and less delegated authority. | - The JMT and F&R sub committee of the Board regularly reviews progress with major capital projects and the capital programme overall.  
- Members of the JMT have been identified with accountability for progress on key capital investments and planning initiatives so that the NHS Board's medium term financial plans are realised. | Reviewed Sep 2012 – risk details and grade/rating remain unchanged |

**Updates**: Reviewed Sep 2012 – risk details and grade/rating remain unchanged

**Adequacy of controls**: Uncertain; impact of controls not known at this time and more work required to identify current situation

**Residual Risk Grade**: Medium 9

**Risk level (target)**: Low 2

**Risk Owner**: Director of Finance

**Assurance**: Finance & Resources Committee
1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the progress to date on the inspections of the Care of Older People in Acute Hospitals by Healthcare Improvement Scotland (HIS) and the actions taken by NHS Lothian.

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 actions taken to date following announced and unannounced visits to NHS Lothian, and support the implementation of the site specific action plans.

2.2 Re-confirm support for and note the progress of the overarching Vulnerable Peoples Quality Improvement Framework.

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).

3.2 The focus of the visits to date, have been on patient care, staff attitude and behaviour, and interaction between staff and patients with specific emphasis on patients with a cognitive impairment. As well as reviewing health care records the visiting teams observed patients and staff, paying particular attention to nutrition and hydration.

3.2.1 Formal reports were published and noted areas of strength and areas where improvements were required.

3.2.2 The reports have indicated the following areas of strength:

- Good practice in relation to guardianship/Power of Attorney
- Use of Psychiatric Liaison Service
- Tissue Viability Service, specifically available education and training
• Availability of meals and snacks out with meal times
• Good use of patient aids (Western General site)

There was however a number of areas identified for improvement summarised in following themes:
• Compassion, Dignity & Respect – staff approach and communication. Of particular note was the lack of use of appropriate screening/curtains
• Dementia & Cognitive Impairment – screening for risks
• Nutritional Care & Hydration – screening and support
• Pressure Ulcer Prevention – assessment and documentation
• Care planning – general continuity of care planning and documentation

3.2.3 97% of patients involved in the inspection, through interviews and questionnaires, said the quality of the care they received was good and 86% said they had been given clear information about their condition and treatment.

3.2.4 The most recent findings from the national “Better Together” survey indicated good feedback from patients in relation to care delivery, choice and knowing about medicines on their discharge.

3.3 Following each visit a site action plan is prepared and shared with the relevant staff, a 16 week update is requested by HIS and the most recent update for the RIE visit was submitted in December.

3.3.1 As part of the overarching process each Board is asked to initially provide an overview of their service through the preparation of a self assessment and provision of supporting evidence. NHS Lothian has recently updated this information and a comprehensive updated document was submitted to HIS in December 2012.

3.3.2 Each CMT must consider this assessment and progress activities that relate directly to their specialties, each CMT is required to communicate this work to their teams.

3.4 HIS has now published a 6 month review of the National Inspections on the Care of Older People to date, highlighting key findings and identifying those areas where continued improvement in care is required. Much of this report identifies similarities with all Boards.

3.4.1 HIS, in progressing their work, are developing a specific improvement programme around the national Person-Centred Health and Care agenda and as part of this work NHS Lothian is a HIS test site for the Care Rounding project (see Appendix 1) in terms of wide scale spread plans.

3.4.2 The Person-Centred Health and Care agenda was launched in Glasgow in November and a follow-up to the two day event has been arranged for February in Stirling and representatives from NHS Lothian will attend this event.

3.4.3 HIS have recently published (November) their scrutiny priorities for 2013-5. In this document HIS explain that they are currently reviewing their methodology for the OPAH visits, in particular how these visits will 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. Inspections are currently suspended but will continue throughout 2013 and it is likely that all will be unannounced.

3.4.4 HIS will continue to work with the Mental Welfare Commission and the Ombudsman in progressing this scrutiny work.

3.5 The Vulnerable Peoples Quality Improvement framework was launched in August and is being driven forward by the Vulnerable People’s Steering Group. This is an evolved group from the previous Board Learning Disabilities Steering Group and sees the bringing together/combining of numerous strands of work following the Board approval of the recommendations from the 2010/11 5x5x5 on Improving Care for Vulnerable People in Hospital.

3.5.1 This improvement framework has 13 strands (Appendix 2) and progress has been made in the following:

- Agreement has been reached on the initial screening tool for cognition and delirium (4AT) and evaluation of this document will be completed this month with staff education and rollout thereafter
- Development and implementation of a robust education framework to support this agenda, this is also supported by the work of NES. The uptake of relevant training has been significant e.g. from the implementation of the education drive in January 2012 in excess of 2600 staff have passed the “Understanding Dementia” module, over 200 staff have attended the adult protection training sessions and nearly a 100 sessions have been provided for staff on dementia awareness/support with 500 staff having attended, this work continues
- The capacity and consent module, launched in November 2012, which aims to increase understanding around the legal issues of capacity and consent is now available as a Learnpro e-module and since November 2012 626 staff have accessed this with 621 passes recorded
- The policy and procedure for the management of patients with a learning disability has been updated and the update of the policy and procedure for the management of patients with a cognitive impairment is in progress, with both scheduled to be tabled at the March 2013 Clinical Policy Group
- The development of a support flow chart to enable the trigger of an initial screening for cognitive impairment/delirium and if required a generic risk assessment has been developed and will be available from end of January. One of the frequent observations during the HIS inspection was lack of staff understanding/confusion over terminology and process for specifically screening for delirium and cognitive impairment and the subsequent requirement for further generic and other risk assessment, continual review and documentation. It is anticipated that this flow chart will improve understanding and implementation of process

3.5.2 The Vulnerable People’s Project has commenced and the staff involved with this have achieved the following:

- Production of a newsletter with version one circulated late summer and newsletter 2 with a specific focus on screening and Nutrition being rolled out late January (available on the intranet)
- Development of ward and department posters, with poster one being introduced late summer explaining the definition of a vulnerable patient and poster 2 ready to be rolled out late January with a focus on recognising the triggers for Vulnerability “think Vulnerable”
- A ward resource pack will be introduced to the wards during late January/February. Support will be provided to ward staff on the use of this resource through harnessing the skills of NHS Lothian staff who have completed the Dementia Champions programme, this will be rolled out in a co-ordinated manner
- Production of a leaflet for carers and relatives to be given when a patient is determined to be vulnerable

3.5.3 This improvement work is supported by the ongoing internal audits now called Patient Experience Quality Indicators (PQI) previously PEAT which have been modernised and aligned to the HIS Older Peoples and HEI environment inspection standards. As part of the PQI (local/core) audit an older people’s mock/mini audit is also conducted if appropriate and since February to November a total of 56 audits have taken place with robust feedback mechanisms in place.

3.5.4 Internal audit were asked to consider NHS Lothian’s position in preparedness for inspection and this report has been made available indicating that NHS Lothian is satisfactory in their planning and preparation for inspections but requires to see improvement in the follow-up of actions/areas for improvement identified as part of the inspection/local assessment process and this should be progressed via the Clinical Management Teams with reports now being provided on activity to the Chief Nurse for Quality & Professional Standards.

3.6 To support the implementation of all of the above a delivery hub has been established. Staff within the hub, have been tasked with pulling together all strands of care improvement work to ensure that key messages are being delivered and received, that staff are maximising opportunities for learning and that information from complaints, concerns and incidents are being collated to inform the improvement programme. The hub will ensure the integration of improvement work streams in practice and will be a conduit for information about support, sharing and learning.

4 Key Risks

4.1 Vulnerable patients do not receive the care they require.

4.2 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. There are no new additions to the corporate risk register.
6 Impact on Inequality, Including Health Inequalities

6.1 The focus on older people and those with cognitive impairment is helpful in consolidating existing work streams to address the needs of vulnerable people and improve care.

6.2 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-none Tissue Viability Project is funded by non-recurring monies from Scottish Government. To embed and sustain this work recurring funding for continued facilitation will be required.

Melanie Hornett
Nurse Director
Carol Crowther
Chief Nurse Quality & Professional Standards
Carol.crowther@luht.scot.nhs.uk
9 January 2013

List of Appendices

Appendix 1: Care Rounding
Appendix 2: Work streams Vulnerable People Quality Improvement Framework
1 Care Rounding

1.1 Care rounding aligns a number of patient assessments, nursing care plans and improvement programmes to ensure patients are seen regularly and appropriately, for example at 1, 2, 4 or 6-hourly intervals and are given the individual care they need in one intervention which includes activities in relation to falls and pressure ulcer prevention, food, fluid & nutrition and pain management as well as an opportunity for a caring conversation. At the heart of this process is changing the system from one where patients request and then wait for care, to a system where care needs are anticipated.

1.2 An education programme has been developed, including classroom and short flexible ward based training. A training DVD produced in house ensures consistency in training.

1.3 Measurement and feedback is used to continuously monitor both the implementation and spread of care rounding. Outcome measures include inpatient falls with harm and hospital acquired grade two or above preventable pressure ulcers. In relation to spread work, the rate of training and wards implementing care rounding is monitored.

1.4 Work is in progress around using patient and staff stories as an evaluation tool in relation to care rounding and using a quality of interaction audit tool which has not previously been applied to a care rounding interaction. The Clinical Governance Support Team is taking this work forward in collaboration with the Leadership in Compassionate Care team and the Delivering Better Care hub.

2 Improving Care for Older People in Acute Care

2.1 Health Improvement Scotland invited boards to nominate at least one test site to participate in the Improving Care for Older People in Acute Care work stream. Test sites can be areas where improvement work is already underway and would like assistance to spread and share good practice or an area which requires assistance with improvement.

2.2 As care rounding has been tested and implemented in some areas already, NHS Lothian’s involvement is in relation to the spread of care rounding. Our test sites will be the wards that are leading on the introduction of the supervisory charge nurse role as these wards have been prioritised to receive support from the Clinical Governance Support Team to implement care rounding.

2.3 Our involvement around testing the spread of care rounding will continue throughout the coming year with attendance at national learning sessions and on WebEx calls to both learn from others and to share our improvement work.

Jane Muirhead  
Quality & Safety Improvement Manager  
11 January 2012  
Jane.muirhead@luht.scot.nhs.uk
A Dynamic Quality Improvement Framework for the Management of Vulnerable Patients (Adults) in Hospital across Lothian: November 2012

Workstreams

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Description</th>
<th>Workstream Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screening and Assessment</td>
<td>1a Screening for cognitive impairment/capacity</td>
<td>Dr T Ryan</td>
</tr>
<tr>
<td></td>
<td>1b Behaviour that challenges</td>
<td>Linda Irvine</td>
</tr>
<tr>
<td></td>
<td>1c Legal considerations</td>
<td>Alison Jarvis/Neil Punton</td>
</tr>
<tr>
<td></td>
<td>1d Managing risk – Use of policy and procedure</td>
<td>Carol Crowther</td>
</tr>
<tr>
<td></td>
<td>1e Managing Risk – boarding / transfer of patients</td>
<td>Chris Stirling</td>
</tr>
<tr>
<td>2. Safe, Effective and Person Centred Assessment and Care Planning</td>
<td>2a Assessment and Care Planning – individualised, person-centred</td>
<td>Anne Ovens</td>
</tr>
<tr>
<td></td>
<td>2b Communication/staff approach – attitudes and behaviour</td>
<td>Colin MacDonald</td>
</tr>
<tr>
<td></td>
<td>2c Discharge arrangements</td>
<td>Catriona Rostron</td>
</tr>
<tr>
<td></td>
<td>2d End of life care</td>
<td>Sandy Young</td>
</tr>
<tr>
<td>3. Education - Practice Development, Leadership and Quality Improvement</td>
<td>3a Staff knowledge and awareness of conditions associated with cognitive impairment</td>
<td>Janet Corcoran</td>
</tr>
<tr>
<td></td>
<td>3b Creating an environment suitable for most vulnerable patients</td>
<td>Michelle Finnie</td>
</tr>
<tr>
<td></td>
<td>3c Providing additional support / activities stimulating activity</td>
<td>Diane Loughlin</td>
</tr>
<tr>
<td>4. Essential Care Delivery/Reducing Harm</td>
<td>4a Nutrition / Tissue Viability / Dignity &amp; Respect / Falls</td>
<td>Gillian Wilson</td>
</tr>
</tbody>
</table>

NB. Workstream 1b will merge with workstream 2b during February 2013.
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 It also outlines other areas where patients are facing delays, where action is being pursued and stresses the need for ongoing vigilance on the shortening of waits.

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

2 Recommendations

The Board is recommended to:

2.1 Receive the report outlining progress with provisional information showing the latest position on inpatient waits and outpatient numbers, where outturn was consistent with expectations;

2.2 Note the work ongoing to reduce the long delays experienced by patients waiting for diagnostic, surveillance and other “repeat” endoscopies;

2.3 Endorse the work being undertaken to enable a software development to be taken forward to prevent the waiting time recorded for a small number of patients to be incorrect, acknowledging that while delivery of the development is awaited, there is the possibility of this occurring.

2.4 Anticipate receipt of an audit into services not covered by waiting time standards at its next meeting; and

2.5 Recognise the variables, risks and areas of uncertainty around these actions.
3 Background

3.1 As reported to the Board and its subcommittees over recent months, additional activity was commissioned both internally and externally to reduce the number of patients waiting longer than current national standards due to the inappropriate practices identified by PricewaterhouseCoopers last year\(^1\) and to prepare services for the introduction of the Treatment Time Guarantee. This guarantee, outlined in the Patients’ Rights Act, came into force on 1 October 2012 and requires that Health Boards treat patients within 12 weeks from the date of agreeing their treatment.

3.2 To address the long waits facing some patients, NHS Lothian has developed and is implementing detailed plans to improve performance.

4 Current Position – Inpatients and Daycases

4.1 The table below shows the numbers waiting more than 12 and 9 weeks as well as availability levels and overall list size since April 2012, with those over 12 weeks reducing to 568 by the end of 2012, with list sizes down on previous months and falls below 500 when one removes the types of patients excluded from treatment time guarantee. In June 2012, 1969 patients were over 12 weeks.

<table>
<thead>
<tr>
<th>Table 1 - Inpatient and Daycase Waiting List Characteristics</th>
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<tbody>
<tr>
<td><strong>Over 12 Weeks</strong></td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Available</td>
</tr>
<tr>
<td>Unavailable</td>
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<tr>
<td>Total List Size</td>
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<tr>
<td>Percentage Unavailable</td>
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</tbody>
</table>

Source: MMI returns; Performance Review

4.2 The trend since April 2011 is shown in Figure 1 alongside changes in overall list size and unavailability.

4.3 Figure 2, using operational information, shows that the overall reduction of waits continuing with a slight bump evident as elective operating wound down over Christmas and New Year. The rising pressure in Women’s and Children’s, highlighted in the last board paper, has stabilised, in respect of primarily scoliosis and spinal patients waiting beyond 12 weeks, as has their overall list size (Figure 3). Board members will be aware that both groups are currently excluded from the Treatment Time Guarantee.

\(^1\) For more information see [http://www.scotland.gov.uk/Resource/0039/00390166.pdf](http://www.scotland.gov.uk/Resource/0039/00390166.pdf)
Table 3 (page 13) identifies the appointments in train for neurosurgery position which allow the spinal waits to be reduced. This guarantee is expected to apply to these procedures from this coming October.

4.4 As the treatment time guarantee came into force for those agreeing treatment from 1 October, it became possible to breach this standard towards the end of last month and by 31 December, 44 patients – predominately plastics and urology patients – had not been treated within the timeframe expected.

4.5 The trend in reported patients over 12 weeks by specialty is shown in appendix 1.

Figure 1 – Inpatient and Daycase Waiting List

Source: Management MMI; ISD Data Warehouse

---

2 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
3 Board members will recall that the ophthalmology waiting list figure was previously excluded from the total due to inconsistent recording. As waiting list numbers in the specialty has been less variable, these are now included in the figure shown.
4.6 Activity year to date remain ahead of the equivalent period last year. Elective admissions on Lothian sites, which include Medinet activity, were up 5.3%, with particular rises in oncology (9.7%), urology (21.3%) and plastics (9.1%). This is detailed in appendix 4. This increase in local provision was added to by procedures undertaken in the independent sector and Golden Jubilee – making an overall increase of 8% on 2011/12.

4.7 Figure 4 shows November’s theatre utilisation and is similar to that reported at the last board meeting. Although the uptake of sessions has improved due to the implementation of 6:4:2:1 approach, which aims to maximise the use of available theatre time, in a number of areas the duration of the sessions used remains below the level sought in Demand, Capacity, Activity and Queue (DCAQ) and efficiency discussions.

4.8 The DCAQ exercise requires the implementation of improvement plans to address combined utilisation where is falls below 88% in their specialty improvement plans (combined included both uptake of sessions and duration of sessions used as a percentage total).

4.9 Additionally, the Theatre Management Board is currently assessing how to improve both efficiency within the operating area and accurate measurement.

![Figure 4 – Internal Theatre Utilisation (Selected Specialties) - November](source)

Source: Theatres and Anaesthetics, 14 December

5 Current Position - Outpatients
5.1 The table below outlines the number of outpatients over 12 weeks, unavailability and overall list size since April 2012. Figure 5 presents a longer time period graphically.

5.2 The outturn of 2856 at the end of December is consistent with that anticipated in October’s Board paper once the 267 endoscopy patients over 12 weeks (covered under section 7) are set aside, which also account for the rise from 2635 the previous month. 5177 patients were over 12 weeks at the end of June.

Table 2 - Outpatient Waiting List Characteristics

<table>
<thead>
<tr>
<th>Source: MMI returns; Performance Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 12 Weeks</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Over 12 Weeks</td>
</tr>
<tr>
<td>Available</td>
</tr>
<tr>
<td>Unavailable</td>
</tr>
<tr>
<td>Total List Size</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
</tr>
</tbody>
</table>

Figure 5 - Outpatient Waiting List

OUTPATIENT WAITING LIST - MONTH END

Source: MMI Return; ISD Data Warehouse

5.3 Reductions in numbers over 12 weeks (appendix 1) are matched, as one would expect, in reductions in overall list size. These reductions are shown in Figure 6 alongside rises in a number of specialties – most notably sleep medicine and neurology – which are linked to medical capacity. The appointment process for Consultant Neurology is underway with interviews scheduled next month. Options to address the pressure in sleep medicine are currently being considered.

---

4 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
5.4 Activity in outpatients remained above 2011/2 by 2.8% with the largest increase occurring in the General Surgery CMT, where longest waits feature. (Appendix 5)

Figure 6 - Outpatient Waiting List in selected specialties

<table>
<thead>
<tr>
<th>Sleep Medicine</th>
<th>Ophthalmology</th>
<th>Gastroenterology</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep Medicine</td>
<td>Ophthalmology</td>
<td>Gastroenterology</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Neurology</td>
<td>Neurosurgery</td>
<td>Urology</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Urology</td>
<td>Neurology</td>
<td>Neurosurgery</td>
<td>Gastroenterology</td>
</tr>
</tbody>
</table>

Source: Performance Review (report issued for operational management), 11 January

6 Timescales and Routes to Recovery of Inpatient and Outpatient Waits

6.1 Clinical Management Teams continue to reduce the number of inpatients and daycases waiting longer than 12 weeks. At the time of writing, 339 patients are likely to be over 12 weeks internally at the end of January with up to a further 120 externally, suggesting that the history of improvement will continue, although less marked than in recent months.

6.2 Discussion with Clinical Management Teams suggests that this slower rate of reduction will continue over the next few months and anticipates 200-300 over 12 weeks at the end of March, between a third or half of whom will be in areas excluded from the treatment time guarantee in recognition of the limited capacity available for such procedures nationally. Of those in areas covered by the treatment time guarantee, although some patients will have been waiting since prior to the guarantee coming into effect, plastics and urology continue to predominate and it is anticipated that these complex patients currently waiting over 12 weeks will have been treated by June.

6.3 Consultants continue to work flexible patterns to support this initiative. In Urology to address the waits of those requiring complex surgery, the Consultant has been dedicated to theatre, with clinic activity for this subspecialty deferred. An additional consultant has been appointed to work in this area to support additional capacity for these patients.
As board members will understand, this does not mean that all patients from now on will be seen within 12 weeks. A patient agreeing treatment now for one of these complex pathways is unlikely to be able to be offered a date locally until those patients referred to above have all been treated as capacity locally has already been committed, i.e. from June – six months from time of writing. As Board members will understand, this timescale is being kept under constant review. Appointments made to increase capacity are likely to impact on these timeframes.

Such patients are not appropriate to treat in independent hospitals normally referred to and few have accepted offers further afield outside the 97 minute boundary agreed by the Board in June last year, opting to remain with the local clinical team.

As indicated earlier, the number of outpatients over 12 weeks reduced significantly in the second half of 2012. However provisional management information shows that the number waiting over this standard has increased in the first part of January, partly due to the festive period but also to a variety of pressures in different specialties – ophthalmology, urology, general surgery, ENT, Neurology and Sleep Medicine (Figure 7).

Booking data suggests that this rise is now slowing and the reduction will have recommenced by the end of January. Discussions with Clinical Management Team anticipate that the improvement will thereafter be at a slower pace. The change in pace is due to the inability to use “see and treat” model readily to accommodate these patients as they tend to have long term conditions which will involve ongoing liaison with health professionals. An outturn at the end of March of 1500-2000 is seen as likely, once endoscopy patients have been taken into account, with the position improving as new appointments come into post.

![Figure 7 – Outpatients over 12 week – management reporting](image)

source: Performance Review, 11 January

7 Current Position – Diagnostics
7.1 In line with the agreement with the Scottish Government Health and Social Care Directorates, waiting times for some tests covered by the diagnostic standard (upper and lower endoscopy and colonoscopy) will fluctuate between four and six weeks.

7.2 As had been anticipated the number of diagnostic patients waiting longer than 6 weeks continued to rise at the end of December. The trend in endoscopy numbers over the 6 week standard is shown in Figure 8 with 1439 waiting over six weeks, rising from 1356 the previous month. Cystoscopy numbers over 4 weeks increased over previous months with 175 waiting longer than this.

7.3 No patient was waiting longer than 4 weeks for any of the radiological examinations covered by the national standard.

7.4 As indicated in November’s paper is anticipated that the waits in diagnostic endoscopy will peak in January and return within six weeks by August/September 2013.

7.5 The additional capacity to address this pressure is being generated will be generated through the provision of CT colonography, planned from February and maximising the potential for additional sessions both at the weekend and at Roodlands hospital. Use of the independent sector will also be kept under consideration.

7.6 These initiatives are in addition to the extra weekend and weekday activity already underway.
8 Current Position – Surveillance and Review Waits

8.1 November’s board paper highlighted that the national return had been established on surveillance patients. At the end of December 2,531 endoscopy patients were waiting beyond their planned review date, of which 1,798 were colonoscopy.

8.2 A further 96 patients were not able to be categorised on the return.

8.3 This continues the gradual trend of reduction previously reported – in November 2,652 were overdue, colonoscopies accounting for 1,891.

8.4 In November’s Board paper, it was anticipated that the backlog have been addressed by the end of 2013 through the use of both existing internal sessions and capacity being arranged through the independent sector. However access to independent sector provision has been delayed as facilities in the one hospital have taken longer to be made ready than had been suggested. Dependent on the throughput feasible in partner organisations it may be possible for the timescale reported at the last meeting to be met. This position is being monitored.

9 Recording and Management of Patient Waiting Times

9.1 Work described to the Board previously on ensuring robust arrangements for the management of waiting times continues.
9.2 An audit, highlighted previously to the Board, into waits not covered by waiting time standards has been completed and the results are currently being considered by Clinical Directors to determine those areas of concern. The results of this exercise are to be presented in next month’s board paper.

9.3 NHS Lothian has been working with other Boards who use the TrakCare system to agree the specifications for the changes required following the introduction of the new waiting time guarantee and receipt in December of technical requirements for national extracts from ISD. Agreement by the boards to specification is expected in the coming weeks. It is anticipated that the resulting changes to the TrakCare System will then be possible from the autumn.

9.4 In the interim, a number of alternative processes have been put in place to mirror the national changes as best as possible. For example, it has been specified that letters are to be sent to patients when they indicate to Boards that they are unavailable because, for example, they are to go on holiday. TrakCare does not have functionality to produce these letters currently and thus they are produced using the mailmerge facility on a word processing package.

9.5 The national guidance has also altered some of the calculations for a patient’s waiting time. In one situation, where a waiting time clock would have historically been reset (for example as two dates had been refused) and the patient had already exceeded the waiting time standard, the new guidance indicates that the clock should not be reset. It has not been possible to replicate this in TrakCare and thus there is the risk that the locally calculated waiting time clock will be incorrect for some patients. eHealth colleagues are exploring the potential for a software development to be implemented alongside TrakCare to overcome this issue. If successful it is anticipated that April is the earliest point this would be available. Board members are asked to note this risk.

9.6 At its meeting next month, the Board’s Audit Committee is due to receive an update on progress against the actions identified in the Internal Audit Report.

9.7 The Committee will seek an update on aspects relating to proposals over waiting list management, training and operating procedures, user restrictions on TrakCare and information provided to the Board.

9.8 In his statement to parliament on 20 December, the Cabinet Secretary indicated that it was expected that all actions identified in the internal audit reports, except those dependent on external factors, such as system changes, are to be concluded by the end of March and that the chair of each board’s Audit Committee is to provide a letter of assurance on this matter by the end of April.

9.9 The internal audit reports were one element of an examination into waiting times in Scotland. The related Audit Scotland report is expected to be published towards the end of February.

9.10 Planning of the development session for board members on waiting times, agreed at November’s Board meeting, is underway currently.

9.11 As Board members will know meetings are held each week with each of the Clinical Management Teams to revise progress and plans to date. Previously these discussions have been informed by a suite of reports of waiting list changes. This
set of reports is now being replaced by a preliminary DCAQ (Demand, Capacity, Activity and Queue) dashboard, which presents key points for management consideration graphically. With arrangements being finalised to mainstream the DCAQ work undertaken by the Government’s Quality and Efficiency Support Team (QuEST) to inform the investment, consultant job planning and improvement, the same management approach to using information to support elective performance is being embedded at both the operational and strategic levels.

9.12 It is intended that the DCAQ approach be one theme in the development session for members.

10 Investment in Sustainable Capacity
10.1 Board members will recall from previous papers and discussions that a number of additional posts have been approved following the initial output of the DCAQ exercise as the first steps towards providing sustainable capacity for the prompt treatment of patients. This is in addition to the changes in job plans for consultants already in post. For example, 6 PAs were agreed to support the breast pathway in plastics.
### Table 3 – Current Position on Appointments Agreed

<table>
<thead>
<tr>
<th>Specialty &amp; Theatre</th>
<th>Grade</th>
<th>Occupant</th>
<th>Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
<td>Upper Limb Surgeon</td>
<td>Consultant</td>
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</tr>
<tr>
<td></td>
<td>Back Surgeon</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Admin Support</td>
<td>Band 3</td>
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<td>Urology</td>
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<td>Specialty Doctor</td>
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<td></td>
<td>Physiotherapist</td>
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<td></td>
<td>Admin Support</td>
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</tr>
<tr>
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<td>Colorectal Surgeon</td>
<td>Consultant</td>
<td>1</td>
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<td></td>
<td>GastroEnterologist</td>
<td>Specialty Doctor</td>
<td>1</td>
</tr>
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<td>Band 5</td>
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<td></td>
<td>Nursing</td>
<td>Band 2</td>
<td>4.67</td>
</tr>
<tr>
<td></td>
<td>Admin</td>
<td>Band 3</td>
<td>2</td>
</tr>
<tr>
<td>Anaesthesia &amp; Theatre</td>
<td>Anaesthetist</td>
<td>Consultant</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Pain Management</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Theatre Nursing/ODP</td>
<td>Band 6</td>
<td>4.8</td>
</tr>
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<td>Band 5</td>
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</tr>
<tr>
<td>Neurosurgery</td>
<td>Consultant Neurosurgeon</td>
<td>Consultant</td>
<td>1 + 2 replacements</td>
</tr>
</tbody>
</table>

10.2
Table 3 summarises the position at the time of writing of those posts previously highlighted and including others – such as the consultant neurologist and neurosurgeon, more recently agreed.

10.3 A second tranche of investments is currently under consideration and picks up on further analysis; concluding Sleep, Anaesthetics and Colorectal.

11 Key Risks

11.1 NHS Lothian is engaged in the largest recovery operation against waiting times ever undertaken by a Scottish NHS Board. The establishment of a co-ordinated recovery programme that is bringing forward potential and actual solutions in short-timescales is a credit to the NHS Lothian staff steering and delivering the recovery. However, the recovery of waiting times contains a significant number of assumptions and thus confers risk.

11.2 The logistical challenges that have to be met over a short period of time to offer large volumes of patients both outpatient and inpatient appointments; co-ordinate treatment with external providers; arrange transport; provide information to patients; liaise with significant numbers of clinical and administrative staff and ensure that the whole process ‘hangs together’ and is co-ordinated, should not be underestimated. The complexity and sheer scale of the recovery programme is a risk in itself, but it is clear that the staff in Lothian are progressively meeting the challenge of this risk.

11.3 Particular risks reside around the extent to which patients will be willing to travel outside Lothian for treatment. The establishment of the External Provider Office is an attempt to mitigate this risk. However, should this mitigation prove insufficient, recovery will be delayed.

11.4 It is possible that some specialist work will be unable to be accommodated elsewhere. Where possible, expertise will be concentrated on such cases and the capacity for this maximised by displacing routine work so that it can be undertaken by others. This will further be sought to be minimised by seeking out providers able to undertake such procedures.

11.5 Recovery could also be slowed by difficulties in co-ordinating the various elements required to increase internal activity, such as lack of availability of additional anaesthetic staff, or disruption to existing core capacity, such as bed pressures from emergency admissions, as has occurred particularly effecting Orthopaedics in December. Both of these aspects have been mitigated through the introduction of a recommended lead time for the former and retention of seasonal bed capacity for the latter.

11.6 Sustained progress will also be dependent upon the willingness of staff to undertake additional hours above contractual levels for a prolonged period. To reduce the level of risk this presents it will be necessary to continue to invest in core capacity and also to seek alternative capacity to see those patients potentially affected.

11.7 Seasonality will affect patient availability as an unwillingness for patients to be treated for routine conditions was seen during the holiday period. Future plans will take better account of this through phasing. Core capacity could also be affected by
further industrial action in light of the ongoing discussions over public sector pensions.

11.8 If the risks above are not managed successfully, the Board could be in breach of the Patients Rights Act.

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

List of Appendices

Appendix 1 – Trend in Patients reported over 12 weeks since April 2011
Appendix 2 - Time since added to the Inpatient List for those Currently Waiting.
Appendix 3 - Time since added to the Outpatient List for those Currently Waiting.
Appendix 4 - Elective Inpatient and Daycase Activity
Appendix 5 - Outpatient Activity
Historical figures relating to levels of attainment of the waiting times standard and levels of patient unavailability are known to be inaccurate.


Source: MMI returns
Time since added to the Inpatient List for those Currently Waiting

<table>
<thead>
<tr>
<th>Specialty Description</th>
<th>&gt;6m</th>
<th>&gt;9m</th>
<th>&gt;12m</th>
<th>&gt;15m</th>
<th>&gt;18m</th>
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<tbody>
<tr>
<td>PLASTIC SURGERY</td>
<td>94</td>
<td>62</td>
<td>21</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>73</td>
<td>42</td>
<td>17</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>GENERAL SURGERY (EXCL VASCULAR)</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>GYNAECOLOGY</td>
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<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>ORAL AND MAXILLOFACIAL SURGERY</td>
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<td>GASTROENTEROLOGY</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>223</strong></td>
<td><strong>132</strong></td>
<td><strong>55</strong></td>
<td><strong>20</strong></td>
<td><strong>8</strong></td>
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</tbody>
</table>

The figure below shows how the position has changed since August 2012.

**January 2013 Extract**

Takes no account of periods of unavailability nor clock resets

Figures should not be added – eg 223 patients were waiting longer than 6 months, of whom 132 were waiting longer than 9 months

Source: Performance Review
18 January 2013
APPENDIX 3

Time since added to the Outpatient List for those Currently Waiting.

<table>
<thead>
<tr>
<th>Specialty Description</th>
<th>&gt;6m</th>
<th>&gt;9m</th>
<th>&gt;12m</th>
<th>&gt;15m</th>
<th>&gt;18m</th>
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<tbody>
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<td>EAR, NOSE &amp; THROAT (ENT)</td>
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<td>12</td>
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<tr>
<td>GENERAL SURGERY (EXCL VASCULAR)</td>
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<td>NEUROSURGERY</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESPIRATORY MEDICINE</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>419</td>
<td>237</td>
<td>95</td>
<td>30</td>
<td>5</td>
</tr>
</tbody>
</table>

The figure below shows how the position has changed since August.

January 2013 Extract
Takes no account of periods of unavailability nor clock resets
Figures should not be added – eg 419 patients were waiting longer than 6 months, of whom 237 were waiting longer than 9 months
Source: Performance Review 18 January 2013
## Elective Inpatient and Daycase Activity

### ACTIVITY BY CMT - MONTHS OF APRIL - DECEMBER

#### Combined Elective Inpatient and Day Case Admissions by CMT (Excluding independent sector, GJNH etc)

<table>
<thead>
<tr>
<th>CMT, Specialty</th>
<th>Apr - Dec</th>
<th>Apr - Dec</th>
<th>Variance</th>
<th>%age variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>41</td>
<td>10</td>
<td>-31</td>
<td>-75.6%</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>245</td>
<td>162</td>
<td>-83</td>
<td>-33.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>56</td>
<td>74</td>
<td>18</td>
<td>32.1%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>157</td>
<td>149</td>
<td>-8</td>
<td>-5.1%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>473</td>
<td>337</td>
<td>-136</td>
<td>-28.8%</td>
</tr>
<tr>
<td>Medical CMT</td>
<td>972</td>
<td>732</td>
<td>-240</td>
<td>-24.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>202</td>
<td>207</td>
<td>5</td>
<td>2.5%</td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>5</td>
<td>71</td>
<td>66</td>
<td>1320.0%</td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>13</td>
<td>6</td>
<td>-7</td>
<td>-53.8%</td>
</tr>
<tr>
<td>REAS CMT</td>
<td>220</td>
<td>284</td>
<td>64</td>
<td>29.1%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>564</td>
<td>501</td>
<td>-63</td>
<td>-11.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2884</td>
<td>2874</td>
<td>-10</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>1807</td>
<td>1972</td>
<td>65</td>
<td>3.4%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>581</td>
<td>620</td>
<td>39</td>
<td>6.7%</td>
</tr>
<tr>
<td>CTR CMT</td>
<td>6035</td>
<td>5967</td>
<td>-69</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Critical Care CMT</td>
<td>36</td>
<td>43</td>
<td>8</td>
<td>22.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1245</td>
<td>1207</td>
<td>-39</td>
<td>-3.1%</td>
</tr>
<tr>
<td>General Surgery (excl Vascular)</td>
<td>5372</td>
<td>5489</td>
<td>117</td>
<td>2.2%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>240</td>
<td>223</td>
<td>-17</td>
<td>-7.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>3354</td>
<td>4070</td>
<td>716</td>
<td>21.3%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1053</td>
<td>1131</td>
<td>78</td>
<td>7.4%</td>
</tr>
<tr>
<td>General Surgery CMT</td>
<td>11265</td>
<td>12120</td>
<td>855</td>
<td>7.6%</td>
</tr>
<tr>
<td>Ear Nose &amp; Throat</td>
<td>2071</td>
<td>2181</td>
<td>110</td>
<td>5.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4395</td>
<td>4428</td>
<td>33</td>
<td>0.8%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2629</td>
<td>3355</td>
<td>426</td>
<td>14.5%</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>883</td>
<td>1007</td>
<td>124</td>
<td>14.0%</td>
</tr>
<tr>
<td>Head &amp; Neck CMT</td>
<td>10278</td>
<td>10971</td>
<td>693</td>
<td>6.7%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>4743</td>
<td>4817</td>
<td>74</td>
<td>1.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>61</td>
<td>101</td>
<td>40</td>
<td>66.6%</td>
</tr>
<tr>
<td>MSK CMT</td>
<td>4804</td>
<td>4916</td>
<td>114</td>
<td>2.4%</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>3766</td>
<td>3969</td>
<td>223</td>
<td>5.9%</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>1130</td>
<td>1240</td>
<td>110</td>
<td>9.7%</td>
</tr>
<tr>
<td>Haematology</td>
<td>7584</td>
<td>8334</td>
<td>750</td>
<td>9.9%</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>6093</td>
<td>6798</td>
<td>706</td>
<td>11.6%</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>47</td>
<td>58</td>
<td>11</td>
<td>23.4%</td>
</tr>
<tr>
<td>Oncology CMT</td>
<td>18520</td>
<td>20420</td>
<td>1800</td>
<td>9.7%</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>3</td>
<td>0</td>
<td>-3</td>
<td>-100.0%</td>
</tr>
<tr>
<td>Clinical Services CMT</td>
<td>3</td>
<td>0</td>
<td>-3</td>
<td>-100.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>4547</td>
<td>4585</td>
<td>-262</td>
<td>-5.3%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>98</td>
<td>80</td>
<td>-18</td>
<td>-18.4%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>1737</td>
<td>1916</td>
<td>181</td>
<td>10.4%</td>
</tr>
<tr>
<td>Paediatric Specialities</td>
<td>7613</td>
<td>8012</td>
<td>399</td>
<td>5.2%</td>
</tr>
<tr>
<td>Women &amp; Children CMT</td>
<td>14395</td>
<td>14695</td>
<td>300</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>Total Elective Admissions</strong></td>
<td>66628</td>
<td>70150</td>
<td>3522</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

Source: Performance Review, 21 January
### Outpatient Activity – update required

**ACTIVITY BY CMT - MONTHS OF APRIL-DECEMBER 2010 TO 2012**

#### New Outpatient Attendances by CMT

<table>
<thead>
<tr>
<th>CMT, Specialty</th>
<th>Apr. Dec 11</th>
<th>Apr. Dec 12</th>
<th>Variance</th>
<th>%age variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>10</td>
<td>1</td>
<td>.9</td>
<td>90.0%</td>
</tr>
<tr>
<td>Communicable Disease</td>
<td>1962</td>
<td>2148</td>
<td>186</td>
<td>9.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>15365</td>
<td>14839</td>
<td>-527</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1248</td>
<td>1183</td>
<td>-65</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>1377</td>
<td>1484</td>
<td>107</td>
<td>7.8%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>2387</td>
<td>2865</td>
<td>478</td>
<td>20.9%</td>
</tr>
<tr>
<td>Medical CMT</td>
<td>22350</td>
<td>22510</td>
<td>160</td>
<td>0.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>1991</td>
<td>2065</td>
<td>74</td>
<td>3.7%</td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>65</td>
<td>95</td>
<td>30</td>
<td>46.2%</td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>1043</td>
<td>990</td>
<td>-53</td>
<td>-5.1%</td>
</tr>
<tr>
<td>REAS CMT</td>
<td>3699</td>
<td>3140</td>
<td>41</td>
<td>1.1%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>253</td>
<td>257</td>
<td>-4</td>
<td>-1.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4698</td>
<td>4779</td>
<td>80</td>
<td>3.7%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>4828</td>
<td>5131</td>
<td>303</td>
<td>6.3%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>537</td>
<td>542</td>
<td>5</td>
<td>0.9%</td>
</tr>
<tr>
<td>CTR CMT</td>
<td>10237</td>
<td>10799</td>
<td>562</td>
<td>5.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>5313</td>
<td>5704</td>
<td>391</td>
<td>7.3%</td>
</tr>
<tr>
<td>General Surgery (excl Vascular)</td>
<td>9889</td>
<td>10111</td>
<td>222</td>
<td>2.2%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>410</td>
<td>425</td>
<td>15</td>
<td>3.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>5556</td>
<td>5571</td>
<td>15</td>
<td>0.9%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1965</td>
<td>2007</td>
<td>42</td>
<td>2.1%</td>
</tr>
<tr>
<td>General Surgery CMT</td>
<td>23133</td>
<td>23954</td>
<td>821</td>
<td>3.5%</td>
</tr>
<tr>
<td>Ear Nose &amp; Throat</td>
<td>11724</td>
<td>11984</td>
<td>260</td>
<td>2.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>20760</td>
<td>21342</td>
<td>582</td>
<td>2.8%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>5774</td>
<td>5805</td>
<td>31</td>
<td>0.5%</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>2058</td>
<td>1784</td>
<td>-274</td>
<td>-13.3%</td>
</tr>
<tr>
<td>Head &amp; Neck CMT</td>
<td>40316</td>
<td>40915</td>
<td>599</td>
<td>1.5%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>19415</td>
<td>20678</td>
<td>1263</td>
<td>6.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>2676</td>
<td>2964</td>
<td>288</td>
<td>10.8%</td>
</tr>
<tr>
<td>MSK CMT</td>
<td>22091</td>
<td>23642</td>
<td>1551</td>
<td>7.0%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>1027</td>
<td>1075</td>
<td>48</td>
<td>4.7%</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>2263</td>
<td>2267</td>
<td>4</td>
<td>0.2%</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>5217</td>
<td>6313</td>
<td>996</td>
<td>15.3%</td>
</tr>
<tr>
<td>Haematology</td>
<td>2262</td>
<td>2530</td>
<td>268</td>
<td>10.5%</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>838</td>
<td>892</td>
<td>54</td>
<td>6.4%</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>65</td>
<td>77</td>
<td>12</td>
<td>18.4%</td>
</tr>
<tr>
<td>Oncology CMT</td>
<td>11635</td>
<td>12139</td>
<td>504</td>
<td>4.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>13799</td>
<td>13835</td>
<td>36</td>
<td>0.3%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>5677</td>
<td>6078</td>
<td>401</td>
<td>6.7%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>6353</td>
<td>6360</td>
<td>7</td>
<td>0.1%</td>
</tr>
<tr>
<td>Paediatric Specialties</td>
<td>12411</td>
<td>12405</td>
<td>-16</td>
<td>0.0%</td>
</tr>
<tr>
<td>Women &amp; Children CMT</td>
<td>38090</td>
<td>36678</td>
<td>1412</td>
<td>4.0%</td>
</tr>
<tr>
<td><strong>Total New Outpatients</strong></td>
<td><strong>171978</strong></td>
<td><strong>178782</strong></td>
<td><strong>6804</strong></td>
<td><strong>3.9%</strong></td>
</tr>
</tbody>
</table>

Source: Performance Review, 21 January
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 NHS Lothian performance data as reported through local and national systems. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Receive this update on the current performance against each of the current HEAT targets, standards and a number of other local and national targets, as outlined in Appendix 1. And to note that only areas of exception are being reported in the main report. Updates will be provided at the meeting.

3 Discussion of Key Issues

3.1 Of the 42 items monitored within Appendix 1, the most recent data indicates NHS Lothian:

<table>
<thead>
<tr>
<th>Performance</th>
<th>Table Key</th>
<th>December 12</th>
<th>January 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Items Monitored</td>
<td>42</td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>Meets the overall target</td>
<td>✓</td>
<td>10 occasions</td>
<td>10 occasions</td>
</tr>
<tr>
<td>Is on trajectory to meet, but has not yet met the final target</td>
<td>✓</td>
<td>8 occasions</td>
<td>5 occasions</td>
</tr>
<tr>
<td>Is off trajectory</td>
<td>×</td>
<td>7 occasions</td>
<td>9 occasion</td>
</tr>
<tr>
<td>Does not meet the overall target</td>
<td>× ×</td>
<td>17 occasions</td>
<td>16 occasions</td>
</tr>
<tr>
<td>No data available yet (new or revised target)</td>
<td>blank</td>
<td>2 occasions</td>
<td>2 occasions</td>
</tr>
</tbody>
</table>

4 Key Risks

The following performance measures in the report are those where NHS Lothian is currently off trajectory or require to be highlighted to the Board.

4.1 Heat Targets

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

In November 2012, NHS Lothian's performance was 5% above the trajectory for accident and emergency attendances. Total number was 17179 attendances.
4.1.2 Child Fluoride Varnishing (Responsible Director: Director of Public Health and Health Policy)

Data for the period from 1 April 2011 to 30 June 2012 shows NHS Lothian provided two fluoride varnishing applications to 31.11% of three year old and 36.58% of four year olds in the most deprived SIMD quintile (quintile 1).

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 set HEAT target. NHS Lothian Infection Prevention & Control Team is working with Health Protection Scotland support team to review data and systems, and identify possible modifications that could reduce healthcare associated Staphylococcus aureus bacteraemia. Recommendations include further work by clinical teams to review device use and associated practices. Additional work is also underway to reattribute the source of Staphylococcus aureus bacteraemia when links can be established to a healthcare contact out-with the current patient location e.g. from the front door areas to other clinical areas and points of the patient pathway.

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

NHS Lothian has agreed with the Scottish Government to undertake height and weight measurement in part of its Child Healthy Weight Programme. Work is underway to recruit additional schools for terms 2 and 3 of the 2012/13 school year, and for the 2013/14 school year. This will enable consent to be obtained to measure height and weight from parents, stagger school nurse workload and train additional staff to undertake the measurements. The trajectory will be realigned to meet the 2014 target accordingly. Updated information on progress to date should be available in early February.

4.2 HEAT Standards

4.2.1 Inpatient, Daycase, outpatient, diagnostic (inc endoscopy) Waiting Times (Responsible Director: Medical Director)

Performance on the above areas of activity is reported through the Medical Directors report to the Board on waiting times.

4.2.2 4-hour Emergency Access (Responsible Director: Nurse Director)

For November was 88.1% and 86.7% for December.

4.2.3 12hr Breaches – October 2012 (Responsible Director: Nurse Director)

For November there were 34 and for December 67.

4.2.4 Cancer Waiting Times (Responsible Director: Medical Director)

Overall, cancer waiting times are:

- 62 days – 96.7%
- 31 days – 94.8%
These headline results for all cancers combined are based on the November 2012 monthly management information report, which is the most recently reported period.

Colorectal and Urology tumour group performance against the 62-day standard was the main concern in quarter 3. In quarter 3 2012 colorectal 62-days performance was 79.6%, and urology 62-days was 82.5%. Performance has improved in these groups as shown in the November monthly report (colorectal 62-day performance at 92.3%, and urology at 88%). A continued focus on maintaining performance, supported by ongoing capacity planning, is being provided. Performance data for Quarter 4 2012 is due to be published by ISD Scotland in March 2013. Our outline forecast for the quarter is that NHS Lothian’s 62-day and 31-day performance levels should exceed the 95% standard.

4.2.5 Stroke (Responsible Director: Nurse Director)

Data for November shows 62% adherence to this target across Lothian down from 68% in October. Of the 27 occurrences of fails in November, seven patients were admitted to a stroke unit bed within two days, and three patients were admitted to a stroke unit bed (or discharged) within three days. Weekly exception reports to identify which patients are failing the standard will be in place by the end of January. Discussions with Scottish Ambulance Service have reiterated the importance of their teams to pre-alert Emergency Departments for the arrival of stroke patients. This needs to be done in conjunction with Bed Bureau so that crews are directed to the site with availability on the stroke unit.

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

The table gives a summary of headline figures from the December 2012 census

<table>
<thead>
<tr>
<th>Total ISD Delays (incl. X-codes)</th>
<th>Total Delays (Excel. X-codes) NHSL target 66</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 Days (non- x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td>139</td>
<td>78</td>
<td>61</td>
<td>16</td>
<td>28</td>
<td>8</td>
</tr>
</tbody>
</table>

- 78 delays after X codes removed (112 Nov, 120 Oct, 143 Sept)
- 139 overall including X codes (151 Nov, 164 Oct, 187 Sept)
- 16 Patients (all Edin) delayed >6wks (14 Nov, 21 Oct, 21 Sept)
- 29 days is the average length of stay (25 Nov, 26 Oct, 26 Sept)
- 2 Non-Lothian delays (3 Nov, 1 Oct, 5 Sept)

East, West and Midlothian, continue to have no delays over six weeks. Both Mid and West meet the 4 weeks standard, (due to replace the 6 week standard in April this year). Work is on-going with both East and City of Edinburgh in how we can get down to the 4 week standard. City of Edinburgh is working with the Joint Improvement Teams to eliminate communication delays and improve assessments. East Lothian is working with the CHP to have better links with the Edinburgh Hospitals and Clinical staff in Roodlands for improved referral pathways.

The table below shows both the overall delays and the ISD reportable delays. We have seen a slight dip in overall numbers across November/December. This dip
occurred despite the level of Norovirus in our system, which has seen 19 patients ready for discharge, but not declared in the main census return, as they were due on wards that were closed temporarily because of Norovirus patients.

The number of patients who are coded as complex has risen. All of the rise can be attributed to patients on wards closed, so not able to be discharged on the actual census day. These patients are reported to ISD under complex codes, specifically designed to indicate they were ready for discharge but the ward or the intended care home was closed for infection control reasons.

4.2.7 Emergency Bed Days (Responsible Director: Director of Strategic Planning, Performance Reporting and Information)

The trajectory for emergency bed days for those 75+yrs continues to rise above NHS Lothian’s agreed stretch target. The chart illustrates the line of travel by CHP.

4.2.8 Palliative & End of Life Care (Responsible Director: Director of Strategic Planning, Performance Reporting and Information)
Overall, for all Lothian, the proportion of deaths in acute hospitals is not reducing (comparing our position in the strategy baseline year of 2008-09 to the end year position in 2011/12). A small improvement (slight increase) in the proportion of Lothian deaths in residential settings has been made (+1.2% in care homes, and +1.1% in the domiciliary setting, again comparing the baseline year of 2008-09 to 2011/12). Over the same period we have seen a small decrease in the proportion of deaths in NHS continuing care hospitals (-1.6% from 2008-09 to 2011/12).

4.2.9 Vasectomy: 12 week OP and 18 week RTT (Responsible Director: Joint Director Edinburgh CHP)

Data for patients treated in October showed compliance against the 18 week RTT standard of 72.9%, with 20 breaches of the 12-week outpatient target. The service has commenced migration of data management over to the TRAK system. This will make management of pathways simpler, and bring a higher level of data quality assurance. The most recent work done on TRAK shows that performance against RTT is 100% for December.

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
14 January 2013  
moray.paterson@nhslothian.scot.nhs.uk  alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Performance Management Scorecard
### Health Improvement

#### Child Healthy 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)

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr 11 - Mar 12</td>
<td>682</td>
<td>Apr 12-Jun 12</td>
<td>119</td>
</tr>
</tbody>
</table>

The figures for Apr 11-Mar 12 have now been validated. While we reported previously that we had missed the trajectory by one intervention (679 vs 680) the final figures exceeded the trajectory. This was because 574 interventions were recorded on the national Child Health Surveillance Programme. School system rather than the 571 initially anticipated from locally held data. A relatively small number of school-based interventions were completed between Apr-Jun 2012. This is because most schools agreeing to participate expressed a preference to avoid the shorter summer term. Most of the interventions for 2012-13 are planned for September - November 2012 which will bring us back on course. A smaller number of interventions completed between April - June in one of the attached nursery schools will be reported in the next quarter.

#### Child Healthy Weight - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14

- Number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14

<table>
<thead>
<tr>
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#### Suicide Reduction
- % of suicides per yr per 100,000 population

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>20%</td>
<td>2008-10</td>
<td>14.1%</td>
<td>2009-11</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

There were 128 suicides in Lothian in 2011 (16.5% of the Scottish total). This is an increase on 2010 (122) but lower than 2009 (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.

#### Smoking Cessation
- To deliver universal smoking cessation services to achieve 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

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-14</td>
<td>11,686</td>
<td>Aug-12</td>
<td>4,148</td>
<td>Sep-12</td>
<td>7,180</td>
</tr>
</tbody>
</table>

Performance is measured against the lowest performing quintile. Children in this quintile will have fluoride varnish applied by general dental practitioner. SIMD have not yet released data on the first full year performance for GDP application of varnish, and so the reported figures do not reflect actual performance. The numbers recorded are likely to be children living in the least deprived quintile who attend a nursery in the most deprived quintile and are therefore seen by the salaried dental service Childsmile Team.

#### Child Fluoride Varnishing Aged 3
- Achieve at least 30\% 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

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-14</td>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>01/04/2011</td>
<td>30/06/2012</td>
<td>60%</td>
</tr>
</tbody>
</table>

Performance is measured against the lowest performing quintile. Children in this quintile will have fluoride varnish applied by general dental practitioner. SIMD have not yet released data on the first full year performance for GDP application of varnish, and so the reported figures do not reflect actual performance. The numbers recorded are likely to be children living in the least deprived quintile who attend a nursery in the most deprived quintile and are therefore seen by the salaried dental service Childsmile Team.

#### Child Fluoride Varnishing Aged 4
- Achieve at least 30\% 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

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-14</td>
<td>01/04/2011</td>
<td>31/03/2012</td>
<td>01/04/2011</td>
<td>30/06/2012</td>
<td>60%</td>
</tr>
</tbody>
</table>

Performance is measured against the lowest performing quintile. Children in this quintile will have fluoride varnish applied by general dental practitioner. SIMD have not yet released data on the first full year performance for GDP application of varnish, and so the reported figures do not reflect actual performance. The numbers recorded are likely to be children living in the least deprived quintile who attend a nursery in the most deprived quintile and are therefore seen by the salaried dental service Childsmile Team.

#### Detection of Cancer Early
- Of all those diagnosed with breast, colorectal and lung cancer, 50\% are to be diagnosed while in the first stage of the disease

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-15</td>
<td>25%</td>
<td>Nov-13</td>
<td>85.14%</td>
<td>Sep-12</td>
<td>89.62%</td>
</tr>
</tbody>
</table>

Details of local trajectories for the three cancers are still being agreed with the Scottish Government.

### Efficiency

#### Reduce Carbon Emissions
- % reduction year-on-year (Tonnes of CO2)

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 1, 12/13</td>
<td>1.89%</td>
<td>Qtr 2, 12/13</td>
<td>6.36%</td>
</tr>
</tbody>
</table>

A detailed briefing is circulated on a monthly basis as appropriate and can be shared with Board members on request.

#### Reduce Energy Consumption
- % reduction year-on-year (Energy GJ)

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-15</td>
<td>-2.97%</td>
<td>Qtr 1, 12/13</td>
<td>1.19%</td>
<td>Qtr 2, 12/13</td>
<td>6.94%</td>
</tr>
</tbody>
</table>

A detailed briefing is circulated on a monthly basis as appropriate and can be shared with Board members on request.

### Access to Services

#### 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

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-13</td>
<td>90%</td>
<td>Qtr 1, 12/13</td>
<td>83.90%</td>
<td>November</td>
<td>86.90%</td>
</tr>
</tbody>
</table>

We have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. Scottish Government QUEST monies are being used to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.

#### Faster access to CAMHS
- Deliver 26 wks Referral to Treatment

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar-13</td>
<td>0</td>
<td>Aug-12</td>
<td>6</td>
<td>Sep-12</td>
<td>7</td>
</tr>
</tbody>
</table>

Performance is measured against the lowest performing quintile. Children in this quintile will have fluoride varnish applied by general dental practitioner. SIMD have not yet released data on the first full year performance for GDP application of varnish, and so the reported figures do not reflect actual performance. The numbers recorded are likely to be children living in the least deprived quintile who attend a nursery in the most deprived quintile and are therefore seen by the salaried dental service Childsmile Team.

#### Faster access to Psychological Therapies
- Deliver 18 wks Referral to Treatment

<table>
<thead>
<tr>
<th>Target</th>
<th>Target Date</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec-14</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Summary of NHS Lothian Performance Measures - HEAT Targets, Standards and other Local / National Targets

**Appendix 1**

#### Treatment Appropriate for Patient

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Mar-13</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>AMcM</th>
<th>AKM</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Attendances - rate of A&amp;E attendances per 100,000 population</td>
<td>1,911</td>
<td>2.068</td>
<td>2.042</td>
<td>1.948</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA / MSSA Reductions - achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MRSA) cases to 0.26 or less per 1,000 acute occupied bed days</td>
<td>0.26</td>
<td>0.31</td>
<td>0.32</td>
<td>0.28</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. diff Infections - achieve a reduction of the rate of Clostridium difficile infections in patients aged 65 and over to 0.39 cases or less per 1,000 total occupied bed days</td>
<td>0.39</td>
<td>0.34</td>
<td>0.34</td>
<td>0.39</td>
<td>✓ ✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in emergency bed day rates for patients aged 75+</td>
<td>5,143</td>
<td>5,073</td>
<td>5,097</td>
<td>5,143</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed Discharges - no people to wait more than 28 days to be discharged from hospital into a more appropriate care setting from April 2013</td>
<td>0</td>
<td>28</td>
<td>28</td>
<td>24</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed Discharges - no people to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015</td>
<td>0</td>
<td>65</td>
<td>47</td>
<td>0</td>
<td>× ×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke Unit - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>90%</td>
<td>68%</td>
<td>62%</td>
<td>85%</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assessment**

- **✓ ✓** Meets the overall target
- **✓** Is on trajectory to meet, but has not yet met, the final target
- **X** Is off trajectory
- **XX** Does not meet the overall target
### Summary of NHS Lothian Performance Measures - HEAT Targets, Standards and other Local / National Targets

#### Appendix 1

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Dtrr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Brief Interventions - maintain the same total level of delivery of ABIs as under the HEAT H4 target for 2011-12 - at least 90% of delivery to be in priority settings.</td>
<td>Standard</td>
<td>9,938</td>
<td>2011-12 17,093 April to Oct 2012</td>
<td>9,755 6,625</td>
<td>✓</td>
<td>AKM</td>
<td>Current performance does not include ABIs delivered by Lothian and Borders Police which was not available at the time of the report.</td>
</tr>
</tbody>
</table>

| 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&E, or referred from one of the national cancer screening programmes. | Standard    | Oct-12 | Nov-12 95% | 99% ✓ | DF | Due to the recent downward trend in cancer waiting times performance, details of the monthly performance will be included in future performance reports. We are also reporting weekly to the Scottish Government on performance. |

| 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. | Standard    | Oct-12 | Nov-12 95% | 99% ✓ | DF | Now sits within the Unscheduled Care Group set up and chaired by the Nurse Director and the Joint Director, Edinburgh. |

| 18 weeks Referral To Treatment - 90 per cent of patients to wait no longer than 18 weeks from referral to a first decision to treat. | Standard    | 90%    | Oct-12 98.10% | Nov-12 97.80% | 95% ✓ | AMcM | Reported through the Medical Directors report to the Board |

| 12-week Outpatients - no patient to wait longer than 12 weeks from referral to a first | Standard    | 0      | Oct-12 3176 2639 | 0 96.97% | 98% X | MH | Now sits within the Unscheduled Care Group set up and chaired by the Nurse Director and the Joint Director, Edinburgh. |

| 4-hour A&E - % of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&E treatment | Standard    | 98%    | Nov-12 88.10% | Dec-12 86.31% | 98% X | MH | | |

| GP Access - advance booking more than 2 days in advance | Standard    | 90%    | n/a 80.0% | 90% 90% AMcM | | | | |

### Assessment

- ✓ Meets the overall target
- ✓ Is on trajectory to meet, but has not yet met, the final target
- X Is off trajectory
- XX Does not meet the overall target
<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Dtrr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>Total number of Delayed Discharges over 6 weeks (monitor nationally)</td>
<td>0</td>
<td>Nov-12</td>
<td>14</td>
<td>Dec-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Total number of Delayed Discharge in Short-Stay setting (monitor locally)</td>
<td>0</td>
<td>Nov-12</td>
<td>14</td>
<td>Dec-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Inpatient/Day Case Max 12 wks</td>
<td>0</td>
<td>Oct-12</td>
<td>893</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Inpatient/Day Case Max 9 wks</td>
<td>0</td>
<td>Oct-12</td>
<td>1387</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Wait for key diagnostic tests &gt; 4 weeks (Monitor Nationally)</td>
<td>URG</td>
<td>Oct-12</td>
<td>1</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Cataract Waiting Times - max wait 18 wks outpatient and inpatient combined (Monitor Locally)</td>
<td>0</td>
<td>Oct-12</td>
<td>99</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Hip Surgery - waiting times % of Hip Fracture operations within 24 safe operating hours (Monitor Locally)</td>
<td>98%</td>
<td>Oct-12</td>
<td>89.7%</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>wait for cardiac intervention to be &lt; 15wks (angiography, angioplasty and CABG) (Monitor Locally)</td>
<td>0</td>
<td>Oct-12</td>
<td>0</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Audiology (Adults) - number of patients waiting over 9 weeks</td>
<td>0</td>
<td>Oct-12</td>
<td>0</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Audiology (Paediatrics) - number of patients waiting over 12 weeks</td>
<td>0</td>
<td>Oct-12</td>
<td>3</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Oct-12/13</td>
<td>Palliative Care strategy - proportion of deaths occurring in acute hospital</td>
<td>Dec-15</td>
<td>38%</td>
<td>Qrt 1</td>
<td>ELS=42.2%</td>
</tr>
<tr>
<td>Oct-12/13</td>
<td>Palliative Care strategy - proportion of deaths occurring in community residential settings</td>
<td>Dec-15</td>
<td>39%</td>
<td>Qrt 1</td>
<td>ELS=40.3%</td>
</tr>
<tr>
<td>Oct-12/13</td>
<td>Vasectomy - 12 Week OP Breaches</td>
<td>Ongoing</td>
<td>0</td>
<td>Sep-12</td>
<td>5</td>
</tr>
<tr>
<td>Oct-12/13</td>
<td>Vasectomy - 18 Week RTT Compliance</td>
<td>Ongoing</td>
<td>90%</td>
<td>Sep-12</td>
<td>67.3%</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Wheelchair - referral to fitting - Patients still waiting 18 weeks+</td>
<td>90%</td>
<td>Dec-15</td>
<td>96.39%</td>
<td>Nov-12</td>
</tr>
<tr>
<td>Mar-13</td>
<td>Sickness Absence</td>
<td>4%</td>
<td>Sep-12</td>
<td>4.08%</td>
<td>Oct-12</td>
</tr>
</tbody>
</table>

### Assessment

- ✔ ✔ Meets the overall target
- ✔ is on trajectory to meet, but has not yet met, the final target
- X is off trajectory
- X X Does not meet the overall target
1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the financial position to the end of December 2012 and to confirm that NHS Lothian continues to forecast delivery of break even against the in year Revenue Resource Limit target for 2012/13.

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

2 Recommendation

2.1 The Board is asked to note the:

- Financial position for the nine months to the end of December 2012;
- Forecast break even position for 2012/13; and
- The key associated risks.

3 Discussion of Key Issues

Overview

3.1 Whilst NHS Lothian reported an overspend each month during the first half of this financial year, the mid year review concluded that financial break even was achievable and set out how this would be achieved. The associated adjustments are reflected in the financial results to date, which show an underspend of £0.6m for the 9 month period. This underspend will reduce as the year end approaches and the level of unachieved efficiency savings (currently £1.1m) reaches the forecast level of £3.9m.

3.2 The position is summarised in table 1 below. A detailed analysis of the financial position by expenditure type is attached as Appendix 1 and by operational unit in Appendix 2.
### Table 1: Financial Position to 31 December 2012

<table>
<thead>
<tr>
<th></th>
<th>Year to date £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline position</td>
<td>(5,834)</td>
</tr>
<tr>
<td>Outstanding efficiency savings</td>
<td>(1,064)</td>
</tr>
<tr>
<td><strong>Operational position</strong></td>
<td>(6,897)</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>(3,660)</td>
</tr>
<tr>
<td>Release of provisions and reserves</td>
<td>11,115</td>
</tr>
<tr>
<td><strong>Total under/(over) Spend</strong></td>
<td>558</td>
</tr>
</tbody>
</table>

### Baseline Position

3.3 Whilst performance improved in December, with a £0.6m underspend reported in the month, no change to underlying trends is evident. However, an initial review of activity data for the month of December suggests that there was a reduction in activity, which may have impacted on the underlying expenditure position for the month. Further robust analysis is required; activity data for the period is attached at Appendix 3.

3.4 In line with the mid year review, reserves and provisions have been released to offset a number of financial pressures. The key in year issues are detailed below:

- *Income from other health systems* – the impact on income caused by a fall in non Lothian activity is estimated at £2.8m for the year, £2.1m of which is now reflected in the results to date;

- *Pay costs* – vacancies in a number of staff groups, mainly medical and dental and Allied Health Professionals (AHPs), are offset by pressures on nursing costs, driven by incremental drift and increased cost of enhancements. The financial impact of the current nursing recruitment drive will become evident in 2013/14 when the ability to manage these pressures through vacancies will be significantly reduced;

- *Clinical supplies and equipment costs* – the upward expenditure trend continues to concern with a combined variance of £4.7m. The variance is driven by factors including: historical pressures; changes in case mix; and specific service issues. In addition to the ongoing work to better understand the drivers, the unscheduled care investment proposals are being revisited to incorporate provision for related clinical supplies costs. The position with expenditure related to elective activity will be reviewed in 2013/14 when the waiting times backlog has been addressed;
• Property costs - increases in energy costs and property maintenance (both £0.6m) across a number of sites continue to impact on expenditure within the Facilities & Estates budget; and

• Other non pay costs – this heading incorporates the net reduction in the research and development allocation (£1.2m for the year), the additional waiting times recovery plan (£4.9m for the year), increased costs of unplanned activity (UNPACs) and the release of provisions and reserves to supporting the year to date position.

3.5 Not all issues are specifically highlighted above and there are areas of offsetting overspend and underspend which are actively being managed by operational units. It should also be noted that prescribing costs remain on trajectory to break even.

3.6 Board members are asked to note that the Draft Financial Plan for 2013/14 and beyond will be scrutinised by the Joint Management Team and the Finance & Resources Committee in February. Whilst the key in year financial pressures from 2012/13 will be taken into account through the financial planning process, there is also a requirement to ensure the efficiency target remains at an achievable level. As ever, additional investment beyond our uplift and NRAC allocation must be supported by savings across the organisation. The Financial Plan will be presented to the NHS Board in March for approval.

Efficiency & Productivity

3.7 For the nine month period to December, efficiencies of £20.8m have been delivered against a plan of £21.9m, an under delivery of £1.1m. This remains in line with the mid year review forecast of in year under delivery of £3.9m and an estimated carry forward of £12.2m.

3.8 Over the next 3 months significant effort will focus on ensuring the forecast (both in year and recurring) can be met and, indeed, improved upon.

3.9 At the time of writing, an updated year end forecast is being prepared, for consideration by the NHS Lothian Efficiency and Productivity Group; this will also identify the key risks for achievement of this target.

3.10 The figures are summarised in table 2 below:
### Table 2: Efficiency and Productivity 2012/13

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target £k</th>
<th>Slippage to December £k</th>
<th>Forecast In Year Slippage £k</th>
<th>Forecast Recurring Carry Forward £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Interventions Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Value</td>
<td>537</td>
<td>(340)</td>
<td>(495)</td>
<td>(369)</td>
</tr>
<tr>
<td>Primary &amp; Community Care Bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction</td>
<td>650</td>
<td>(243)</td>
<td>(346)</td>
<td>198</td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>3,233</td>
<td>(66)</td>
<td>(542)</td>
<td>(611)</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>(1,082)</td>
<td>(1,546)</td>
<td>(1,430)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>11,411</td>
<td>(639)</td>
<td>(836)</td>
<td>(534)</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>(6)</td>
<td>(1,410)</td>
<td>(615)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>(92)</td>
<td>(643)</td>
<td>(1,237)</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td>1,945</td>
<td>(227)</td>
<td>(152)</td>
<td>(1,279)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,779</td>
<td>(447)</td>
<td>(599)</td>
<td>(696)</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>5,171</td>
<td>222</td>
<td>346</td>
<td>(1,046)</td>
</tr>
<tr>
<td>UHD Local</td>
<td>3,893</td>
<td>1,856</td>
<td>2,071</td>
<td>(2,129)</td>
</tr>
<tr>
<td>LAMS</td>
<td>2,000</td>
<td>0</td>
<td>(113)</td>
<td>(100)</td>
</tr>
<tr>
<td><strong>Total Planned Savings</strong></td>
<td><strong>37,902</strong></td>
<td><strong>(1,064)</strong></td>
<td><strong>(4,265)</strong></td>
<td><strong>(9,848)</strong></td>
</tr>
<tr>
<td><strong>Residual Gap</strong></td>
<td>(362)</td>
<td></td>
<td>361</td>
<td>(2,365)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37,540</strong></td>
<td><strong>(1,064)</strong></td>
<td><strong>(3,904)</strong></td>
<td><strong>(12,213)</strong></td>
</tr>
</tbody>
</table>

**Waiting times**

3.11 The total cost of delivering additional waiting times activity to the end of December is £19.7m, an increase of £1.9m in the month. In addition to the cost of reducing the backlog, expenditure includes recurring investment in core capacity.

3.12 The position remains in line with the mid year review forecast of £26.8m. The key risks associated with full delivery include case mix, which is likely to increase internal costs, and continued reliance on independent sector providers.

3.13 Further details are given in a separate paper.

**Capital**

3.14 The forecast cost of the in year programme is £47.8m, of which £18.0m has been incurred to the end of December 2012. The detail relating to individual schemes is included in Appendix 4 and significant points to highlight include:
• The programme is currently showing a small but manageable over commitment (£0.5m). The quarter 3 review of the capital programme is underway and it is anticipated this will identify further slippage in schemes where building has not yet commenced;

• The backlog maintenance programme represents the most significant risk in the capital programme. Whilst the programme is underway with 281 individual schemes agreed to tackle the areas of high and significant risk full delivery of the £5m in year budget will be challenging.

4 Key Risks

4.1 The key ongoing risks already highlighted in previous monthly finance reports include:

• Delivery of the agreed recurrent efficiency schemes and the need to identify further plans to address the shortfall;

• Continued management of the financial exposure on waiting times’ related additional activity delivery;

• The solution(s) agreed to address the system wide unscheduled care pressures, including any double running costs associated with any continued use of the Royal Victoria Hospital;

• The potential cost of changes to pay terms & conditions (including revised on call arrangements); and

• The increasing trend of expenditure on clinical supplies, hotel and equipment costs.

5 Risk Register

5.1 There is nothing to add to the Risk Register at this stage.

6 Health and Other Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Involving People

7.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.
8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
16 January 2013
Susan.goldsmith@nhlothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Income & Expenditure Summary December 2012
Appendix 2: NHS Lothian Summary by Operational Unit December 2012
Appendix 3: NHS Lothian Inpatient & Day Case Activity December 2012
Appendix 4: NHS Lothian Capital Expenditure Programme December 2012
### NHS LOTHIAN CORE POSITION

#### INCOME

<table>
<thead>
<tr>
<th>Income Item</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from other health systems</td>
<td>(115,306)</td>
<td>(74,630)</td>
<td>(73,358)</td>
<td>(1,272)</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(58,376)</td>
<td>(44,062)</td>
<td>(44,069)</td>
<td>7</td>
</tr>
<tr>
<td>National services</td>
<td>(31,647)</td>
<td>(35,170)</td>
<td>(35,337)</td>
<td>167</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,814)</td>
<td>(2,142)</td>
<td>(1,826)</td>
<td>(316)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(2,401)</td>
<td>(1,801)</td>
<td>(1,586)</td>
<td>(215)</td>
</tr>
<tr>
<td>Other income</td>
<td>(44,087)</td>
<td>(36,450)</td>
<td>(38,515)</td>
<td>2,065</td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,264,431)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>(1,519,061)</td>
<td>(194,254)</td>
<td>(194,691)</td>
<td>437</td>
</tr>
</tbody>
</table>

#### EXPENDITURE

<table>
<thead>
<tr>
<th>Expense Item</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Dental Staff</td>
<td>204,318</td>
<td>150,947</td>
<td>149,040</td>
<td>1,907</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>327,380</td>
<td>243,779</td>
<td>245,334</td>
<td>(1,556)</td>
</tr>
<tr>
<td>Allied Healthcare Prof</td>
<td>59,881</td>
<td>44,387</td>
<td>43,235</td>
<td>1,153</td>
</tr>
<tr>
<td>Ancillary/Estates/Other</td>
<td>47,939</td>
<td>33,855</td>
<td>34,101</td>
<td>(246)</td>
</tr>
<tr>
<td>Professional/Technical</td>
<td>38,527</td>
<td>28,603</td>
<td>27,796</td>
<td>807</td>
</tr>
<tr>
<td>Pharmacy/Psychology</td>
<td>20,404</td>
<td>15,345</td>
<td>14,672</td>
<td>673</td>
</tr>
<tr>
<td>GMS</td>
<td>3,580</td>
<td>2,684</td>
<td>2,560</td>
<td>124</td>
</tr>
<tr>
<td>Management/Admin Staff</td>
<td>84,752</td>
<td>62,201</td>
<td>61,879</td>
<td>322</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td>786,781</td>
<td>581,802</td>
<td>578,618</td>
<td>3,184</td>
</tr>
<tr>
<td>Non-Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>95,976</td>
<td>67,328</td>
<td>66,827</td>
<td>501</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>66,680</td>
<td>50,520</td>
<td>54,307</td>
<td>(3,787)</td>
</tr>
<tr>
<td>Equipment</td>
<td>17,414</td>
<td>12,355</td>
<td>13,297</td>
<td>(941)</td>
</tr>
<tr>
<td>Hotel Costs</td>
<td>19,692</td>
<td>14,789</td>
<td>14,527</td>
<td>261</td>
</tr>
<tr>
<td>Other Non Pays</td>
<td>171,646</td>
<td>102,772</td>
<td>96,296</td>
<td>6,476</td>
</tr>
<tr>
<td>GMS</td>
<td>114,229</td>
<td>87,764</td>
<td>87,915</td>
<td>(151)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>125,075</td>
<td>93,453</td>
<td>93,469</td>
<td>(17)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>7,253</td>
<td>4,805</td>
<td>5,780</td>
<td>(975)</td>
</tr>
<tr>
<td>Property/Transport</td>
<td>40,698</td>
<td>29,639</td>
<td>32,006</td>
<td>(2,367)</td>
</tr>
<tr>
<td>Staff/Admin Expenses</td>
<td>15,983</td>
<td>10,968</td>
<td>11,858</td>
<td>(889)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Total Non-Pay</strong></td>
<td>674,645</td>
<td>474,392</td>
<td>476,281</td>
<td>(1,890)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>1,461,427</td>
<td>1,056,193</td>
<td>1,054,999</td>
<td>1,294</td>
</tr>
</tbody>
</table>

### SUB TOTAL CORE BASELINE POSITION

<table>
<thead>
<tr>
<th>LRP</th>
<th>(57,635)</th>
<th>861,939</th>
<th>860,208</th>
<th>1,732</th>
</tr>
</thead>
</table>

| LRP |  (6,347)  |  (1,064)|  (1,064)|      |

### SUB TOTAL CORE POSITION

|  (63,981) |  860,875 |  860,208 | 667 |

### NHS LOTHIAN NON CORE POSITION

| Depreciation & Capital Grants |  5,901 |  4,426 |  4,426 | 0 |
| Revenue Funded Capital Schemes |  42,018 |  24,801 |  24,911 | (110) |
| Impairments, Provisions & Donated Depreciation |  16,063 | 15,367 | 15,367 | (0) |

|  63,982 |  44,594 |  44,704 | (110) |

### TOTAL NHS LOTHIAN CORE/NON CORE POSITION

|  0 |  905,469 |  904,912 | 558 |
## APPENDIX 2

**NHS Lothian Summary by Operational Unit to December 2012**

### UNIVERSITY HOSPITALS DIVISION

<table>
<thead>
<tr>
<th>Service</th>
<th>Annual Budget £k</th>
<th>Variance £k</th>
<th>YTD Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Associated Services</td>
<td>125,140</td>
<td>(1,812)</td>
<td>(1,047)</td>
<td>(765)</td>
</tr>
<tr>
<td>Medicine of the Elderly</td>
<td>27,823</td>
<td>(373)</td>
<td>(298)</td>
<td>(75)</td>
</tr>
<tr>
<td>Surgical Directorate</td>
<td>84,229</td>
<td>(483)</td>
<td>44</td>
<td>(527)</td>
</tr>
<tr>
<td>Labs, A&amp;T, Critical Care &amp; HSDU</td>
<td>122,462</td>
<td>(218)</td>
<td>(1,113)</td>
<td>895</td>
</tr>
<tr>
<td>Women, Children &amp; Neuroscience</td>
<td>91,957</td>
<td>(477)</td>
<td>(242)</td>
<td>(235)</td>
</tr>
<tr>
<td>Radiology, Cancer, Head &amp; Neck</td>
<td>102,814</td>
<td>334</td>
<td>12</td>
<td>322</td>
</tr>
<tr>
<td>Corporate</td>
<td>(18,903)</td>
<td>1,468</td>
<td>1,433</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td><strong>535,522</strong></td>
<td><strong>(1,561)</strong></td>
<td><strong>(1,211)</strong></td>
<td><strong>(349)</strong></td>
</tr>
</tbody>
</table>

### CHPs/CHCP/PCCO

<table>
<thead>
<tr>
<th>CHP/CHCP</th>
<th>Annual Budget £k</th>
<th>Variance £k</th>
<th>YTD Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lothian CHP</td>
<td>70,007</td>
<td>(79)</td>
<td>(79)</td>
<td>(0)</td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>239,322</td>
<td>131</td>
<td>130</td>
<td>1</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>69,792</td>
<td>19</td>
<td>59</td>
<td>(41)</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>98,993</td>
<td>60</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Primary Care Contractor Organisation</td>
<td>8,655</td>
<td>(3)</td>
<td>(3)</td>
<td>0</td>
</tr>
<tr>
<td>REAS</td>
<td>39,288</td>
<td>78</td>
<td>78</td>
<td>(0)</td>
</tr>
<tr>
<td>Corporate</td>
<td>(6,641)</td>
<td>(2)</td>
<td>(2)</td>
<td>(0)</td>
</tr>
<tr>
<td></td>
<td><strong>519,417</strong></td>
<td><strong>205</strong></td>
<td><strong>244</strong></td>
<td><strong>(40)</strong></td>
</tr>
</tbody>
</table>

### CORPORATE BUDGETS

<table>
<thead>
<tr>
<th>Service</th>
<th>Annual Budget £k</th>
<th>Variance £k</th>
<th>YTD Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>652</td>
<td>(2)</td>
<td>0</td>
<td>(3)</td>
</tr>
<tr>
<td>Consort</td>
<td>45,703</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Communications</td>
<td>1,142</td>
<td>36</td>
<td>36</td>
<td>(0)</td>
</tr>
<tr>
<td>Ehealth</td>
<td>26,931</td>
<td>(80)</td>
<td>(80)</td>
<td>(0)</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>80,240</td>
<td>(2,287)</td>
<td>(1,839)</td>
<td>(448)</td>
</tr>
<tr>
<td>Finance &amp; Capital Planning</td>
<td>10,617</td>
<td>182</td>
<td>228</td>
<td>(46)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>11,344</td>
<td>(75)</td>
<td>13</td>
<td>(88)</td>
</tr>
<tr>
<td>Medical Director</td>
<td>976</td>
<td>58</td>
<td>58</td>
<td>(0)</td>
</tr>
<tr>
<td>Nursing</td>
<td>3,150</td>
<td>133</td>
<td>133</td>
<td>(0)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12,132</td>
<td>194</td>
<td>207</td>
<td>(13)</td>
</tr>
<tr>
<td>Planning</td>
<td>3,580</td>
<td>250</td>
<td>250</td>
<td>0</td>
</tr>
<tr>
<td>Public Health</td>
<td>3,558</td>
<td>9</td>
<td>86</td>
<td>(77)</td>
</tr>
<tr>
<td>Other</td>
<td>139</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td><strong>200,165</strong></td>
<td><strong>(1,582)</strong></td>
<td><strong>(908)</strong></td>
<td><strong>(674)</strong></td>
</tr>
</tbody>
</table>

### STRATEGIC BUDGETS

<table>
<thead>
<tr>
<th>Service</th>
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<th>Variance £k</th>
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| Grand Total Planned + Unplanned | 126,362 | 13,567 | 14,099 |
### Appendix 4

NHS Lothian Capital Expenditure Programme 2012/13

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### NHS Lothian Formula and Other Funding Programme

#### Rolling Programmes

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### NHS Lothian Capital Expenditure Programme 2012/13

#### Agreed Programme vs Expenditure as at December 2012

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<th>Expenditure as at December 2012 £k</th>
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<td>(200)</td>
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<td><strong>Grand Total</strong></td>
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ROYAL INFIRMARY OF EDINBURGH CAMPUS REDEVELOPMENT

1 Purpose of the Report

1.1 The purpose of this report is to inform Board members of the programme of work taking place on the Royal Infirmary of Edinburgh (RIE) site commencing this year.

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

2 Recommendations

The Board is recommended to:

- Note the significant programme of work to take place on the RIE Campus over the next 5 years to support the re-provision of RHSC/DCN, the creation of additional capacity, and to support ongoing Service Redevelopment;

- Note the proposal/intention to use car park F to re-provide staff parking during the works.

3 Discussion of Key Issues

3.1 In December 2012 the re-provision of the RHSC/DCN hospital incorporating CAMHs took a major step forward with the publication of the advert in the European Journal. This advert invites bidders to note interest in the project and in March a number of bidders will be selected to move forward in the dialogue process. This process culminates in August 2014 a preferred bidder is chosen to work with NHS Lothian to move the project to a final business case and financial close. Following this, construction can begin.

3.2 The business case for the Project highlighted the benefits of a range of service linkages with current services on the RIE site. In order to facilitate these a number of changes are required in the hospital, in addition to the infrastructure changes now agreed with Consort and the University.

3.3 There are 2 main groups of works – enabling and clinical enabling. These works are all subject to supplemental agreements to the RIE Project Agreement –the enabling works is just complete, and work to prepare the supplemental agreement for the clinical enabling work has just commenced.

3.4 The enabling works are mainly works external to the RIE itself and there are now 7 packages of work:
Upgrading of the site flood defences on the site from 1:200 years to 1:1000 years
Moving the VIE (medical gases) from outside A+E to behind OPD6
Rerouting the main county sewer away from the end of the ward arc where the new joint A+E department will be built.
Removing any redundant services from car park B
Altering the road and cycle network in preparation for the closure of Little France Crescent which will allow the two A+E departments to join together
Preparation of the A+E and theatre link
Off site flood works on the other side of Old Dalkeith Road

These works will be carried out by Contractors working for Consort.

3.5 There are a number of groups of work referred to as clinical enabling works to allow the operational functionality of the two hospitals. These include:

- Creation of a new renal and transplant HDU on the second floor
- Changes to the level 2 and 3 critical care wards on the first floor to create 2 large wards and provide critical care capacity to absorb the neuroscience patients
- Alterations to the pharmacy store, aseptic suite and dispensary to absorb the paediatric and neuroscience work
- Changes to the medical photography department to make age appropriate accommodation
- Relocation of the staff and services displaced from the second floor

These works will be carried out by Contractors working for Consort.

3.6 In recognising the requirement to increase the bed capacity with the RIE, and supporting ongoing service development, there are also a number of other projects taking place on RIE site. These are being coordinated through the project team to ensure the whole programme is managed. These works include:

- Creation of additional bed capacity in the old HR corridor and the patient hotel
- Creation of additional assessment capacity in OPD6 displacing orthopaedic clinics to OPD5
- Relocation of the staff and services displaced from the space required for additional beds
- Upgrading of endoscopy decontamination and development of a research MRI on RIE site

3.7 The enabling works will begin in early January with relocation of the medical gases being the first project to start. This is closely followed by the other projects in spring. These works require to be completed before financial close, scheduled for August 2014.

3.8 Given the extent of work scheduled to take place on the site a Little France Campus Working Group has been established to ensure coordination of the activities and appropriate communication links into the NHS, University and Consort. The group will report into the RIE Health and Safety Group and will
3.9 These programmes of work will last for 5 years during which time there will be changes made on the campus to support them. In April Consort will erect a site establishment on car park B opposite A+E from which to manage this work lasting up to 18 months. The clinical enabling work will require a site establishment the site for which has not yet been identified and once financial close has been reached a site establishment will be set up on car park A to service the new build.

3.10 Some of these programmes will alter access to the site and require changes to blue light routes, deliveries and patient and visitor access. Arrangements will need to be put into place to support this nearer the time. Some of the work will displace car parking spaces from different areas on the site at different times starting in January with disruption in car park A where additional spaces are being created to replace some lost from the relocation of the VIE gases to OPD6.

3.11 The long term intent is that car parks C and D will be changed to patient and visitor parking as these spaces are nearest to the hospital and also additional non paying disabled spaces and drop off spaces will be created outside the new hospital. Staff parking will be relocated to car park F. Spaces lost during construction will be reprovided thus maintaining the current overall number of spaces until the new hospital opens when the spaces available increase by over 300.

3.12 It is proposed that patient and visitor parking be protected as much as possible during the works and that any lost public spaces be moved to car park C and D and any spaces displaced by this be provided for staff on car park F.

4 Key Risks

4.1 The key risks during this work will be the health and safety of our patients and staff and also the potential for confusion to arise with changes being made to road layouts and parking at various times during the works. The creation of the Little France Campus Working Group has been established to mitigate this risk.

5 Risk Register

5.1 The health and safety of the campus is a key risk that should be contained in the Lothian Risk register.

6 Impact on Health Inequalities

6.1 The Equality Diversity Impact Assessment will be carried out in January 2013.

7 Impact on Inequalities

7.1 The impact assessment will be carried out in January 2013.
8 Resource Implications

8.1 The resource implications are covered in each of the business cases for each sub project.

Jackie Sansbury
Project Sponsor
14 January 2013
jackie.sansbury@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: RIE Site Plan
NHS Waiting Times Arrangements

November 2012

Overall Opinion | Requires Improvement

Contents
Page 1 Executive summary
Page 5 Background, objective & scope
Page 7 Audit issues & management actions
Page 19 Definition of ratings & distribution list
Executive Summary

<table>
<thead>
<tr>
<th>Overall opinion</th>
<th>Objectives</th>
<th>Control Opinion</th>
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<td>Requires improvement</td>
<td>Patients’ records are accurate and TrakCare cannot be changed inappropriately</td>
<td>Requires improvement</td>
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<tr>
<td></td>
<td>Reporting is accurate and consistent at every level</td>
<td>Satisfactory</td>
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<tr>
<td></td>
<td>Local guidance is consistent with national guidance, and guidance is being applied validly and reliably</td>
<td>Requires improvement</td>
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Overall opinion

While various workstreams over the past year have improved how waiting lists are managed, further actions are required to strengthen the control framework and close some remaining gaps.

In September 2011, the Waiting Times Group within University Hospitals Division (UHD) commissioned Standing Operating Procedures (SOP) based on guidance issued by the Scottish Government and NHS Scotland’s Information Services Division (ISD). During March and April 2012, Awareness Sessions were held as part of rolling out the SOP across UHD and Health Records. However, the SOP did not fully reflect national guidance and staff did not always receive sufficient training. Meanwhile, waiting lists are managed by many teams and individuals spread across NHS Lothian, which has contributed to different practices being followed, including when applying Periods of Unavailability. Also, many users who do not require access can input or amend waiting list information on TrakCare. Further, the framework for reporting on waiting lists is complex, with the potential for errors increased through the number of parties and stages involved.

Recently, Health Records has been asked to develop proposals for taking on responsibility for managing all waiting lists, with the aim of standardising processes further. With the Treatment Time Guarantee now in place, the SOP is being revised, with Engagement Events held for waiting list staff. Thereafter, plans for further training are to be taken forward. Also, a Forensic Dashboard has been developed to monitor waiting list data more closely, including numbers, trends and unusual activity.

Patients’ records and TrakCare

Internal Audit identified over 35 teams or individuals who manage waiting lists, excluding Medical Secretaries, Receptionists and Ward Clerks. At present, the bulk of outpatient appointments are booked by Health Records, with 5 teams covering the main specialties. While outpatient appointments are booked by Health Records, inpatient appointments for those specialties are usually booked by teams of UHD staff. Meanwhile, appointments for some Outpatient Departments at the Royal Infirmary of Edinburgh and other specialties are booked by their own teams of staff. In addition, Medical Secretaries, Receptionists and Ward Clerks have varying roles with regards waiting lists, including booking appointments and updating TrakCare when patients Can Not Attend (CNA) or Do Not Attend (DNA) for some specialties (issue 1).

When asked about specific scenarios, waiting list teams advised of some different practices being followed. In particular, teams do not deal consistently with patients who request to be treated by named consultants or in particular locations. Also, Medical Secretaries sometimes book inpatients onto theatre lists before waiting list staff add the patients to waiting lists. Meanwhile, teams tend to go beyond guidance by allowing patients to CNA more than twice before being referred to clinicians, or allowing patients to DNA more than once before taking further action. In addition, waiting list teams have developed their own variations on standard
Internal Audit
NHS Waiting Times Arrangements

letters, which do not always comply with the SOP (letter templates are being revised in response to the requirements of the Treatment Time Guarantee) (issue 1).

While not covered by the Scottish Government’s guidance, the SOP instructs that patients can be suspended for 6 weeks after declining to be treated by another healthcare provider. Based on the SOP, the External Provider Office and Orthopaedics have been applying 6 weeks of Social Unavailability when inpatients or daycases turn down offers of treatment at Golden Jubilee National Hospital or Spire Murrayfield. Also, although not covered by national guidance or the SOP, Orthopaedics applies Periods of Unavailability when patients plan to take airplane flights within 12 weeks of operations. Orthopaedics explains that patients would have an increased risk of Deep Vein Thrombosis during flights. Similar practices are followed by Vascular Surgery and Gynaecology. Nevertheless, the Strategic Planning team has confirmed with the Scottish Government that both practices are appropriate (issue 3).

As part of the audit, data from TrakCare was extracted for patients on waiting lists between January and June 2012. Using the extracted data, specific queries were run to highlight activity which might indicate non-compliance with waiting times guidance. In general, records held in TrakCare are not always adequate to confirm or question the validity of actions, including Periods of Unavailability. Therefore, Internal Audit accepted as valid any actions that seemed reasonable within the context of patients' circumstances, which was about 72% of the time, with a further 12% of actions accepted following discussions with waiting list staff. From the other cases, practices to be addressed were identified within individual teams that are not part of Health Records. Practices included applying Periods of Unavailability after patients agreed to be treated by external providers, applying retrospective Periods of Unavailability when patients cannot be contacted, and not removing historic Periods of Unavailability when patients cannot be contacted, and not removing historic Periods of Unavailability that may not have been appropriate (issue 3).

Currently, about 14,700 users have active access to TrakCare, with 13,500 of those users believed to be able to change waiting list information. However, eHealth is considering how to restrict more users to read-only access. Each month, eHealth receives lists of staff leavers to be removed from TrakCare, as well as de-activating users who have not accessed the system for 90 days. Also, activity on TrakCare is recorded on audit trails, with transactions attributed to individual users (issue 4).

Over the past few months, Health Records has been asked to develop proposals for taking on responsibility for managing all waiting lists. However, the impact needs to be explored further for smaller specialties where effective local procedures are already in place. Also, the Health Intelligence Unit has been developing a Forensic Dashboard to monitor waiting list data more closely. The dashboard reports on numbers added and removed from waiting lists, types and lengths of Periods of Unavailability, retrospective changes to patients’ records and waiting list trends. The dashboard allows figures to be analysed for the main specialties, with any issues to be escalated to the Medical Director.

Reporting

As well as internal reporting, waiting list figures are uploaded to ISD’s National Data Warehouse. Using the National Data Warehouse and other returns, ISD publishes waiting list reports each quarter. While total figures concur between NHS Lothian’s internal reports and ISD’s reports, ISD’s reports cannot be reconciled back to TrakCare. In particular, the uploads from TrakCare to the National Data Warehouse comprise only new records and changes to existing records, rather than all records held. As a result, later changes on TrakCare can affect earlier positions (issue 5).

For internal purposes, the Performance Review team uses data downloaded from TrakCare into an Access database to run daily and weekly operational reports for Directors of Operations and Service Managers. Meanwhile, reports relating to cancer waiting times across specialties are run by the Cancer team within UHD. Performance Review and the Cancer team send separate reports for Service Managers and waiting list teams to address any cases being reported as exceptions and correct any errors.
For each meeting of the Board and Corporate Management Team, Strategic Planning prepares Waiting Times Progress & Performance reports, including waiting list trends, analysis of waiting lists and issues within particular specialties. Over recent months, additional information has been added to the reports, although some data could be made clearer (issue 5).

As already mentioned, the Health Intelligence Unit has been developing a Forensic Dashboard to monitor waiting list data more closely. A prototype of the dashboard was presented to the Board in July, with results from analysing the dashboard mentioned in the Waiting Times Progress & Performance report presented to the Board in October.

Local guidance

In September 2011, the Waiting Times Group commissioned the SOP to be produced, with the SOP largely based on guidance issued by the Scottish Government and ISD. The draft SOP was presented to UHD’s Senior Management Team (SMT) in December 2011, along with proposals for training staff and developing a framework to monitor compliance with the SOP.

While the SOP was later approved by the SMT, the Corporate Improvement team advises that the SOP was accepted as still being incomplete, with the plan being to update the SOP during a later phase. As part of the audit, the SOP was reviewed against source guidance and some aspects found where the SOP does not fully reflect national guidance, as well as places where directions in the SOP could be made clearer. For example, the SOP does not include specific allowances for armed-forces personnel, the SOP instructs that patients are to be suspended for 6 weeks after declining to be treated by another healthcare provider, the SOP wrongly instructs staff to mark patients’ records as “Could Not Attend” when appointments are cancelled by hospitals, and the SOP refers to an Exception Policy about DNAs which appears to be no longer available (issue 2).

During March and April 2012, Corporate Improvement organised Awareness Sessions for UHD and Health Records staff as part of rolling out the SOP. In an effort to provide training, Awareness Sessions took place before the SOP was finalised and all relevant details had been agreed. Thereafter, Corporate Improvement focused on other waiting list priorities, leaving the training framework still to be developed (issue 2).

From 1 October 2012, the 12-week Treatment Time Guarantee took effect, with guidance issued by the Scottish Government through Chief Executive Letters issued in May and August. Strategic Planning met with the Scottish Government in September to clarify specific aspects of the guidance, and further direction from the Scottish Government is awaited. During October, the SOP started to be revised to reflect requirements of the Treatment Time Guarantee, with Engagement Events about the Treatment Time Guarantee rolled out from late October to waiting list staff. Plans for further training are being taken forward, including the possibility of developing a learnPro training module (issue 2).
Management Response

Internal Audit has identified a number of issues around the recording, reporting and practices relating to waiting times arrangements in NHS Lothian. This assessment is broadly consistent with one taken by the Chief Executive’s Waiting Times Group earlier this year, with actions agreed at that point. The interaction with Internal Audit over the findings has allowed these actions to be given additional focus and also identified where additional aspects could be incorporated. In considering Internal Audit’s report, it is appropriate that observations are considered against the actions already underway to address the issues highlighted and their materiality.

Periods of Unavailability have dropped significantly in NHS Lothian over the last year. NHS Lothian now has one of the lowest levels for Periods of Unavailability in Scotland. The chart below shows the position of health boards nationally at the end of June, the latest figures published by ISD.

This suggests that the potential for misuse of Periods of Unavailability is significantly lower than when NHS Lothian featured at the other end of this range. Furthermore, the level of entries warranting investigation through the Forensic Dashboard is proportionally small: less than 100 a week are being identified, against a background of an estimated 14,000 additions a week on average.

Many of the Management Actions in response to Internal Audit’s report were underway prior to the report being issued. The importance of concluding these actions is fully accepted as a key priority in addressing waiting times.
Internal Audit
NHS Waiting Times Arrangements

Background, Objective & Scope

Background

In October 2011, NHS Lothian made public that some patients had been offered treatment at hospitals in the north of England in an effort to reduce waiting lists. In response to reports in the media and questions in the Scottish Parliament, the Chief Executive set up a Waiting Times Management Group chaired by the Medical Director to investigate claims that patients had been offered unrealistic appointments which had been deemed to meet waiting times targets. As part of the investigation, the Waiting Times Management Group reviewed the management framework for waiting lists, including administration, capacity planning and training.

The Waiting Times Management Group reported in November 2011 that offers of treatment in England had been a genuine attempt to reduce patients’ waiting times. The report advised that the option had now been withdrawn and additional surgical capacity was being commissioned locally. Meanwhile, the group offered several recommendations including reviewing roles and responsibilities for managing waiting lists, modifying TrakCare to be fully New Ways compliant, providing staff with ongoing training and continuous monitoring over waiting lists.

Despite the report from the Waiting Times Management Group, internal concerns continued to grow about waiting lists. In January 2012, NHS Lothian commissioned PricewaterhouseCoopers (PwC) to review specific aspects of how waiting lists were being managed. In particular, doubts had arisen about the application of New Ways guidelines around the use of Periods of Unavailability.

In March 2012, PwC reported to the Scottish Government that excessive and inappropriate use had been made of Periods of Unavailability within NHS Lothian, including retrospective changes to patients’ records. As a result of adjustments, patients were no longer being reported correctly as breaching waiting times targets. In particular, PwC noted that Periods of Unavailability were being applied just before month-end reporting. Also, PwC noted that data taken from TrakCare to produce waiting times reports was being amended manually, thereby masking the true number of patients waiting for treatment.

Following PwC’s report, the Scottish Government directed that an audit of NHS Waiting Times Arrangements be included within each health board’s internal audit plan for 2012/13. The Terms of Reference for the audit was issued by the Scottish Government in May 2012.

Objective

The Terms of Reference issued by the Scottish Government set 3 main objectives. The objectives were to ensure that:

1. individual patients’ records are accurate and that systems are in place to ensure that the patient management system cannot be inappropriately changed;
2. reporting on waiting times is accurate and consistent at every level up to and including the Board; and
3. local guidance is consistent with national guidance, and that the implementation of guidance is both valid and reliable (ie not open to different interpretation in use).

Scope

The Terms of Reference directed that the 3 objectives were to be achieved through specific activities.

1. Undertaking a comprehensive review of waiting times reporting to executive management, relevant committees of governance, the Board and the Scottish Government. This was to include tracing the content of these reports back to the waiting times system and through intermediate systems, if relevant.
2. Tracing a sample of waiting times data from input through amendment/updating within systems to output within the various reports presented to management, relevant committees and the Scottish Government, through to publication to ensure consistency through every level of reporting.

3. Investigating and reporting any variation, unusual matters or obvious omissions identified in relation to activities 1 and 2 above.

4. Reviewing the board’s local guidance for completeness and consistency with the Scottish Government’s guidance on waiting times management. In particular, this was to include an assessment of accessibility, availability and applicability of that guidance in the waiting times process.

5. Reviewing the systems and process controls that exist and the operation of those controls for data input, processing data through the waiting times system and final reporting, through sample checking. The existing systems, processes and controls should be fully documented to allow a transparent review of documented and actual performance.

6. Assessing the completeness of recording for New Ways data fields, including reasons for amendments to patients’ records. Analysing core data to identify key issues including, but not restricted to, trends and adjustments to Periods of Unavailability and other adjustments of patients’ waiting times clocks, making use of all relevant data available including local data and nationally available data from ISD.

7. Interviewing a sample of staff involved in the waiting times management process at all levels of the organisation, including clinicians, managers and data-entry staff, to provide a further dimension to the assessment of data, controls and processes.

The Scottish Government instructed that the minimum time period to be covered by the audit was to be January to June 2012.

The scope of the audit included:

- guidance and procedures;
- adding patients to waiting lists;
- amending patients' records for waiting lists;
- applying Periods of Unavailability;
- removing patients from waiting lists;
- user access rights to TrakCare;
- monitoring of waiting lists, including trends and exceptions; and
- internal and external reporting.

The scope excluded:

- community hospitals, mental health services, allied health professionals – per direction given by the Scottish Government;
- specialist waiting times targets, eg cancer, cataracts, cardiac treatment – per direction given by the Scottish Government;
- data analysis and user rights for waiting lists held outwith TrakCare, eg Auditbase for Audiology, Soelhealth for Edinburgh Dental Institute and Carestream for Radiology within Primary Care; and
- initiatives and actions to address the backlog of cases on waiting lists.
Audit Issues & Management Actions

| Issue 1 | Waiting lists are managed by many teams, with some different practices being applied across teams |

With no central record of waiting list teams being held by UHD, Internal Audit identified over 35 teams or individuals who manage waiting lists, excluding Medical Secretaries, Receptionists and Ward Clerks. The bulk of outpatient appointments are booked by Health Records, with 5 teams located across hospital sites to cover the main specialties. While outpatient appointments are booked by Health Records, inpatient appointments for those specialties are booked by teams of UHD staff, except for the Royal Hospital for Sick Children where Health Records books inpatients also. Meanwhile, appointments for some Outpatient Departments at the Royal Infirmary of Edinburgh and other specialties are booked by their own teams of staff. In June 2012, the External Provider Office was set up to offer patients places at non-NHS Lothian hospitals and manage the transfer of patients to other providers, although waiting list teams for Orthopaedics, Gynaeology and Diagnostics have continued to book external providers directly for operational reasons. Furthermore, Medical Secretaries, Receptionists and Ward Clerks have varying roles with regards waiting lists, including booking appointments and updating TrakCare when patients CNA or DNA for some specialties.

When asked about specific scenarios, waiting list teams advised of some different practices being followed. In particular, the SOP contains guidance for when patients insist on being treated by named consultants with longer waiting lists, despite other consultants being available to provide treatment sooner. The SOP directs that patients are to be given Reasonable Offers with other consultants, with refusals recorded and waiting times clocks reset. However, 70% of waiting list teams advised that patients waiting for named consultants would have Periods of Unavailability applied, while 30% of staff would leave patients on waiting lists to breach waiting times targets. One team advised that Periods of Unavailability would be applied where patients were going to breach targets because only a specific consultant could perform a particular procedure, which is contrary to the SOP.

Waiting list staff are often going beyond strict guidance in order to accommodate patients’ circumstances and wishes. Examples include the number of Reasonable Offers made and the number of times patients are allowed to CNA or DNA. Several teams advised that patients are offered more than 2 appointment dates, with staff eager to respond positively to patients’ circumstances. Also, about 70% of teams advised that patients are allowed to CNA more often than twice before being referred to clinicians, and over 70% of teams allow patients to DNA at least twice before taking further action.

The SOP sets out the expected content for some standard letters to patients. While most letters are produced from TrakCare, waiting list teams have developed their own variations which do not always comply with the SOP or expectations. For example, letters tend not to give expected timeframes for patients to respond to offers, or explain the consequences of not responding to letters or not turning up for appointments. However, letter templates are being revised in response to the requirements of the Treatment Time Guarantee.

While mainly limited to individual teams, waiting list staff mentioned various practices which may affect the accuracy of waiting list numbers for particular specialties. For example, Medical Secretaries book inpatients onto theatre lists for 2 specialties before waiting list staff add the patients to waiting lists and send out appointment letters, meaning that patients may be missing from waiting lists on TrakCare for several weeks. Due to an apparent misunderstanding about TrakCare, one waiting list team updates TrakCare to show that appointments have been accepted when patients telephone to rearrange appointments within 7 days of offer letters being issued. Meanwhile, contrary to the SOP, 3 waiting list teams advised that referrals for patients passed between consultants for the same existing medical conditions are treated as new referrals, ie waiting times clocks are reset to zero.
Over the past few months, Health Records has been asked to develop proposals for taking on responsibility for managing all waiting lists. While the structure needs to be rationalised, some waiting list staff expressed reservations during the audit about centralising the management of waiting lists, especially for smaller specialties where effective local procedures are already in place.

Having waiting lists managed by so many different teams increases the potential for different standards and practices to develop. Even though many practices benefit patients, practices may result in waiting lists being made bigger resulting in longer waits for other patients.

Management Response

The variety in those overseeing waiting list teams was discussed at the Chief Executive’s Waiting Times Group in June, which agreed in principle that all such staff should transfer to Health Records by September/October.

Subsequent debate agreed to defer the implementation of any change until the level of activity in waiting list teams relating to the backlog of patients abates and the extent to which such a change can accommodate the particularly close liaison between waiting list teams and the clinical body over inpatient booking.

It is recognised that a change in line management arrangements alone is liable to be insufficient to address variations in practice given the number of waiting list transactions undertaken. Hence the identification of guidance, training and monitoring requirements at the same meeting in June and covered in more detail under issues 2 and 3.

Management Action

The Joint Management Team has agreed that the Medical Director will explore the potential for bringing waiting list teams under a single management structure, with appropriate input from clinical teams. A plan will be developed with Health Records, with clear timescales proposed for the transition. The transition will take a phased approach, with an evaluation stage built into the first phase.

Responsibility:  
David Farquharson  
Medical Director

Target date:  
31 December 2012
In September 2011, the Waiting Times Group within UHD commissioned the SOP to be produced. The draft SOP was presented to the SMT in December 2011, along with proposals for training staff and developing a framework to monitor compliance with the SOP.

During March and April 2012, Corporate Improvement organised Awareness Sessions for UHD and Health Records staff as part of rolling out the SOP. While many staff attended, Service Managers and waiting list staff commented during the audit that Awareness Sessions were brief (circa 20 to 30 minutes) and copies of the SOP were not yet available (Awareness Sessions were rolled out before the SOP was finalised). Also, presenters could not answer questions raised by waiting list staff, such as what constituted a Reasonable Offer (NHS Lothian's interpretation had not yet been decided).

When the draft SOP was presented to the SMT, the covering paper proposed developing a framework of induction and mandatory update training, probably with a training module developed on learnPro. Meanwhile, the SOP promises standard-level training tailored to individual responsibilities, plus annual compulsory refresher training. While this remains the intention, Corporate Improvement was required to focus on setting up the External Provider Office, leaving the training framework still to be developed.

With no training provided centrally, local training or team discussions have been held by a few waiting list teams, with other teams relying on staff’s existing knowledge and on-the-job training. Quite often, staff report not referring to the SOP or not knowing that the SOP existed. In particular, staff such as Medical Secretaries who work outside of waiting list teams are less likely to be familiar with the SOP.

While the SOP was approved by the SMT, Corporate Improvement advises that the SOP was accepted as being incomplete at that time, with the plan being to update the SOP during a later phase. As part of the audit, the SOP was reviewed against source guidance and some inconsistencies found, as well as places where directions in the SOP could be made clearer. For example, the SOP does not make clear how priority is to be given to military veterans or instruct that armed-forces personnel and their families moving between health boards are to keep their places on waiting lists. Also, the SOP instructs that patients are to be suspended for 6 weeks after declining to be treated by another healthcare provider (refer to issue 3). Following a decision by the SMT in March, the SOP is more generous than national guidance by instructing that patients who DNA are to be re-instated on waiting lists if patients make contact within 14 days. When processing appointments cancelled by hospitals, the SOP wrongly instructs staff to mark patients’ records as “Could Not Attend”. In a section headed Exceptions to DNA Procedures, the SOP refers to further information within NHS Lothian’s Exception Policy which appears to be no longer available.

While TrakCare is the main patient management system, Audiology uses Auditbase and the Edinburgh Dental Institute uses Soelhealth, with parts of Radiology only moving from Carestream to TrakCare in October 2012. However, the SOP refers only to TrakCare.

From 1 October 2012, the 12-week Treatment Time Guarantee took effect, with guidance issued by the Scottish Government through Chief Executive Letters issued in May and August. Strategic Planning met with the Scottish Government in September to clarify specific aspects of the guidance, and further direction from the Scottish Government is awaited. As directed in a Chief Executive Letter, a Local Access Policy has been drafted, with the draft likely to be presented to the Board for approval. During October, the SOP started to be revised to reflect requirements of the Treatment Time Guarantee, with Engagement Events about the Treatment Time Guarantee rolled out from late October to waiting list staff.
Without adequate training, the likelihood is increased for waiting lists and individual cases to be handled differently.

Management Response
The need for training to progress, linked to the then-forthcoming Treatment Time Guarantee guidance, was discussed at the Chief Executive’s Waiting Times Group in June.

The SOP was introduced to provide a reference point for practice at a time when revised national guidance was overdue and expected to sit within a wider framework of training and data quality processes.

Training recommenced and procedures were revisited, also addressing aspects identified by Internal Audit, once the national guidance was issued and clarity on some aspects forthcoming.

Management Action
As anticipated in the SOP, a training framework comprising of initial and annual mandatory update training will be developed. The framework will detail how training is to be rolled out across all staff involved with managing waiting lists. If possible, a training module on learnPro will be developed. Also, staff will be given a single point of contact for seeking clarity on any particular patient scenarios, and a generic version of the SOP will be produced for specialties that do not use TrakCare.

After being approved by the Joint Management Team, any instructions within the SOP that are not drawn directly from national guidance will be detailed in the Local Access Policy.

Responsibility:
David Farquharson
Medical Director

Target date:
31 December 2012
### Issue 3

**Significant**

Examples were found of Periods of Unavailability being applied which do not reflect national guidance.

While not covered by the Scottish Government’s guidance, the SOP instructs that patients can be suspended for 6 weeks after declining a Reasonable Offer for treatment by another healthcare provider. The SOP was based on guidance issued in March 2012 on behalf of the Chief Operating Officer, following discussions with the Scottish Government. The practice is based on the understanding that Golden Jubilee or other providers would have offered 2 reasonable dates had patients accepted the provider in principle.

Based on the SOP, the External Provider Office and Orthopaedics have been applying 6 weeks of Social Unavailability when inpatients or daycases turn down offers of treatment at Golden Jubilee or Spire Murrayfield. Head & Neck, General Surgery and Vascular Surgery were doing the same before the External Provider Office was formed to make bookings.

Although not covered by the Scottish Government’s guidance or the SOP, Orthopaedics applies Periods of Unavailability when patients plan to take airplane flights within 12 weeks of operations. Orthopaedics explains that patients would have an increased risk of Deep Vein Thrombosis during flights. As such, patients can be marked Socially Unavailable for relatively long periods, including time before going on holiday and afterwards. Similar practices are followed by Vascular Surgery and Gynaecology. While not covered by guidance, Strategic Planning has confirmed with the Scottish Government that the practice is appropriate.

As part of the audit, data from TrakCare was extracted for patients on waiting lists between January and June 2012. Using the extracted data, specific queries were run to highlight activity which might indicate non-compliance with waiting times guidance. As at 30 June 2012, NHS Lothian reported to ISD that 39,384 outpatients and 9,267 inpatients and daycases were on waiting lists. The data extracted from TrakCare for the audit highlighted no particular trends or changes in patterns to indicate irregular activity. Therefore, Internal Audit sampled cases from the wider range of data queries and specialties, although the sample was still targeted towards previous areas of concern. Internal Audit reviewed records on TrakCare for over 370 patients, representing less than 1% of the 48,651 patients on waiting lists at 30 June.

In general, records held in TrakCare are not always adequate to confirm or question the validity of actions, including Periods of Unavailability. While TrakCare requires a reason for Periods of Unavailability to be selected, often no supporting narratives are given to make clear what has happened. Therefore, Internal Audit accepted as valid any actions that seemed reasonable within the context of patients’ circumstances, which was about 72% of the time. Following discussions with waiting list staff, a further 12% of actions were accepted as valid.

In May, the Board received a report explaining that inappropriate retrospective changes to patients’ records had been identified within particular specialties. Internal Audit’s sampling identified further practices that need to be addressed within individual teams (the teams are not part of Health Records).

In one specialty, Periods of Unavailability have been applied after patients telephone to rearrange appointments. In particular, the practice relates to patients who do not accept the first date offered, which should not affect waiting times clocks. However, when appointments are rebooked, Periods of Unavailability are applied to push guarantee dates forward and prevent patients being reported as breaching targets.

In another specialty, Periods of Unavailability have been applied as soon as patients agree to be treated by an external provider. Generally, Periods of Unavailability were being applied for 4 weeks from the date patients agreed to be treated externally. However, the Periods of...
Unavailability were sometimes being applied back to the date when patients were added to waiting lists. The Waiting List Manager for the team advises that the practice stopped in September in response to Internal Audit’s current review.

Within the same specialty, sampling patients’ records found examples from June of Periods of Unavailability being applied for 3, 4 or 5 weeks, back to the dates when patients were added to waiting lists. The reasons for the Periods of Unavailability were recorded as “unable to contact patient”. The Waiting List Manager advises that the team’s practice is to apply Periods of Unavailability for 7 days to allow patients time to respond to letters, if the team has been unable to contact patients by telephone. After 7 days, patients are then removed from waiting lists and passed back to the referrers. Even so, the Waiting List Manager could not explain the longer retrospective Periods of Unavailability noted during the audit.

Within a third specialty, examples were found of Periods of Unavailability being applied from the date patients were added to waiting lists in October 2011 until the date when bookings were made in June 2012. The Service Manager suggested that longer Periods of Unavailability may have been placed against these patients to reflect the limited capacity of a particular consultant. When bookings were made in June, the Periods of Unavailability were ended. However, cutting short rather than removing what appear to be unexplained Periods of Unavailability has resulted in patients being reported as receiving treatment within a few days of being added to waiting lists, rather than many months.

Within the same specialty, the Service Manager and Patients Admissions Manager were unable to explain several other long Periods of Unavailability that were applied retrospectively in June. In about half the cases, the Patients Admissions Manager concluded that errors had been made, while no explanation was offered for other cases. Nevertheless, the cases sampled did not indicate any pattern to the Periods of Unavailability applied across different patients.

As explained later (refer to issue 5), the Health Intelligence Unit has been developing a Forensic Dashboard to monitor waiting list data more closely, including numbers added and removed from waiting lists, types and lengths of Periods of Unavailability, retrospective changes to patients’ records and waiting list trends. In response to the dashboard, Directors of Operations and Service Managers have been investigating particular examples of Periods of Unavailability and other changes.

While reasons can be given for practices, individual teams are applying Periods of Unavailability that do not reflect national guidance.

Management Response

Internal Audit identified that the variation from national guidance arises on two fronts: that local guidance proposes actions not covered or differing from national guidance; and that practice in some areas differs from local guidance.

The differences between national and local guidance have either been discussed with Scottish Government representatives where not covered nationally or agreed with stakeholders locally. This is already considered under issue 2.

As reported by Internal Audit, changes in retrospective Periods of Unavailability were identified and reported to Board members at the meeting in May, leading subsequently to the commissioning of the Forensic Dashboard to highlight practices at variance from recommendations. This tool, currently reporting variations to the Medical Director, forms one element of the framework discussed in the response to issue 2.
**Management Action**

As well as the Management Actions under issue 2, the sampling of waiting list transactions will be considered to confirm that staff are complying with the SOP. Sampling would be in addition to ongoing use of the Forensic Dashboard.

| Responsibility: David Farquharson Medical Director | Target date: 31 December 2012 |
| Issue 4 | Many users who do not require access can input or amend waiting list information on TrakCare |

Currently, about 14,700 users have active access to TrakCare. While most users are NHS Lothian staff, some users work or study with external bodies, eg University of Edinburgh or staff within GP practices. As TrakCare does not distinguish between users’ employers, the number of such users is not easy to determine, although eHealth has recently introduced a field within TrakCare to start collecting this information.

From the 14,700 users, about 330 Clinical Users (mainly medical students from University of Edinburgh) have read-only access, and about 850 General Enquiry or General Enquiry Extended Users cannot amend waiting lists. Otherwise, eHealth advises that all users are able to change waiting list information through a general patient enquiry screen. However, eHealth is considering how to restrict more users to read-only access following an upgrade to TrakCare, and reconfiguring TrakCare to limit unnecessary access to waiting list functions. Also, activity on TrakCare is recorded on audit trails, with transactions attributed to individual users.

Each month, eHealth receives lists of staff leavers from Human Resources’ Empower system and de-activates users on TrakCare. Using other reports from TrakCare, eHealth de-activates users who have not accessed the system for 90 days (due to several eHealth staff leaving around the same time, the practice had fallen away, but was re-introduced during the current audit).

Meanwhile, TrakCare previously prevented staff from booking patients past waiting times targets, unless bookings were authorised by a supervisor. In January, the restriction was removed for operational reasons, meaning that all staff can book patients past target dates, after being alerted by the system. During the audit, 6 waiting list supervisors and managers suggested that the restriction be restored, as waiting list staff have booked patients past target dates without appreciating the implications (reports are produced listing patients who have been booked past target dates).

After patients have breached waiting times targets, waiting times clocks are still reset to zero if patients decline later Reasonable Offers, CNA or DNA. Also, waiting times targets that have been breached are adjusted when Periods of Unavailability are entered for later periods. As such, later events can result in cases that have breached targets no longer being reported as breaches. Strategic Planning explains that TrakCare replicates how waiting times clocks are calculated within the National Data Warehouse, with TrakCare to be updated in due course to reflect changes to calculations resulting from the Treatment Time Guarantee.

Despite Board and other reports measuring waiting times for inpatients against a 12-week standard, waiting times targets within TrakCare continue to be set at 9 weeks. While different views are held, Strategic Planning explains that the shorter target within TrakCare recognises the requirement to meet the 18-week Referral to Treatment target.

With large numbers of people having access to TrakCare, the risk is increased for waiting list information to be input or changed without legitimate reasons, although activity by individual users is recorded on audit trails.
**Management Action**

As already proposed, eHealth will review user groups and authority levels within TrakCare with the aim of restricting more users to read-only access.

<table>
<thead>
<tr>
<th>Responsibility:</th>
<th>Target date:</th>
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<tbody>
<tr>
<td>Martin Egan</td>
<td>31 January 2013</td>
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<tr>
<td>Director of eHealth</td>
<td></td>
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</table>
As well as NHS Lothian’s internal reporting, ISD’s National Data Warehouse is updated 3 times a month when eHealth uploads data from TrakCare. As the Edinburgh Dental Institute does not use TrakCare, the external supplier of the Soelhealth system runs data extracts which the Edinburgh Dental Institute uploads to the National Data Warehouse each quarter. Also, Performance Review completes Monthly Management Information returns for ISD using data extracted from the National Data Warehouse, as well as monthly data provided manually by Radiology (until September, part of Radiology was using the Carestream system rather than TrakCare). In addition, adult and child Audiology services (which use Auditbase rather than TrakCare) provide weekly reports which Performance Review uses to inform ISD, and the Cancer directorate produces monthly reports which Performance Review submits to ISD.

Using the National Data Warehouse and Monthly Management Information returns, ISD publishes waiting list reports each quarter. While total figures concur overall, ISD’s reports cannot be reconciled back to the internal reports run by Performance Review. In particular, ISD runs various validation checks which result in 1.5% to 2% of patients’ waits being removed from ISD’s figures. Also, the uploads from TrakCare to the National Data Warehouse comprise only new records and changes to existing records, rather than all records held. As a result, later changes on TrakCare can affect earlier positions (eg the keying of retrospective adjustments) and the historical position on TrakCare cannot be recreated to check against figures reported by ISD.

For internal purposes, Performance Review uses data downloaded from TrakCare into an Access database to run daily and weekly operational reports for Directors of Operations and Service Managers. Meanwhile, reports relating to cancer waiting times across specialties are run by the Cancer team within UHD. Performance Review and the Cancer team send separate reports for Service Managers and waiting list teams to address any cases being reported as exceptions (eg waiting times targets about to be breached, or patients booked past waiting times targets) and correct any errors.

For the 18-week Referral to Treatment target, Performance Review completes data returns for ISD using information in the Access database downloaded from TrakCare. To report against the target, Performance Review relies on “fuzzy matching” whereby outpatient and inpatient episodes are linked, with particular complications where the same patients are being treated for different conditions, undergoing bilateral procedures or waiting for diagnostic tests before treatment progresses. Also, reporting is complicated by specialties using systems other than TrakCare.

For each meeting of the Board and Corporate Management Team, Strategic Planning prepares Performance Management and Waiting Times Progress & Performance reports, including waiting list trends, analysis of waiting lists and issues within particular specialties. Over recent months, additional information has been added to the reports, although some data could be made clearer.

For example, the number of patients on waiting lists was not explicitly stated within Board and Corporate Management Team reports until October. Instead, the total number of patients was presented in bar charts with large intervals, which did not make clear the exact numbers. Similarly, the number of patients marked with Periods of Unavailability was not stated. Meanwhile, reports do not indicate the total number of patients who breached targets before being treated.

While a few particular specialties are mentioned, the reports do not give sufficient information for specialties to be compared. Where problems are highlighted within specialties (eg Diagnostics in the Board paper for 26 September), numbers of patients on waiting lists are not
Internal Audit
NHS Waiting Times Arrangements

always stated or trends presented. Recent reports (eg Board paper for 26 September) advise that Ophthalmology has been removed from figures being reported, without making clear the exact reason or indicating how many patients are on Ophthalmology’s waiting lists (the Board report for October refers to June’s report which advised that Ophthalmology patients had been removed due to a change in the groups for recording patients).

Although waiting list targets relate mainly to new patients, the reports could provide further context by quoting figures for returning patients who are waiting for appointments. While the Waiting Times Progress & Performance report to the Board on 26 September mentioned returning patients for diagnostic tests, several waiting list teams commented during the audit on the volumes of repeat patients across their specialties.

The sections of reports that cover cancer patients are mainly restricted to quoting achievement percentages against 62-day and 31-day targets, without making clear the periods to which the percentages relate. Across NHS Lothian, various Cancer Trackers have been appointed to oversee cancer referrals and promote achievement of cancer waiting times targets. While ISD produces specific quarterly reports on cancer waiting times (mainly percentages, but with data tables behind), Board and Corporate Management Team reports do not present numbers of cases, breakdowns of cases across specialties or present any patterns or trends.

Over past months, eHealth had been running data queries on TrakCare to help identify any untoward activity, such as Periods of Unavailability being applied retrospectively or changes being made to the dates patients were added to waiting lists. Based on eHealth’s data queries, the Health Intelligence Unit has been developing a Forensic Dashboard to monitor waiting list data. The dashboard is populated from TrakCare and the National Data Warehouse. The dashboard reports on numbers added and removed from waiting lists, types and lengths of Periods of Unavailability, retrospective changes to patients’ records and waiting list trends. The dashboard allows figures to be analysed for the main specialties, with any issues to be escalated to the Medical Director. A prototype of the dashboard was presented to the Board in July, with results from analysing the dashboard mentioned in the Waiting Times Progress & Performance report presented to the Board in October.

The potential for errors is increased through the complex reporting framework, including the number of parties and stages involved. Meanwhile, clearer information may help the Board’s appreciation of the waiting list position.

Management Response

The depth of waiting times reports to the Board has increased over recent months, with further detail added to the October report in recognition of some of the initial feedback from Internal Audit.

Board members have been asked what further improvements they would wish to see and these aspects, covering recruitment and activity, are to be incorporated from the coming report.
**Management Action**

Board members will be offered a session on waiting times as part of Board development, including reviewing the structure and content of Board reports. Proposals from Board members will be incorporated into future reports.

| Responsibility: Alex McMahon  
| Director of Strategic Planning, Performance Reporting & Information | Target date: 31 December 2012 |
Definition of Ratings

Audit Opinions

- Fully satisfactory - the control framework is fully adequate and effective to manage the main risks within acceptable limits.

- Satisfactory - although improvement is possible, controls are adequate and effective to manage the main risks within acceptable limits.

- Requires improvement - significant issues exist with the adequacy or effectiveness of controls which could result in disruption, loss or reputational damage.

- Unsatisfactory - the control framework is generally inadequate or ineffective with issues that require immediate attention to prevent disruption, loss or reputational damage.

Issue Ratings

- Critical - the issue has a material effect upon the wider organisation.

- Significant - the issue is material for the subject under review.

- Important - the issue is relevant for the subject under review.

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Stuart Wilson, Director of Communications
Audit Scotland, External Audit

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1. **Purpose of the Report**

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Government:

<table>
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<th>No.</th>
<th>Communication ID</th>
<th>Description</th>
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<td>1</td>
<td>PCA(P)(2012)0015</td>
<td>Community pharmacy services: Drug Tariff remuneration arrangements October 2012 rate changes. Community migration/cms/shadow fees payments</td>
<td>2/10/12</td>
<td>DSP&amp;PC, GMPCC</td>
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<td>PCA(P)(2012)016</td>
<td>Pharmaceutical services: Community pharmacy practitioner champions</td>
<td>02/10/12</td>
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<td>3</td>
<td>SGHD(CDO)(2012)001</td>
<td>IR(Me)R</td>
<td>02/10/12</td>
<td>DPHPP, DSP&amp;PC, GMPCC</td>
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<td>SGHD(CMD)(2012)009</td>
<td>Temporary programme of pertussis (whooping cough) vaccination of pregnant women</td>
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<td>PCA(M)(2012)012</td>
<td>Influenza, pneumococcal and pertussis vaccination directed enhanced service</td>
<td>02/10/12</td>
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<td>Primary medical services (Directed enhanced services) (Scotland) (no.2) directions 2012</td>
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<td>PCS(AFC)(2012)004</td>
<td>Arrangements for agenda for change staff who undertake on-call duties</td>
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<td>23/11/12</td>
<td>GME&amp;MCHP, GMPCC</td>
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<td>Community pharmacy services: Drug tariff changes:- Phasing Payment (CMS)</td>
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<td>General Dental Services, Introduction of tooth specific information</td>
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</table>

**Douglas Weir**  
**Corporate Services Manager**  
15 January 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