NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 24 OCTOBER 2012

TIME: 9:30 A.M. - 12:30 P.M.

VENUE: BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

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

For further information please contact Peter Reith,☎ 35672,✉ peter.reith@nhslothian.scot.nhs.uk
4. Chairman’s Report (9.50am - 10.00am)  
   CJW *

5. Governance (10:00am - 10:30am)  
   5.1. Quality Report  
      DF/MH *  
   5.2. Healthcare Associated Infection Update  
      AKM *

6. Performance Management (10.30am - 11.30am)  
   6.1. Waiting Times Progress and Performance  
      DF *  
   6.2. Unscheduled Care  
      MH *  
   6.3. Performance Management  
      AJ *  
   6.4. Financial Position to 30 September 2012  
      SG *  
   6.5. Backlog Maintenance  
      SG *

7. Policy & Strategy (11.30am - 12.10pm)  
   7.1. Improving Care for Older People in Acute Hospitals Healthcare Improvement Scotland Inspections  
      MH *

8. Other Items (12:10pm - 12:30pm)  
   8.1. Committee Membership  
      CJW *  
   8.2. Committee Terms of Reference  
      CJW *  
   8.3. NHS Lothian: Report on the 2011/12 Audit  
      SG *

9. Communications Received  
   TD *

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

11. Resolution to take items in closed session

   **LUNCH 12:30 p.m.**

Dates of Meetings in 2013:  
23 January 2013  
27 February 2913  
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, 26 September 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; Mr M Ash; Mr J Brettell; Dr M Bryce; Mr E Egan (Vice-Chair); Councillor D Grant; Councillor R Henderson; Professor J Iredale; Mr P Johnston; Councillor C Johnstone; Mrs A Meiklejohn; Mrs A Mitchell; Councillor F Toner; Mr G Walker; Mr I Whyte; Dr R Williams and Mr R Wilson.

In Attendance: Dr A Coull (For Item 62); Mrs M Christie (Deputing for Mr J Forrest, Director, West Lothian Community Health and Care Partnership); Mr P Gabbitas (Director of Health and Social Care, City of Edinburgh Council); Professor A McMahon (Director of Strategic Planning and Primary Care); Mr A Jackson (Associate Director of Strategic Planning) (For Item 61); Mr D Small (General Manager, East and Midlothian Community Health Partnership); Mr C Stirling (Associate Director of Operations, University Hospitals Division) (For Item 62); Mr S R Wilson (Director of Communications and Public Affairs) Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mr J Forrest, Mrs J McDowell, Mr B Peacock and Mr G Warner.

Declaration of Financial and Non-Financial Interest

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

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

54.1 The Chair welcomed members of the public and press to the meeting. He also welcomed a number of new Board members to their first meeting, as well as welcoming Mr T Davison to his first Board meeting as substantive Chief Executive.

54.2 The Chair advised that this would be Mr E Egan’s final Board meeting, both as a Board member and Vice-Chair of the Board and he would make further comment on this under his Chair’s report.
55. Minutes of the Previous Meeting of Lothian NHS Board held on 25 July 2012

55.1 The Minutes were approved as a correct record.

56. Matters Arising

56.1 Lease for the Musselburgh Primary Care Centre – Mrs Goldsmith undertook to provide Dr Williams with details, outwith the meeting, of the Hubco position on standard leases.

56.2 Backlog Maintenance – the Vice-Chair questioned whether there was any update on the backlog maintenance position. The Chair noted there was a potential for disposal proceeds to become available to Boards and this was currently under discussion.

56.2.1 Mrs Goldsmith advised she was working on a paper for presentation to the Finance and Performance Review Committee on 10 October dealing with backlog maintenance and how this reflected the national position, as well as how to address local issues including disposals and risk management. She commented dialogue was underway with the Scottish Government Health Directorates in respect of retention of receipts. She advised details of the high risk local areas would be reported to the Finance and Performance Review Committee and thereafter to the Board.

56.3 Board-on-Board Event – Mrs Hornett commented at the previous meeting it had been reported the Board-on-Board event would be held on 8 and 9 November. She advised this position had since been clarified and the November date would host a learning event, with the formal Board-on-Board event being held in February 2013 with further information awaited.

56.4 Medical Staffing (Paediatrics) – Dr Farquharson commented challenges still remained across Scotland in respect of medical staffing in paediatrics. He commented locally a number of appointments had been made to St John’s Hospital, Simpson Memorial Maternity Pavilion and the Royal Hospital for Sick Children. He commented at the moment the staffing position was stable, although six people were due to go on maternity leave out of a total of 47 trainees. He commented the system had moved into the “grid season” where people applied for additional training, which required them to be released from their existing commitments and this caused problems in maintaining rotas.

56.4.1 Dr Farquharson, in response to a question from the Chair, commented on 12 October National Education Scotland (NES) and the Scottish Government Health Directorates would look at training issues around advanced neonatal specialists and this would hopefully address some of the points the Chair had been aware of during a recent visit. The Chair commented it would be helpful if Dr Farquharson, in a future report, could provide a summary on where the support of the Board was required.
56.4.2 Mr Johnston commented he was delighted to learn of the five new consultant appointments at St John’s Hospital and asked how far this took the system towards the provision of a consultant-led service. Dr Farquharson advised this was a significant step and the provision of neonatal and paediatric advanced nurse practitioners would be the next step in the process. He commented the 12 October meeting with NES would inform the non-medical support position. Mr Walker congratulated Dr Farquharson on the progress being made and questioned whether, in respect of the reduction in paediatric trainees, funds were transferring from NES to Boards to help fund alternative models. Dr Farquharson advised, in theory, this was happening although the number of trainees in paediatrics was not falling with people not coming out of the programme as early as previously because of maternity leave and out-of-programme training. Mrs Goldsmith commented there had been a transfer of resources in some specialties.

56.4.3 The Vice-Chair commented, given the previous concern, it would be appropriate to put out a positive communication statement. Councillor Toner welcomed this suggestion, which would be pursued by the Director of Communications and Public Affairs.

56.5 Royal Hospital for Sick Children / Department of Clinical Neurosciences – Little France – Mrs Goldsmith commented since the previous Board meeting, two important milestones had been achieved. The first of these was that the signing of Supplemental Agreement 6, transferring the land to NHS Lothian, had occurred on 10 August 2012. In addition to this, the Outline Business Case had been signed by the Cabinet Secretary for Health and Well-Being. She commented a further two steps had to be concluded before the project could go to OJEU advertisement. The first of these was the conclusion of Supplemental Agreements in respect of enabling work and the completion of the Scottish Futures Trust key stage review. She advised the anticipated advert would be placed by the end of November and, thereafter, progress would be made on the development of clinical enabling work.

56.5.1 The Vice-Chair commented it would be useful to revisit the Communications Strategy, given the timescale for the completion of the project had slipped to 2017 and this would provide an opportunity to engage members of the public and service users. The Director of Communications and Public Affairs would address.

56.6 Lothian 2011-2016 Sexual Health and HIV Strategy: First year Update – Dr McCallum and Professor McMahon commented the circulated report provided a first year update on the revised strategy and outlined progress made in improving the health of vulnerable groups through ensuring universal access to services. They commented the service worked closely with the public and people who used the service and the strategy met all but one of the recommendations of the previous review, with work in progress to address the outstanding issue around long acting reversible methods of contraception.

56.6.1 Mrs Allan stressed the need for people using services to be engaged in developing revised specifications. Dr McCallum and Professor McMahon commented this work was already underway and had, indeed been commended by the Scottish Government Health Directorates. Dr Bryce commended the work with the third sector commenting this demonstrated collaborative working allowing participants to provide leverage in making changes to services.
56.6.2 Professor McMahon undertook to bring forward more detailed analysis of the extensive existing relationship with the third sector, as well as details of proposed future engagement.

56.6.3 The Board noted the Sexual Health and HIV Strategy update.

57. Committee Minutes

57.1 Minutes of the Audit Committee Meeting held on 26 June 2012 – the Board adopted the Minutes. The Vice-Chair commented he was disappointed issues still pertained in relation to inappropriate items being received by the Laundry service and it was getting to the point where staff would be withdrawn for their own safety. The Chair commented he too was disappointed, particularly given the fact he had personally visited the Laundry and he felt there was a need for an improved audit culture and structure to address current issues.

57.2 Minutes of the Finance and Performance Review Committee Meeting held on 15 August 2012 – the Board adopted the Minutes.

57.2.1 Mr Walker commented the next meeting of the Finance and Performance Review Committees would have a planned session looking at the Royal Hospital for Sick Children/Department of Clinical Neurosciences and he would encourage new and existing Non-Executive Board members to attend the meeting, which would be chaired by Mr Johnston in his absence. The Chief Executive commented the meeting would also discuss backlog maintenance.

57.2.2 Dr Williams questioned what the communication strategy would be in respect of the provision of reasonable offers of alternative treatment to patients on the waiting list. Professor McMahon advised a communication would be sent to patients and General Practitioners about the effect of the treatment time guarantee, which would become legal on 1 October. It was anticipated this would be issued later in the week. He advised a question and answer sheet would also be provided to staff to ensure a consistency of approach. It was noted the Finance and Performance Review Committee had also discussed the provision of leaflets being included with appointment letters.

57.3 Minutes of the Healthcare Governance and Risk Management Committee Meeting held on 7 August 2012 – the Board adopted the Minutes. It was noted the Committee had received a helpful presentation on the Scottish Patient Safety Programme. It was noted there was a need to remain sighted on the need to avoid staff working in excess of the European Working Time Regulations.

57.3.1 The Chair commented it would also be important to remain sighted on the management of significant adverse events. Dr Bryce advised this linked to the Scottish Patient Safety Programme and work was ongoing.

57.4 Minutes of the Service Redesign Committee Meeting held on 11 June 2012 – the Board adopted the Minutes. Professor Iredale advised the Committee remained sighted on obesity and Dr Bryce and Dr McCallum, along with other colleagues,
were trying to identify successful interventions from elsewhere. He advised the Committee was also debating telehealth and telecare and this would link with the integration of health and social care agenda. He commented this was an area that would require to be subject to hard economic review.

57.5 Minutes of the Staff Governance Committee Meeting held on 29 August 2012 – the Board adopted the Minutes. The Vice-Chair advised the Committee had received a report and had supported the introduction of re-licensing and validation of doctors by the General Medical Council. He commented, moving forward, it would be important for the Board to support the Medical Director and his colleagues in staying on top of this difficult challenge.

57.6 Minutes of the West Lothian Community Health and Care Partnership Sub-Committee Meeting held on 1 June 2012 – the Board adopted the Minutes.

57.7 Minutes of the West Lothian Community Health and Care Partnership Board held on 19 May 2012 – the Board adopted the Minutes.

58. Chair’s Report

58.1 The Chair advised, as previously intimated, this would be Mr Egan’s last meeting of the Board, both as a Board member and Vice-Chair. He commented Mr Egan’s position was unique in Scotland as he was the only Employee Director who had been appointed to the Vice-Chair position. The Chair commented Mr Egan had been a significantly effective Employee Director and, through his role as Vice-Chair, he had been incredibly supportive to him personally.

58.2 The Chair commented he would welcome expressions of interest for the non-remunerated post of Vice-Chair and these should be submitted to his office by 5 October. He advised if more than one person expressed an interest, a process to make the appointment would be put in place.

58.3 The Chair provided an update on the position in respect of the Lothian and Edinburgh Abstinence programme (LEAP) at Malta House advising he had supported management colleagues in discussions with the Church of Scotland regarding their intended sale of Malta House. He commented helpful discussions had been held with Councillor Henderson about possible funding options, although eventually the gap between sale expectation prices could not be met. Mr Small advised he was confident an alternative site could be obtained for LEAP.

58.4 Mrs Allan commented the Chair had also visited the Edinburgh Community Health Partnership, which had included the Ellen’s Glen and Willow Project, with his attendance having been well received.

59. Financial Position to 31 August 2012

59.1 Mrs Goldsmith commented the current financial year was challenging because of the number of variables in place, particularly in respect of addressing waiting time capacity and meeting the Local Reinvestment Programme (LRP). She commented
the quarter 1 financial review had projected a break-even position and this was still
the forecast.

59.2 Mrs Goldsmith commented that within the baseline position, there was a significant
underspend in prescribing and this would be required to address the gap in LRP,
with this position had been discussed with primary care colleagues. She stressed,
however, the position in respect of prescribing related to pricing benefits and did
not involve the restriction of drugs. Mrs Goldsmith commented pressures remained
in Facilities and clinical supplies with part of the issue around clinical supplies
relating to waiting time activity reflecting changes in case mix. This position would
be further addressed as part of the mid-year financial review.

59.3 Mrs Goldsmith commented that only £8m of efficiency and productivity had been
delivered to date and that it would be important this position did not worsen, as it
would impact on the financial position moving into the next year. She advised the
Efficiency and Productivity Group had agreed actions. In addition, the Medical
Director and Nurse Director were holding detailed discussions later in the week in
respect of the University Hospitals Division financial position. Mrs Goldsmith
advised she and her team continued to meet corporate leads in respect of
managing the financial position.

59.4 Mr Wilson questioned whether pressures were being experienced in both areas.
Mrs Goldsmith commented the financial position could only be addressed by taking
money out of the system and as work progressed in looking at building capacity
issues around productivity would be important. She commented this was the first
year credit had been given for productivity and its impact on keeping costs down.

59.5 Mrs Goldsmith, in response to a question from Councillor Toner, provided a break-
down on the usage of the £20m identified for waiting times. She commented as
NHS Lothian's internal capacity increased, there would be less reliance on the
private sector. She advised in respect of waiting times spend that this was broadly
in line with expectations, although there was some evidence of a higher cost per
case for external work, although this was to an extent mitigated by using Medinet
on NHS Lothian's own sites. She would expect to see significant increases in
spend during September as a consequence of an operational push on the backlog
position. Mrs Goldsmith commented waiting time spend was being carefully
monitored.

59.6 The Board noted slippage on capital schemes, particularly in respect of the Royal
Hospital for Sick Children/ Department of Clinical Neurosciences, the quantum of
which had been ring-fenced and carried forward by the Scottish Government
Health Directorates. She commented discussions were ongoing in respect of the
availability to utilise some of this slippage internally with the priorities being around
backlog maintenance and medical equipment.

59.7 Mrs Goldsmith apologised for the lack of activity data in the financial report
advising she would re-instate this. She stressed in terms of activity gained for the
waiting times spend, this was closely monitored. Mr Walker commented he would
be seeking re-assurance total activity was increasing. Professor McMahon advised
work was underway to develop capacity plans for each of the Clinical Management
Teams to identify what capacity was needed and to confirm internal capacity was
fully maximised to minimise the reliance on external use. Mrs Goldsmith undertook to bring a paper on total capacity to the Finance and Performance Review Committee meeting on 10 October.

59.8 The Chief Executive commented issues remained around the triangulation of data and this needed to be refined. He reminded the Board the majority of the waiting time investment was used to maintain a stand-still position, as core capacity was insufficient to meet ongoing demand. He commented in the weekly Waiting Time Group meeting, which he chaired, work was underway to capture the totality of activity. He stressed, however, there was a need to take as many patients off the waiting lists as possible in order to move the position more into equilibrium, although this was a complicated process.

59.9 Mr Brettell commented he was encourage by the underspend in prescribing, although it would be important to confirm this was not at the expense of providing patients with the most effective medicine. Mrs Goldsmith confirmed this was not the case and, given the significant price reductions in drugs, effectively the budgets had been set at an overly cautious level.

59.10 The Board noted the financial position to 31 August 2012 and the fact that the Director of Finance was forecasting a break-even position at the end of the financial year.

60. Performance Management

60.1 Professor McMahon commented the purpose of the report was to provide an update to the Board on the most recently available NHS Lothian performance data as reported through local and national systems. He commented the focus on the report would be to escalate information on areas currently under-performing.

60.2 Professor McMahon commented for the first time, the report included details on wheelchair waiting times; inpatient/ day cases waiting over 12 weeks; those children and adults waiting for access to an insulin pump, as well as staff sickness absence levels. Also included was information on patients waiting longer than 8 hours and 12 hours in accident and emergency departments and data on patients with a length of stay of over 28 days.

60.3 Professor McMahon referred to the areas as requiring additional focus, some of which were being taken forward directly with the Scottish Government Health Directorates, e.g. psychological therapies and suicide reduction.

60.4 Professor McMahon commented pressures were still being experienced around delayed discharges with work underway to address some of the pressures through the increased provision of care home packages and earlier assessment of patients. It was noted, however, there remained more people in the system and colleagues across partner organisations were working to address this position. The Vice-Chair reminded the Board one-third of delayed discharge patients were dementia patients who were not receiving the care they needed. He stressed at the previous Board meeting, he had stated there was a need for urgent action to deal with this significant organisational problem.
60.5 Mr Gabbitas commented the current delayed discharge position was not positive, although it was important to remember in previous times the delayed discharge position had been significantly worse. He commented the number of discharges were being charted on a weekly basis with supported actions being put in place. He commented, however, despite significant additional investment, the position was not abating. He advised care home capacity was the key issue and 160 extra beds would come into operation over the next year, although there were financial issues yet to be addressed in this regard.

60.6 Mr Walker commented delayed discharges was an area where the Finance and Performance Review Committee had been persuaded to receive less detailed reporting. He commented this advice had been taken and it was, therefore, concerning to receive the report at the current meeting advising the numbers had gone up. He stressed the need for an urgent action plan to be developed. Professor McMahon commented the creation of an action plan was important and would be further discussed under the Unscheduled Care Workstream. Mrs Allan commented in respect of suicide reduction, it was disappointing the numbers had increased over the course of the current year and would like to hear about steps taken to address the position.

60.7 Dr Bryce questioned whether the current stroke pathway model was correct and whether patients were being treated quickly enough, as this was a key requirement to a successful outcome and would become more pertinent as demographic changes impacted. Professor McMahon commented the Joint Management Team had discussed the desirability of moving patients quickly into a stroke ward and had agreed the integration of two wards to make better use of pathways and resources. He confirmed this plan had been developed in conjunction with the Scottish Ambulance Service.

60.8 The Board noted the update performance report.

61. Waiting Times Progress and Performance

61.1 Dr Farquharson advised at the June Board meeting, it had been reported more than 2,000 inpatients had been waiting more than 12 weeks with the current projection being that this figure would be at 850 by the end of September and close to zero by the end of December 2012. The overall size of the waiting list was falling. He advised focussed work remained around urology, ENT and plastic surgery. The position in respect of outpatients had been greater than 5,000 patients waiting more than 12 weeks in June. Through the use of internal capacity and external providers, the position had improved to around 4,000 by the end of September with a projected out-turn of close to zero by the end of March 2013. Dr Farquharson stressed patients were being validated by NHS Lothian consultants before they passed to external providers for treatment. Arrangements were also in place to ensure continuity of care.

61.2 The Board were advised there had been an increase in demand for endoscopy, partly due to the success of the bowel screening programme and other detect cancer early initiatives. Dr Farquharson reported initially the first priority had been
to address diagnostic patients, although the focus had now shifted to surveillance aspects with appropriate plans having been put in place. The Board noted patients delayed since 2008 had now been booked appointments and those from 2009 were subject to focussed attention and communication. Clinicians were working on validating patients to reflect the fact guidelines had changed. In addition, a project team had been established to work on creating and identifying additional capacity.

61.3 Mr Jackson, Associate Director of Strategic Planning provided the Board with a presentation covering recent work undertaken to mitigate the waiting times backlog.

61.4 The Vice-Chair commented he remained concerned about the pressures on staff and their ability to continue to provide safe and sustainable care. Dr Farquharson hoped the recruitment of additional theatre staff and surgeons would help to relieve the pressures on staff. The Chair commented he felt the system was turning the corner, although he conceded there was still a long way to go.

61.5 The Chief Executive commented he was impressed with performance and felt a corner had been turned. He reminded the Board a few months previously the overall position had been worsening. He commented the relationship between outpatients and inpatients was important, particularly in respect of conversion rates into inpatient treatment. He reminded colleagues the endeavour was not just to address the backlog but to move to a sustainable equilibrium position on a day-to-day basis, although it was important to note this would take a number of years to achieve. The Chief Executive commented he was aware staff were working hard and this needed to be acknowledged. He commented, however, to address the waiting times position would require an unremitting effort over the next 2 years.

61.6 The Chair commented it was clear there was a need to build capacity and work had already progressed in this regard.

61.7 Dr Bryce questioned in respect of the endoscopy surveillance programme going back to 2008/2009 whether the position had been investigated adequately and whether there had been communication with the people with the longest waits. Dr Farquharson reminded the Board the 2008 patients had already received dates and, by the end of the week, the position with the majority of the 2009 patients would also have been addressed.

61.8 The Chief Executive commented the investment plan around endoscopy was still developing, partly because it was not a static position. He advised the Board the demand for endoscopy had trebled in 7 years. He commented a number of diagnostic endoscopes would become surveillance issues. The Chief Executive advised the Board people were now living longer with multiple conditions and this, aligned with the introduction of more efficient screening programmes, had a cumulative impact on demand.

61.9 Mr Wilson commented he understood the complexity of the position and questioned whether the system had bottomed the scale of need and demand challenges and turned this into plans for resources and timescales to move to a normalised position. The Chief Executive advised work was underway to look at current resources to meet current demand, although it was important to recognise
over the next 10 years the population of Lothian would increase by 1% with a disproportionate number of these people being elderly. In that regard, therefore, the capacity plan had not yet been future proofed and this would need links to increased income. The Board was reminded NHS Lothian remained £50m adrift from parity in respect of the National Resource Allocation Committee (NRAC) formula. The Chief Executive advised he and colleagues were working closely with the Scottish Government Health Directorates to move the position back to equilibrium and this would represent work in progress over the next few years.

61.10 Councillor Toner questioned whether Medinet and the private sector using NHS Lothian facilities impacted adversely on the organisation’s own internal capacity. Dr Farquharson commented by and large Medinet worked at weekends and were using vacant theatre capacity out-of-hours. The Chief Executive reported Medinet were using facilities NHS Lothian could not currently staff and over time the intention was to grow internal staff capacity and capability to mitigate the need for private use, although this would take a number of years to achieve, as previously reported.

61.11 The Board noted the positive progress being made in respect of responding to the waiting times position.

62. Unscheduled Care

62.1 Mrs Hornett introduced Mr Gabbitas, Dr Coull and Mr Stirling advising they would provide the Board with a presentation on work in progress and plans around moving forward the unscheduled care agenda.

62.2 The Board received a presentation from Mr Gabbitas covering the allocation of financial resources in respect of older people’s services in Edinburgh. Dr Coull provided a supplementary presentation on preventing admissions and provided the Board with three patient stories highlighting the significant benefits to patients if the proper patient pathway was adopted.

62.3 Mr Wilson commented in respect of the presentation provided by Dr Coull what stopped the implementation of the positive aspects of the patient pathway in practice. Dr Coull commented a real opportunity lay in developing a collaborative plan between primary and secondary care services with a particular view to managing the impact on the front door of the acute sector.

62.4 Mrs Hornett commented it was important to recognise in the past clinicians had been working hard to make improvements in this area, although it had perhaps not received the strategic attention it deserved at Board level. She commented, however, the Chief Executive had brought a much more focussed approach to this area. Mr Gabbitas commented he was aware of an enthusiasm for moving forward this agenda at clinical level. He advised in response to Mr Ash that there was work underway to bottom out capacity to get supply and demand in balance. Mr Ash questioned whether NHS Lothian was meeting unmet demand in the system irrespective of supply and demand. Mr Gabbitas commented in the past people had been prioritised in hospital and there was now an need to address issues in the community.
62.5 Mr White commented there were different approaches in place in Lothian and this might show up differences in respect of the quality and productivity and it would be important to consider how best to monitor respective processes in order to share best practice. He commented in discussion with community clinicians, it appeared despite putting local agreements in place, some people still attended A&E facilities as the default position and he felt further work was needed in respect of communication. Mrs Hornett commented work was in progress in respect of evaluating investments and outcomes in order to share good practice. She commented a framework for improvement and metrics was under development. She reminded the Board there had been work in the past about encouraging people not to attend accident and emergency services as the first point of contact, although it was important to recognise this was an area that might need to be revisited.

62.6 The Chair questioned whether evidence was available in respect of the quality of A&E presentation. Professor McMahon commented evidence was in place, which demonstrated most referrals were appropriate, although case mix complexity was an issue. Dr McCallum commented social economic aspects needed to be considered and addressed in respect of accessing unscheduled care services advising that just under 50% of A&E use was attributable to effects of socio-economic deprivation on health. Dr Williams commented as part of the GP contract, one of the Quality Outcomes Framework (QOF) points related to A&E attendances and educating people in the appropriate use of such services.

62.7 Mrs Allan commented a number of people presenting would do so because something had happened in their lives that meant they needed extra unscheduled help. In that regard, she welcomed the progress being made. She commented, however, in many instances unpaid carers would be involved and they needed to be engaged moving forward. She also questioned whether services were provided free at the point of need. Mrs Hornett advised work would continue with carers and this was a thread that would be further developed in future. The Chief Executive commented some of the services referred to by Mr Gabbitas would be means tested at the point of care.

63. Consultation on Integration of Health and Social Care

63.1 Professor McMahon commented the purpose of his paper was to recommend to the Board acknowledgement of the context and approach taken to respond to the national consultation on the Integration of Health and Social Care, which was submitted to the Scottish Government Health Directorates on 11 September 2012 and to homologate the responses.

63.2 Professor McMahon advised in order to take work forward the three Community Health and Care Partnerships (CHCP) Directors had led a process locally of engagement and had now reached a position where there had been agreement in principle about the responses to the consultation being jointly developed between health and Council partners, providing a response from each of the four local partnership areas. He advised broadly all partners had indicated, in principle, a whole system approach across age groups and departments should, initially at
least, be in scope for consideration. He provided details of the process of developing the responses to the consultation discussions and engagement exercises which had taken place across the four partnerships.

63.3 The Chair commented NHS Lothian was already largely undertaking what the Government was proposing, particularly in respect of the joint Director post within Edinburgh and West Lothian. He advised in East and Midlothian, work was well underway looking at partnership. He advised different parts of Lothian were working to different timescales with the position in Edinburgh being that the ambition was to move to a shadow Health and Social Care Partnership Board by 1 April 2013. He reminded the Board the Government had made it clear it was not expecting Boards to wait until the consultation concluded and, where there were consenting agreement between partnerships, progress should be made and the intention was not to change these arrangements in light of consultation outcomes.

63.4 The Chair noted governance proposals in respect of the Edinburgh position had been drafted and these would be discussed later in the Private session of the Board.

63.5 The Vice-Chair commented he was disappointed in the paper given the requirements of the Staff Governance Standard. Councillor Henderson advised there were opportunities for local structures to have a lead role in promoting community partnership in practice and there would be a need to come back to that point in due course.

63.6 The Chief Executive commented integration was a means to an end to improve the experience of communities who use services. He commented that essentially there were three legs to the stool and currently people were engaged in completely separate silos even to an extent within current joint arrangements. He advised the challenge for organisational arrangements was not just to integrate primary and secondary care but to have fully integrated teams with integrated Heads of Service. He commented the position was not just about health and social care in the community but also integration of primary and secondary care. The Chief Executive advised the Medical Director and Nurse Director had hosted work streams to discuss how organisational arrangements needed to change to stop managing in silos. He commented what was being proposed through the development of health and social care partnerships represented a true paradigm shift in how services would be organised and managed in future.

63.7 Mr Boyter commented sometimes people were resistant to change and the proposed arrangements would represent significant human resource issues. He advised a short life working group had been established by the Scottish Government Health Directorates, which had met on three occasions to address relevant issues. He advised the working group had not yet gone into detail and had, up until this point, not had local authority and trades union involvement. He advised a further meeting would be held the following week, which would include COSLA, local authorities, NHS and trades unions. He would provide an update report on progress to the Board as appropriate.

63.8 The Board noted the context and approach taken in NHS Lothian to respond to the national consultation on the Integration of Health and Social Care, homologated the
four partnership responses and endorsed the next steps as set out in the paper to ensure progress across partnership was made.

64. Creativity, Arts, Health and Wellbeing in NHS Lothian

64.1 Dr Farquharson advised he had circulated the Creativity, Arts, Health and Wellbeing for NHS Lothian 2012/2017 final draft Strategy for background interest.

64.2 The Board endorsed:

- the Strategy and the outline proposals for delivery, to be shared between NHS Lothian and the Edinburgh and Lothian’s Health Foundation
- the position that the collection of art works belongs to the Foundation and that the arrangements for future oversight and management of it should be agreed by the Trustees
- the need for sustainable co-ordination to support the implementation of the Strategy, and support the submission of a proposal for funding to the Foundation.

65. Quality Report

65.1 Dr Farquharson commented the contents of the Quality Report continued to evolve and it was now presented using a dashboard indicator model. He commented although the current report focussed on acute care, future iterations would have a primary care component.

65.2 Dr Farquharson commented on the “Patient Experience – Better Together - Patient Experience Programme Adult Inpatient Survey for August 2012”. He advised the initial assessment of the results suggested NHS Lothian continued to score positively on the summary indicators regarding patients being treated with respect and care. NHS Lothian also scored well for summary statistics regarding “Trusting the People Looking After Me, Understanding What Happening to Me and Physical Comfort”. A more detailed paper, including responses to the results, would be submitted to the Healthcare Governance and Risk Management Committee in October.

65.3 Dr Farquharson also drew the Board’s attention to the outcome of the Better Together GP patient experience survey, which was published by the Scottish Government in May 2012 and contained thirty seven individual patient survey questions. He commented since the 2009/10 survey there had been a small decrease in overall care provided by NHS Lothian GP surgeries as Good or Excellent (-1%) and patient being treated with dignity and respect (-4%). He advised this trend was noted across almost all NHS Boards. Dr Farquharson commented as seen in the 2009/10 survey, nursing staff in Lothian continued to score highly, scoring equal or higher than national averages.

65.4 Mr Ash commented at a glance the contents of the report required to be put within the context of cumulative averages.
65.5 The Board received the updated Quality Report for September 2012.

66. Area Clinical Forum Constitution

66.1 The Board approved the amended constitution to the Area Clinical Forum, which had been revised to include the Nurse Director in the ex officio membership of the Forum. It was noted that as other Executive Directors were already included in the ex officio membership, this revision would formalise the Nurse Director’s engagement with the Forum. It was noted the Divisional Medical Director had been removed from the ex officio membership.

66.2 Dr Farquharson would include comments made by the Vice-Chair about providing further clarity around the definition of clinical/clinicians in respect of the deputising arrangements.

67. Healthcare Associated Infection Update

67.1 Dr McCallum commented the circulated paper represented her regular update on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian.

67.2 Dr McCallum commented during August an increased rate in Clostridium Difficile had been identified across NHS Lothian services following a previously continuous downward trajectory. She commented issues around antimicrobial prescribing had been considered and, although prescribing could be clinically appropriate, it did increase the risk for patients with specific serious infections of Clostridium Difficile, although there was no evidence of any linked cases. A need had been identified to review some cleaning schedules, as well as issues around the speed of patients in isolation rooms receiving dedicated equipment. Dr McCallum advised all issues were being addressed through an agreed action plan and close working with Health Protection Scotland. She commented challenges still remained in respect of infection coming in from the community.

67.3 The Board noted that hand hygiene data showed overall compliance to a level of over 97%, for three consecutive reporting periods and the position was now above 95% for all colleagues including medical staff.

67.4 The Vice-Chair commented on the view in paragraph 4.1 that the Infection Prevention and Control Team did not have sustainable resources to comply with meticillin resistant staphylococcus aureus screening and questioned whether an action plan was in place. Dr McCallum advised non-recurring resources had been received from the Scottish Government Health Directorates for MRSA screening and recognition of the need to mainstream, develop and integrate an IT approach to guide earlier intervention. She advised work was also underway in looking at what needed to be done to enable adequate and sustainable capacity and this was part of the whole debate around capacity in general.

67.5 Mr Brettell commented the C.Diff upward movement appeared to have been driven by St John’s Hospital and Liberton, as well as Out-of-Hours services and
questioned whether there was any particular reason for this. Dr McCallum commented the group reviewing this position had not yet reported, although there had been an appreciation that there was a need to increase monitoring and training with care homes. She commented the position in respect of Liberton was not about the standard of nursing care, but the fabric of the building. The issue in respect of St John’s Hospital was about the volume and complexity of people presenting for treatment.

67.6 Mr Walker questioned why there was a zero data entry in respect of the results of monitoring of cleaning services. Dr McCallum commented this reflected the timing of the national report on cleaning standards versus the timing of the requirements around the Scottish Government Health Directorates’ HAI reporting template. She undertook to pick up this issue and bring it back separately, although she assured Mr Walker monitoring continued.

67.7 The Board noted the progress being made in respect of Healthcare Associated Infection.

68. The Second Joint Health Protection Plan

68.1 The Board supported the implementation of the Second Joint Health Protection Plan 2012-14 in collaboration with local authorities as required by the 2008 Public Health (Scotland) Act.

69. Report from the Organ Donation Committee 2011/12

69.1 Dr Williams reported this was the second annual report from the Organ Donation Committee and commented it was important a high profile was maintained in this area.

69.2 Dr Williams advised the national target was to have increased organ donations by 50% by 2013 and the figure had been achieved nationally ahead of target with NHS Lothian being instrumental to that success. He commented the Lothian team’s commitment and enthusiasm had been impressive. He commented emergency medicine was now represented on the Committee, as well as a family member of a donor and a transplant recipient. He advised 46% of Lothian residents were now registered as donors and this was a more positive position than elsewhere in Scotland.

69.3 Dr Williams commented a key issue was ensuring no opportunity for organ donation was missed anywhere across the organisation. He advised any missed cases must be reported to the Committee. Two missed cases had occurred during 2011/12 but only one might have carried the potential for organ donation. He advised difficulties with eye and tissue retrievals had been noted by the Committee and these were being addressed by the Medical Director with colleagues in ophthalmology and anatomical pathology.

69.4 The Board noted there had been 1,000 liver and kidney transplants in Lothian. Dr Williams advised where NHS Lothian fell short of the UK average figures was in the
donation after circulatory death. He commented the Committee had supported the more conservative approach of the Clinical Leads for organ donation in NHS Lothian, so that patients were not referred as potential donors, and families were not approached, when it was obvious donation and transplantation would not be viable. He commented although the NHS Lothian referral rate was low at 33% compared with 53% for the United Kingdom, it had doubled in the last year and the NHS Lothian conversion rate was almost twice the national average at 22% compared with 13%.

69.5  The Board noted the report and the re-assurance it provided that NHS Lothian was fully engaged with the task of contributing to the Government's goal of improving the UK's organ donation rate. It also noted the population of Lothian registered for organ donation remained the highest in Scotland. The Board supported the proposal to create a memorial in Lothian to those who had donated organs and tissues and the funding for this would be provided by the NHS Blood Transfusion Service.

70.  **Unannounced Inspection of the Care of Older People in the Royal Infirmary of Edinburgh**

70.1  Mrs Hornett advised the inspection of the care of older people was separate to the Environment Inspection exercises NHS Lothian was separately subject to and it focussed entirely on the needs of the elderly. She commented NHS Lothian had taken part in a pilot inspection process at Liberton Hospital last December and had then had an announced inspection of the Western General Hospital in August 2012. At the end of August an unannounced inspection had been made to the Royal Infirmary of Edinburgh. Mrs Hornett commented there was a similarity of findings across all sites and after each visit, including the pilot, a site specific action plan was developed, as well as an over-lapping improvement plan for the care of vulnerable elderly patients, which had been considered by the Board at its January meeting.

70.2  Mrs Hornett commented as part of the unannounced inspection, a number of areas, wards and departments, eight in total, had been looked at and the inspection team had spoken to 28 patients and looked at 30 sets of health records. Feedback at the end of the inspection process had been mixed and subsequent to this a draft report had been received. Mrs Hornett commented this contained inaccuracies and inconsistencies when considered against the original feedback and she had brought this to the attention of the inspection team. She advised, however, despite this issues of disappointment remained in respect of systems and processes and the speed of introducing and rolling these out. She commented issues about the lack of person-centred care had been highlighted and these would be addressed through the acceleration of the vulnerable people’s plan. Mrs Hornett advised the full report would be finalised in early October and would be brought to the Board, along with an action plan, at its October meeting.

70.3  The Board agreed to receive an update report in October.
71. Committee Chairs and Membership

71.1 The Chair commented the Private meeting of the Board had been held earlier in the day as a preamble to this agenda item. It had been agreed at the Private meeting to undertake further work around the Board Committee proposals. He did not feel, however, it would be appropriate to allow a position to present where there was a total paralysis of the Board Committees. He suggested the memberships being proposed were not in conflict with any of the structural issues or remits discussed earlier in the day.

71.2 The Chair advised he had held discussions with new Board members about their proposed appointment and suggested it would be possible, therefore, to put the paper to the Board for approval, as it did not bind the Board’s decision in terms of Committee remits and structures. The Board agreed to consider the paper for approval.

71.3 The Board agreed the recommendation to appoint Chairs of Board Committees, as well as additional members to Board Committees as detailed in the circulated paper.

72. Schedule of Board and Committee Meetings for 2013

72.2 The Board agreed the circulated list of Board and Committee dates, including final deadlines for the submission of papers for consideration at the relevant meetings. The paper would be re-issued in final format once the discussion around the Board Committee structure was finalised.

73. South East and Tayside Regional Planning Group Update

73.1 Professor McMahon advised the purpose of the circulated paper was to provide the Board with details of the progress being made through the South East and Tayside Regional Planning Group. He provided a brief overview of the work of the South East and Tayside Regional Planning Group for the benefit of new Board members.

73.2 The Board noted the information provided within the paper in relation to specific issue as they related to NHS Lothian.

74. Communications Received

74.1 The Board noted the list of communications received from the Scottish Government.

74.2 Mr Walker questioned in respect of the trafficking of human beings whether this had a profile in NHS Lothian, as it appeared to have received an increased focus by a number of charities. Mr Boyter advised the Board had considered this issue about 12 months previously, and had submitted a response to a consultation from which the circular had derived. He undertook to provide colleagues with a copy of the circular referred in the Communications Received list.
74.3 Dr McCallum commented NHS Lothian constantly worked with the police in respect of this distressing area. The Vice-Chair commented his staff side and trades union colleagues were regularly provided with information in relation to this area.

75. Date and Time of Next Meeting

75.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday, 24 October 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

76. Suspension of Standing Order 16b

76.1 The Chair sought permission to invoke Standing Order 16b to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke Standing Order 15.2. The requirement arose from the need to discuss items of commercial confidentiality that would not be appropriate at a meeting in public.
<table>
<thead>
<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Falls Prevention Programme</strong>&lt;br&gt;The Committee requested a further update on the Inpatient Falls Prevention Programme in 6 months.</td>
<td>LD</td>
<td>December 2012</td>
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<tr>
<td><strong>Surgical Profiles</strong>&lt;br&gt;It was agreed that an update report should come back to the Committee in 6 months.</td>
<td>DF</td>
<td>December 2012</td>
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<td><strong>Swab Incidents</strong>&lt;br&gt;An Accountable Items Policy had been implemented and staff would now need to record the number of packs of swabs that had been used for each procedure. Dr Mackenzie reported that an audit of compliance would come back to the Committee in 6 months.</td>
<td>SMk</td>
<td>December 2012</td>
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<td><strong>Dental health protection/infection control</strong>&lt;br&gt;It was agreed that a further update should come back to the Committee in December 2012.</td>
<td>AKM</td>
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<td><strong>Unannounced inspection of the care of older people in the Royal Infirmary of Edinburgh on 27 August 2012</strong>&lt;br&gt;A comprehensive action plan would be developed and discussed in more detail at the next meeting.</td>
<td>MH</td>
<td>December 2012</td>
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<tr>
<td><strong>Compliance with Stroke Standards</strong>&lt;br&gt;An update report on compliance with stroke standards was requested to the February 2013 meeting.</td>
<td>DF</td>
<td>February 2012</td>
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<td><strong>Communication to patients/relatives following major incidents</strong>&lt;br&gt;Members requested an update on this and suggested adding this as a standing item on the Committee agenda.</td>
<td>DF</td>
<td>December 2012</td>
<td></td>
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<tr>
<td><strong>Public Protection Update</strong>&lt;br&gt;Background paper to the next meeting on the public protection arrangements for the benefit of the new members.</td>
<td>MH</td>
<td>December 2012</td>
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<tr>
<td><strong>Quality Report</strong>&lt;br&gt;Members asked for further information on the source of the data used in the report, the Chair suggested annotating the report to show where the data had come from.</td>
<td>DF</td>
<td>December 2012</td>
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</table>
CHAIR’S REMARKS

The Chair welcomed members to the meeting and members introduced themselves. This was the first meeting for a number of members and the first meeting for Dr Bryce as Chair of the Committee. The Chair highlighted good practice and members agreed that the use of technology (with the exception of NHS IPads) should be avoided during the meeting.

22. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF THE PREVIOUS MEETING: 7 AUGUST 2012

22.1 The minutes of the previous meeting on 7 August 2012 were approved as a correct record.

23. MATTERS ARISING

23.1 There were no matters arising.

24. EMERGING ISSUES

24.1 Dr McCallum explained that there had been a recent health protection/infection control issue within a West Lothian local tattoo parlour. Dr Chandler (Public Health & Health Policy) explained the issue and reported that the issue had been investigated alongside West Lothian Council and Environmental Health.

24.2 Mrs Hornett advised that there had been an unannounced inspection of the care of older people in the Royal Infirmary of Edinburgh on 27 August 2012. The report
would be published on 8 October 2012. The inspection had noted a number of strengths as well as a number of areas for improvement. A comprehensive action plan would be developed and discussed in more detail at the next meeting.

25. **NURSING AND MIDWIFERY COUNCIL’S ANNUAL REPORT BY THE LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICERS**

25.1 Ms Bronsky, Local supervising Authority Midwifery Officer, gave a presentation on the Nursing and Midwifery Council’s Annual Report by the Local Supervising Authority Midwifery Officers. The Committee noted the information in the Annual Report.

26. **PERSON CENTRED CARE**

26.1 **Compliance with Stroke Standards**

26.1.1 Dr Dennis, Professor of Stroke Medicine gave a presentation to the Committee on compliance with stroke standards. Mr Wilson asked whether the targets set for compliance with stroke standards were achievable. Dr Dennis reported that the target was necessary and the main issue was bed flow and this impacted across all specialities. He added that the use of the electronic system TRAK would make things more efficient and easier. Mrs Hornett confirmed that she was the executive lead for stroke services. Ms Gillies also pointed out that the move to TRAK based Electronic Patient Record was being developed but further work was required to identify an overall pathway owner.

26.1.2 An update report on compliance with stroke standards was requested to the February 2013 meeting.

27. **SAFE CARE**

27.1 **Healthcare Associated Infection Update**

27.1.1 Dr McCallum gave a verbal update on healthcare associated infection. The full report would be circulated to members after the meeting.

27.2 **Patient Safety in Primary Care**

27.2.1 Dr Black, Clinical Adviser, gave a presentation on patient safety in primary care. The Committee suggested featuring an article on patient safety in primary care in Connections.

27.3 **Review of the Management and System Learning from Significant Adverse Events across NHS Lothian**

27.3.1 Dr Farquharson introduced the report and highlighted that NHS Lothian had submitted baseline information against the Ayrshire and Arran Report Board recommendations. All boards would be visited, starting in November 2012. Boards
The review would include interviews with staff at different levels in the organisation. The Health Improvement Scotland (HIS) review programme would examine the governance arrangements and processes relating to the management of adverse events.

27.3.2 The Committee noted that in preparation for the HIS submission a review of all major harm and death incidents was undertaken. A total of 400 major harm and death incidents were reviewed – 81% were correctly categorised, 8% unknown and 11% incorrectly categorised. Of the 81% correctly categorised, 81% had had an investigation and 19% had no investigation. The Committee noted the key conclusion and the learning points and went through the areas for improvement. Members commented that communication with patients and relatives following a major incident was critical. Ms Bennett highlighted that there was good evidence to show that relatives were communicated with after the incident and during the investigation but it was not always documented that the outcome of the investigation was communicated back to the patient/relatives. Members requested an update on this and suggested adding this as a standing item on the Committee agenda.

27.3.3 The Committee noted the key findings. Members suggested adding timescales to the improvement plan.

27.4 Public Protection Update

27.4.1 Mrs Hornett reported that this was a regular report to the Committee. She agreed to do a background paper to the next meeting on the public protection arrangements for the benefit of the new members.

28. EFFECTIVE CARE

28.1 Primary Care Impact Report 2012

28.1.1 Dr Hardie presented the information in the Primary Care Impact Report 2012 to the Committee. She went through the executive summary and the key information in the report. Members suggested that this report be referred to a future Board meeting, it could perhaps be used as a subject for the development session.

28.2 Quality Report

28.2.1 Dr Farquharson introduced the Quality Report to the Committee. The Committee went through the key issues and commented that the report was comprehensive and easy to assimilate. Members asked for further information on the source of the data used in the report, the Chair suggested annotating the report to show where the data had come from.

29. OTHER MINUTES: EXCEPTION REPORTING ONLY

29.1 The Committee noted the following sets of minutes:
30. EXCEPTION REPORTING ONLY

30.1 The Committee approved the following items:

- NHS Lothian Hepatitis Managed Care Network Annual Report 2011/12
- South East Scotland Cancer Network Annual Report 2011/12
- Better Together Adult Inpatient and GP National Survey
- Cardiology Services: Audit Scotland – February 2012

31. Any Other Business

31.1 The Committee noted that this would be Mrs O’Connor’s last meeting as the Committee Administrator. The Chair thanked her for her hard work and wished her well for the future.

32. DATE OF NEXT MEETING

- 4 December 2012 to be held from 9am – 11:30am in Meeting Room 7 at Waverley Gate.
NHS LOTHIAN
EAST LOTHIAN COMMUNITY HEALTH PARTNERSHIP

Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Wednesday 27th June 2012, in Musselburgh Primary Care Centre.

Present:
- Iain Whyte (in the chair)
- David Small, General Manager (DS)
- Murray Leys, Head of Adult Social Care, East Lothian Council
- Ann McCarthy, PPF Representative (AM)
- Gill Colston, PPF Representative (GC)
- Ronnie Hill, East Lothian Council (RH)
- Fiona Mitchell, Acute Sector (FM)
- Sally Westwick, Interim Assistant General Manager (SW)
- Lorraine Cowan (LC) for Liz Cregan, Chief Nurse
- Morag Barrow, Allied Health Professional Manager
- Dr Donald Grant, GP, Ormiston Medical Practise (DG)
- David Heaney, Strategy & Policy, East Lothian Council (DH)
- David King, Finance Manager, NHS Lothian (DK)
- Thomas Miller, Staff Representative (TM)

In Attendance:
- Miriam Anderson (Minutes)
- Dr Neil Murray, GP Ormiston Medical Centre (NM)
- Moyra Burns, Health Promotion (MB)

Apologies:
- Graham Alexander, GP Representative
- Liz Cregan, Chief Nurse
- Lynn Hollis, Director of Finance
- Duncan Miller, Practitioner Services
- Tony Segal, Carers of East Lothian (TS)

Welcome and Apologies

Apologies were noted as above.

Introductions were made
Iain highlighted to the members the forthcoming departure of significant CHP staff. Thanks were made to Liz Cregan, Morag Barrow and Ian Johnston for all of their contributions, valued input, commitment and hard work to date and over a long period of time. He wished them well on behalf of the sub-committee and staff of East and Midlothian CHPs.

Minutes of the Previous Meeting Held on 14th December 2011

2.1 The minutes were agreed as being a true and accurate record of the meeting subject to the following amendment:
- Iain Whyte was present
- Item 6.3 Prison Healthcare to read ‘Dr Ian Johnston was confident’
- Thomas Miller also wanted it reflected in the last minutes that he had raised concerns regarding tasks being undertaken by untrained personnel within prison healthcare

2.2 Item 5 - Lanfine Unit Redesign Feedback to be c/f to the next meeting

Finance Item to be taken after 3pm when David King will join the committee.
3 **Action Note Previous Meeting**

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

4 **Items for Decision**

4.1 **Tranent Health Centre Extension** –

A paper on the Tranent Health Centre Extension was tabled for members at the meeting. DAS presented the paper.

DAS asked for support from the committee for a Standard Business Case requesting capital funding from NHS Lothian to provide additional 7 Consulting Rooms and 2 Offices within the Tranent Health Centre. It was confirmed that this development would provide some capacity for early housing development at the southern end of Blindwells, but would not accommodate major development there. The CHP will need to work with other practices and consider establishing a new practice in the future.

The CHP Sub-Committee was invited to support the recommendations in the paper. It was noted that the proposal would require subsequent approval by the Finance and Performance Review Committee of the NHSiL Board.

**Decisions**

The report was noted and recommendations approved.

4.2 **Ormiston Medical Practice Reprovision** -

A paper on the Ormiston Health Centre Reprovision was tabled for members at the meeting. FMcJ and DG presented the paper.

FMcJ asked for support to a proposal which sets out the requirement for an additional in revenue expenditure to support the new proposed Medical Practice Building. NM added support to the need for the reprovision to enable the practice to offer enhanced and increased services. ML supported this and offered to assist with resources that would be available via Strategic Officers within Social Work. This was welcomed. DAS reported that it was important to get this proposal into next years financial plan.

The CHP Sub-Committee was invited to support the recommendations in the paper. It was noted that the proposal would require subsequent approval as part of financial planning process.

**Decisions**

The report was noted and recommendations approved.

4.3 **Edenhall Reprovision – Phase 2**

A paper on the Edenhall Reprovision - Phase 2 was tabled for members at the meeting. DAS presented the paper.

DAS highlighted the need for a second phase project with capital and revenue support to enable the migration of remaining services off Edenhall. ML supported this and proposed that discussions to be held between NHS Lothian and East Lothian Council on site disposals.

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

Decisions

The report was noted and recommendations approved.

5. Items for Discussion

5.1 Lanfine Unit Redesign Feedback – postponed update

6. Performance Reports

6.1 General Managers Report

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

Delayed Discharges

The May 2012 validated figure for East Lothian showed 14 EL residents delayed in total with none breaching the national standards of over 6 weeks in post acute care and over 2 days in acute care.

Capital Projects

Musselburgh Primary Care Centre was successfully fully operational by 26th May 2012.

Gullane – start date on site still awaited.

Review Groups for Belhaven and Edington Hospitals. There have been two meetings of the Belhaven Forum since the last meeting of the sub committee. The new administration in East Lothian Council has signalled that some policies of the previous administration will be subject to review and that it is not possible at this stage to provide clarity on the council’s view on the reprovision of Belhaven Hospital and Care Home. It is still intended to bring an update to a future sub committee meeting. The forum has discussed the viability of the minor injuries service at Belhaven Hospital at both of these meetings and a report will be brought to the sub committee on this subject.

Senior Management Changes.

Ian Johnston, Clinical Director will retire at the end of June, Morag Barrow, AHP Manager will move to take up post as Director of Unscheduled Care at NHS 24 and Liz Cregan, Chief Nurse, will return to Edinburgh CHP. All three have made major contributions to East Lothian CHP and to NHS Lothian and will be greatly missed. Arrangements are in hand to fill these posts.

In addition Sally Westwick has temporarily taken up the role of Assistant General Manager.

Decisions

The report was noted.

6.2 Staff Governance Report

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

All areas within the CHP are reviewed and monitored in accordance with NHS Lothian’s Promoting Attendance at Work Policy. Monthly figures are produced for each Service within the CHP.

<table>
<thead>
<tr>
<th>Absence Figure for April 2012</th>
<th>6.17%</th>
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<tr>
<td>Long Term Absence</td>
<td>3.59%</td>
</tr>
<tr>
<td>Short Term Absence</td>
<td>2.57%</td>
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10 employees met the trigger level of 4 absences in a rolling 12 month period as at April 2012.

TM reported that he has been working with HR to increase union and HR input in the support of the management of sickness absence. He believes the local nurse managers require further assistance in order to continue to manage difficult cases.

IW noted that EL is not fairing well compared to other Lothian areas.

AMCA questioned some of the detail within the graph and it was agreed that some thought to the presentation of data would be had with HR. DAS intimated that the CHP do not have resources or the capacity to produce performance stats in further detail. Some work is ongoing within performance systems and reporting and this may assist in the future.

Decisions

The report was noted.

6.3 Finance Report

The report circulated with the papers for this meeting is the Financial Plan for 2012/13 for the East Lothian CHP. The NHS Lothian financial plan which is reproduced was presented to the May 2012 NHS Lothian Board, East Lothian provides an overview for 2013/14. The second part of the plan provides the local elements of the financial plan.

A robust and detailed budget setting exercise was undertaken during February and March 2012. Budget holders were required to sign off their annual budget for 2012/13 by 31 March 2011. This sign off represents the budget holder’s commitment to provide an agreed level of service (and activity) within the overall budget. The budgets include limited increases for pay / prices uplift, additional drugs costs, nursing incremental drift and agreed services changes as set out in the financial plan.

Decisions

The report was noted.

6.4 Clinical Director’s Report

The Sub Committee considered a verbal report from the Clinical Director which included an update on planning for the clinical director and issues with medical
recruitment in prison healthcare

Decisions

The report was noted.

6.5 Chief Nurse Report

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

Lorraine Cowan introduced the paper.

Child Protection
At the end of quarter 4 (Jan – March 2012) there were 66 children on the Child Protection Register (CPR) in 52 families which shows a slight decrease over quarter 3. There are currently 14 sibling groups. The predominant factors remain neglect, poor supervision and substance misuse. In addition there has been a higher incidence of domestic violence. The overall increase in CPR in East Lothian remains above the national average at 3.5 per 1000 where the national average is 2.9 per 1000.

There has been an upward trend in IRDs in the quarter from 100 (Q3) to 138 (Q4) and the number of Child Protection Case Conferences has reduced from 14 (Q3) to 13 (Q4). All cases on the CPR are allocated, have a Lead Professional, Child Protection Plan and a Core Group in place.

Adult Protection
In the Quarter 4 Report (October - December 2011), the number of cases being managed under Adult Protection procedures in East Lothian were 49, with all cases being allocated. This represents a 10% reduction from 55 at the end of quarter 3. The largest number of referrals were for older people and includes people with dementia. The highest categories of harm this quarter are self harm, financial and physical harm. A number of referrals feature vulnerable young people with alcohol / substance misuse issues.

East Lothian Health Visiting and School Nursing Services
The Musselburgh Health Visitor Team relocated to the Musselburgh Primary Care Centre (MPCC) at the end of April and are now co-located with the 3 Musselburgh GP Practices, Community Child Health Services, Community Midwifery, the Child Protection Advisor and numerous other Adult Services.

The Health Visitors are progressing, towards having lead responsibility for chairing the initial Staged Assessment and Intervention (Early Years) process (GIRFEC) for all pre-school children. Further training sessions are planned to support this development.

The School Nursing Service also relocated to the MPCC in April. Staff who are still based in Midlothian will be joining them during June.

Clinical Nurse Manager Integrated Children’s
East Lothian and Midlothian CHPs
Annmarie Burgess has been appointed to the Clinical Nurse Manager Integrated Children’s Health East Lothian and Midlothian CHPs for a 6 month period commencing 1 June 2012. This follows Marie McMillan CNM’s move to her new post in Child Protection.
Releasing Time to Care
All three hospital areas within East Lothian are participating in the Releasing Time to Care project. Day Hospital at Roodlands are participating in the Delivering Better Care Leadership programme.

Patient Safety Programme
Awareness of the patient safety programme has been raised within all three hospital areas.

Joint Advisory Group on Endoscopy
Endoscopy services at Roodlands will be taking part in a JAG inspection on the 27 June 2012. All staff have been working closely to ensure that all aspects of the service being delivered, meets the standards expected of Jag.

HAI Infection Control
A new National Infection Prevention and Control Manual will be implemented across NHS Lothian from September 2012. Launch of the manual is planned from June / July with Road shows for staff during August. Compliance and Quality Improvement audits will be undertaken to ensure that all areas within NHS Lothian are meeting the 10 elements of Standard Infection Control Precautions (SICPs).

HEAT Targets - April 2011- Mar 2012
Outbreaks
Staphylococcus Aureus Bacteraemias as at 30 April 2012 - nil cases in both Hospital and Community.

April 2011- March 2012
Clostidium Difficile 22 cases identified in the Community and 7 in Hospital.
Norovirus - nil cases in both hospital and Community.

There have been no MRSA Bacteraemia for over a year and a decline in the cases of CDI presenting in Community Hospitals

HAI Audits
Monthly hand hygiene audits continue to be submitted and compliance with the audit programme continues to improve across services. Compliance across all East Lothian hospitals is 99% as at March 2012. (Compliance Target is 95%).

Decisions
The report was noted.

6.6 AHP Manager Report

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

Health and Social Care Response and Rehabilitation Service
East Lothian Change fund has supported the development of a health and Social care Response and Rehabilitation service. Both Physiotherapy and Occupational therapy are recruiting to new posts which will enable the development of in-reach and out-reach models of rehabilitation.

East Lothian Telecare for individuals
Telehealthcare continues to develop in AHP models of care. The TelePulmonary Rehabilitation team have won a national award for
6.6.1 Innovation and Quality, and whilst continuing to run the class based Tele Rehabilitation model, and now piloting a game based Tele rehabilitation model, utilising Video-conferencing telephones.

East Lothian Speech & Language Therapy Team update
The Speech and Language Therapy Team have been working with Lothian AHP Stroke Consultant and colleagues in Edinburgh CHP to pilot an innovative model of Therapy utilising Office Communicator to test a model of remote Tele Rehabilitation.

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

External Nursing review underway to scope Nursing capacity and skill mix covering all specialism. The Report will be produced in July 2012.

Medical model of care likely to move to independent 2c practice. Dr Ian McKay, currently Clinical Director in Edinburgh CHP, has commenced sessions to provide clinical direction and leadership to the GPs within the team. Out of Hours cover continues to be provided by NHS Lothian Forensic Medical team, and is running well.

HMP Addiewell completed the first stage of a Lean Pharmacy Review at beginning of the month. HMP Edinburgh completed their review in April 2012.

Telehealth developments continue to thrive. Long Term Conditions self monitoring is in development and will go live after the summer. Vision now installed in both the prisons to replace the old system. Telepsychiatry model ready to go and awaiting ethical clearance. Healthcare team working with colleagues in Lothian Universities Hospitals Division to provide Teledermatology protocol with a view to go-live in July 2012.

No Legionella cases detected in HMP Edinburgh following recent outbreak in South West Edinburgh.

Additional Physiotherapy committed to both Prisons to provide improvements to musculoskeletal service, and also to assess need in physical activity provision and pain management.

Agenda For Change job description work in progress. Revised local job descriptions work completed with help of Partnership colleagues, and will be put forward for matching June 2012.

Finance remains in balance, with 4% non-recurring savings booked

Decisions

The report was noted.

6.7 Hosted Services

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

Sally Westwick introduced the report and highlighted the following points:

- Cover for Golden Jubilee was successful and provided valuable lessons learned which may assist towards working from 4 bases in future as a potential.

Decisions

The report was noted.

6.7.2 Health Promotion

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

Moyra updated on the work of the Healthy Working Lives Literacy Project and its outcomes.

IW suggested endowments may be a potential source of funding for next year. DAS asked for evaluation outcomes.

Decisions

The report was noted.

NHS Lothian Health Promotion Service Annual Report 2010/11

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

Decisions

The report was noted.

6.8 Public Health Team

c/f to next meeting in the absence of John Boyce

7 Carers Forum

There was nothing to update.

8 Public Partnership Forum

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

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

Decisions

The Minutes were noted.

9 Community Health Partnership Committee Appointments

There was no business raised under this item.
10 **A.O.C.B.**

No items raised

11 **Date of next meeting**

It was agreed that the next meeting would take place on 30th **August 2012** at 2.00 pm in the Adam Room, John Muir House, ELC, Haddington
Welcome/Introduction/ Declarations of Interest/ Apologies

Shulah Allan had been appointed as Chair of ECHP to replace Bob Anderson, who had retired. Mrs Allan introduced herself and gave a brief resume of her background, which spanned the voluntary sector, community care, mental health, and most recently in working in the area of public involvement, before becoming a Non-Executive Director of NHS Lothian. Mrs Allan noted that she was delighted to be asked to chair ECHP at such an exciting time in the development of health and social care services.

Mrs Allan also noted that there were several other new members of the Sub-Committee and welcomed them to the meeting. Peter Gabbitas noted that it was important that, with this in mind, the use of acronyms and technical terms should be kept to a minimum.

Apologies were noted as above, and there were no declarations of interest.
69.1 Minutes of the Previous Meeting held on 4th April 2012

The minutes were approved and the following points were noted:

- Duncan Miller has taken up a secondment with the Scottish Government to lead the development of the new Scottish GP Contract.
- A verbal update report on prescribing will be made available at the next ECHP Sub Committee meeting.

69.2 Agenda

The agenda was agreed with no additional items to be added.

69.3 Matters Arising Not Covered on the Agenda

None.

70. Chair’s Report

Mrs Allan has been in post since 1 June 2012 and has been working with the management team to gain an understanding of roles and issues and witnessing service delivery at first hand. The Chair would welcome any further suggestions to help with this period of induction, which she saw as an ongoing process.

71. General Manager’s Report

- Performance - Colin Briggs referred to the paper he had prepared for the Sub-Committee. It was Mr Briggs’ view that the approach to performance management within ECHP needed to be made more robust, in order that ECHP could make more effective strategic decisions and interventions in the management of its work. Mr Briggs explained that he intends to bring a report to future Sub Committee meetings to illustrate ECHP’s performance more clearly to those not in the management team, and indeed to the public. Mr Briggs noted that he was keen to invite challenge from Sub-Committee members in order to ensure that data is robust and to ensure that the Sub-Committee steered the management team appropriately. Mr Briggs noted that there is a wealth of good data that is not currently reported. Mr Briggs and Mrs Allan undertook to explore these issues in more depth at a future meeting of the Performance Management Group and a report brought back to the next meeting of the Sub-Committee.

- Finance – Mr Briggs and Mrs Hollis presented the detail on this item. As at June 2012, Edinburgh CHP is £512,000 overspent. £338,000 of this is due to the additional 62 beds that 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. Other financial pressures were noted from the Joint Equipment Store and the SMART Centre, both with regard to the ordering of equipment for patients. Mrs Hollis and Mr Briggs explained that there is an expectation that funding will be made available to meet the pressure from open beds.
• **Savings Programme (LRP)** ECHP has a target of £2.4m for its savings plans this year. Mr Briggs explained that these are a mix of schemes across all areas of business, although some required significant input from other parts of the system. To the end of June 2012, the LRP has delivered all but £88,000 of its LRP requirement for the year to date.

• **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. There were very few of ECHP’s services which were subject to this standard, which were vasectomy, wheelchair provision, and the Driving Assessment Service. Mr Briggs explained that performance for these was tracked but was not reported as robustly as he would like, and indeed was used to from previous roles. Mr Briggs noted that these issues needed to be included in any performance management framework going forward, and that this would need to also cover areas where services were not subject to the standard but were nonetheless areas where monitoring would provide focus for improvement. Examples of such services included domiciliary physiotherapy.

• Mr Briggs had provided a report and there was discussion regarding the sample reports contained therein. In response to a question from Councillor Day, Mr Briggs explained that part of the issue was that tracking systems were not yet robust. NHS Lothian’s TRAK system had long been in use in acute services but was only now in broader use in the community, and as with all IT systems, implementation periods could throw up inaccurate or misleading data. However, going forward, this will provide information on workloads at sector and base levels and will highlight trends.

• Sickness rates are currently at 4.34%. The NHS Scotland target is 4% and it was noted that there were particular hotspots. Mr Briggs and Mrs Cowie explained that the management team reviewed these hotspot areas at each core management team meeting.

• Complaints. Colin explained that 80% of responses should be within 20 days and should be the type of response we would want to receive ourselves. The CHP is committed to achieving this target, although again data was not routinely and robustly recorded.

• Mrs Allan asked how the Committee would manage such a large report. Mr Briggs suggested that the report would identify what can be measured, providing data and any areas of concern/outline of actions. It is envisaged that there will be perhaps 20 measures and it may be a further year before the report is fully refined. Mr Briggs reiterated that he is looking to gain help and indeed challenge from the Sub Committee and would be happy to meet with members or enter into email discussions re what else to include.

**Decisions**

The report was noted, and Mr Briggs undertook to ensure that a progress report was brought back to the next meeting and every meeting subsequently.
CHP Capital Projects Update

Mr Briggs introduced the paper provided by Mr Whitton, and noted that this was an excellent concise summary of the various primary care projects underway. Highlights included:

- The West End Medical Practice relocation into the grounds of the Anglican Cathedral is due to open in the winter of 2013-14

- The Wester Hailes Healthy Living Centre is due to open in late 2013.

- There had been public safety concerns around access to the new centre. In response to these public concerns, Mr Gabbitas had worked across NHSL and City of Edinburgh Council to find an alternative solution which was much more to the liking of the local community.

- Ratho Surgery is sited in a small facility that is not suitable and a permanent alternative was a ECHP priority. During the winter of 2011-12 a temporary amelioration had been identified, but in Ratho Station as opposed to Ratho proper.

- To date there has been soundings in the community via the Community Council and some public consultation carried out by the local MSP. Mr Briggs noted that some of this had perhaps not been as helpful as it could have been, due to a lack of proper engagement and communication from ECHP about its plans. This had led to the local community understandably becoming concerned about rumours circulating and Mr Briggs and Dr McKay had begun working with the local Community Council and with local city councillors to close the communication gap. This had not been an easy process and Councillor Henderson noted that it was extremely important that a range of views were sought from the community.

- Mr Briggs explained that, fortunately, an alternative option which could provide a permanent solution had become apparent and that the management team were working on this option. An update would be brought back to the next Sub-Committee.

- The North West Partnership Centre (Muirhouse) project was progressing, although it was noted that there were several issues to resolve with regard to what CEC services would be included in the building. In response to a question from Cllr Day, Mr Gabbitas noted that he was leading on this but that CEC’s Chief Executive, Sue Bruce, had a personal interest in this project.

- Cllr Day also noted that he had heard there was a risk associated with the project as NHS Lothian had “objected” to the planning permission. Mr Briggs clarified that there was no objection, but that a query had been lodged by NHS Lothian and that this was to be debated at CEC’s Planning Committee soon. Mr Briggs stressed that NHSL was absolutely committed to delivery of this centre, but again acknowledged that communication had not been all it could have been.

- Mr Briggs undertook to ensure that Cllr Day and others had access to a
project timetable.

- **Firrhill and Oxgangs** It was noted that Heather Levy led a deputation to CEC’s Health, Housing and Social Care Committee on behalf of local community, and that in common with other projects, there was a concern at a lack of information being shared, which had led to a belief that projects had been cancelled. Mr Briggs had invited Ms Levy to attend the Sub-Committee to make this point and join in the discussion about how best to resolve these issues. Mrs Allan, Mr Gabbitas, and Mr Briggs all noted their concern about this theme emerging across several projects.

- Mr Gabbitas explained that the delays to the Firrhill project had been as a result of changes to the capital funding process at the Scottish Government, and that a further recent delay had been as a result of the approvals process for capital projects at SGHD. Mr Gabbitas also noted that in the case of Muirhouse and Firrhill, the local GPs actually owned their practices at the moment and that therefore there was a negotiation process which ran in parallel to the main business case process.

- Ms Levy noted that the main problem, in her opinion, was that ECHP had not explained this effectively to the local community. Mr Briggs also noted that this lack of communication also extended to an awareness of issues such as access to physiotherapy in the Oxgangs community, and that the focus therefore needed to be not just on capital projects but on service provision on a day-to-day basis. Mr Briggs was clear that improving community engagement needed to a high priority for him in this and the next financial years.

- Cllr Day requested that Capital Projects remained on the agenda for subsequent meetings. Mr Briggs agreed and noted that he felt the level of the debate had been very helpful.

- The Chair stated that there is a need for proper engagement and communication strategies. It was noted that this paper only focused on primary care and that there are other capital projects, e.g. Royal Edinburgh Hospital, Astley Ainslie Hospital. It was agreed that these are major pieces of work and that an update on these projects should be brought to the next meeting.

**Decisions**

The report was noted.

**73. Long Term Conditions Programme**

Dr Carl Bickler gave a presentation on ECHP’s Long Term Conditions Programme. The written report gave a historical perspective and Appendix 1 of this report outlined the current work.

Key elements in the care of patients with Long Term Conditions are –
- Supported Self Management
- The use of Telehealth
- The need for completed Anticipatory Care Plans
- Falls Prevention work
This work is ongoing in Pulmonary Rehab, Community Reparatory Team and IMPACT (District Nursing service).

Dr Bickler reported the following:

- Length of stay in hospital for patients with a LTC is falling
- Length of stay in hospital for patients with COPD is falling significantly
- Length of stay in hospital for emergency LTC patients is falling
- Length of stay in hospital for emergency LTC patients aged over 75 is falling significantly

There was a short discussion following the presentation regarding the significant risks associated with being in hospital, the benefits of looking after sick people at home, the need for patient education re safety at home, use of Telehealth to support the patients at home and the culture shift required to do this (no longer a paternalistic approach).

Mrs Allan pointed out that there are two reasons for being in hospital - to be made better and to be looked after and that there had been no mention of how to do this at home. e.g. 3rd sector, families and carers long-term support role.

Ms Levy asked if self care in children’s care was promoted. Mr Briggs stated that in RHSC there is a culture of working with parents to avoid having children in hospital.

Decision

The presentation and report were noted.

Integration

Mr Gabbitas reported that Integration would now be a regular item on the Committee’s agenda.

A draft response to the consultation has been included with the papers for this meeting. This is to be submitted by 13 September 2012. Mr Gabbitas explained that he was currently taking this document to various fora, e.g. City of Edinburgh Council Management Team, NHS Lothian’s Corporate Management Team, as well as meeting with senior colleagues from within the joint directorate and with Chief Executives to ensure that the wording and tone are correct. Mr Gabbitas noted that the existence of the joint directorate for the last seven years means there is already a good understanding of the potential of integration to further improve services for citizens.

Mr Gabbitas briefly outlined the content of the consultation document, which gives an explanation as to why Integration is wished for, the problems this would address, and gives a context for the work required. The responses for all 4 CHPs are being coordinated centrally within NHSL and this ongoing coordinated discussion will ensure that all key stakeholders are aware of the content and can help to agree how best to take forward the management of hosted services, for example.

It was highlighted that the new Chief Executive of NHS Lothian, Tim Davison has noted that integration in Health and Social Care and Community is already strong but that primary and secondary care linkages could be strengthen. Mr
Briggs noted that, having recently moved from secondary to primary, this was an area he saw a real series of opportunities in.

Mr Gabbitas noted that the governance for the new Partnership, which would supercede the CHP structure, was a work in progress, but that the experience with the Joint Board of Governance meant Edinburgh was in a good position to move quickly.

Mrs Hollis said she hoped that the new model would have the teeth to be able to deliver what it needs to deliver. Mr Gabbitas replied that the consultation document is a bit mixed on this point with different views expressed. Similarly, it is still unclear how capital assets will work as current rules are very different for both NHS Lothian and the Council.

Cllr Henderson stated that this was an opportunity to establish local structures that stakeholders could participate in, e.g. locality planning, boundaries for GPs and schools and that local elected members will be involved.

Mr Brown stated that he felt the consultation document was weak re public involvement and that there is need to make sure the Scottish Government are aware that public want to be involved. Mr Gabbitas asked the Chair and the Committee membership to think about a suitable paragraph for inclusion.

There was discussion regarding the importance of public involvement and how this should be seen as everyday business rather than a bolt on. Mr Gabbitas commented that from his perspective the Council, and especially, Social Care, has embedded people in every service re-design and that this involvement was now being extended to fundamental processes

Mrs Allan agreed with this, noting that the route would be different for Council and NHS Lothian.

Mrs Allan asked if this would make a difference to dentistry. Mr Davidson replied that it would have some impact on the salaried service but that large parts are irrelevant to dentistry.

Mr Gabbitas requested that if anyone wanted to express views to contact him directly. He acknowledged that PPFs can make its own response but felt that there is greater strength in presenting a joint, supported paper. It was noted that Edinburgh CHP has to approve the paper prior to submission but that there is no scheduled Sub Committee meeting before this date. Mr Gabbitas undertook to provide further details at the next Sub-Committee meeting.

Decision

The report was noted.
75. **Primary Care in North West Edinburgh**

Mr Briggs highlighted slight concern regarding future capacity in North-West Edinburgh GP practices (from Newbridge to Roseburn). Several of these practices wish to change boundaries especially around Corstorphine and out towards Ratho. There are particular concerns around the surgery at Parkgrove (a branch surgery of East Craigs Medical Practice). Mr Briggs noted that in discussion with both Dr McKay, and with the Clinical Leads, it had been explained to him that branch surgery arrangements are difficult to manage effectively, and can leave some communities feeling that they are missing a key community institution. He noted that the Parkgrove surgery had recently been vandalised, which basically did not happen where a surgery was seen as part of the community.

Mr Briggs’s paper sought approval from the Sub-Committee to commence a tendering process for the Parkgrove area to ensure that there is sufficient capacity. Mr Briggs explained that the authority to approve a new GP surgery is reserved to CHP Sub-Committees and therefore he needed approval to take this forward. This could have resource implications, e.g. changes may require pump priming. An informal programme to be brought to October meeting and a full report to be submitted at the following meeting.

**Decision**

The report noted and Mr Briggs to report back.

76. **Self-Directed Support Pilot**

Mrs Allan spoke to this item and explained that Professor Alex McMahon, Director of Planning for NHS Lothian, is taking forward this pilot which involves providing small amounts of patient funding for appliances, short term sections so that patients can make more personal decisions. This is of great benefit to patients and offers support for nursing too.

**Decision**

The verbal report was noted.

77. **Items for Noting**

77.1 **Care Home Review Group 29 May 2012**

A copy of the minutes was circulated to members and noted, in particular, the ongoing work/support to Care Homes.

77.2 **Primary Care Joint Management Group**

A copy of the minutes was circulated to members and noted, in particular, the Scottish Government review of salaried dentists (remuneration and skill mix) and the interim measure that gives additional control to Boards.

It was noted that the salaried GP services are currently being reviewed by Edinburgh CHP.

Mrs Allan stated that she is also the Chair of the Orthodontic Appeal Panel. The DPP Sub Committee is currently reviewing the Edinburgh Dental Institute. A copy of this paper is to be presented at the next meeting Review.
77.3 **ECHP Health and Safety Committee**
A copy of the minutes was circulated to members and noted.

78. **Any Other Competent Business**

78.1 **Elsie Inglis**
Mr Brown asked if lessons from this matter have been learned. It was understood that the investigations are still ongoing and that it might not be possible to provide a report at this stage.

78.2 **Health Care Governance**
Mrs Allan explained that this changed a few months ago and that whilst the Sub Committee is represented on this committee there is a need to share information between the two groups. Mrs Allan requested that a report from this group (not minutes) comes to the Sub Committee.

79. **Public Question**
Norman Tinlin stated that there is no information on the NHS Lothian/Edinburgh CHP website regarding Integration or minutes for any meeting that has been held during 2012. Anne Crandles explained that this is in hand and that the website is currently being updated by Lesley Baxter, Public Involvement Co-ordinator.

80. **Date and Time of Next Meeting**
The next meeting of the Edinburgh CHP Sub-Committee is scheduled for Wednesday 3rd October 2012 at 1 pm in Meeting Room 7/8 in Waverley Gate.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Decision</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>71 - Performance</strong></td>
<td>Performance to be a standing item on the CHP Sub-Committee Agenda. Discussions to take place at Performance Management Group about how to strengthen arrangements in future.</td>
<td>CDB</td>
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<tr>
<td><strong>72 – Capital Projects</strong></td>
<td>Capital Projects to be a standing item on the CHP Sub-Committee Agenda. Written updates to be brought back on approvals processes and major projects. Timetable for projects to be brought to next meeting. Update at next meeting on work at AAH and REH</td>
<td>CDB</td>
</tr>
<tr>
<td><strong>74 – Integration</strong></td>
<td>Update on progress to next meeting. Update on governance arrangements to next meeting</td>
<td>PG / PG/SA</td>
</tr>
<tr>
<td><strong>75 – North-West Edinburgh</strong></td>
<td>Informal update on progress to October meeting. Formal update on progress to December meeting</td>
<td>CDB</td>
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</tbody>
</table>
1.0 Apologies and Welcome

Apologies were noted as above.

1.1 Stroke Services – Mark Smith

Hard copies of Mark’s presentation will be sent electronically via Wendy Michael.

Approx 84 people are discharged home in Midlothian following a stroke. A Stroke Pathway has been developed.
The pathway specifies what services are available to someone coming into the community following a stroke.

Julie Gardner indicated that it was positive to see the “joining of dots”. Julie will liaise with Nursing staff and link up with Mark re carers support.

Morag Barrow suggested that East and Midlothian critical mass did not allow for a dedicated stroke rehab model which meant generic services are provided.

Tom Welsh - asked about Investing in re-ablement within the services with specific responses to needs. Will this also join up services to younger people.

David Small – asked how for Residents of Midlothian – do the hospitals link with the community staff and what is available to the patient when they go home.

Eddie Egan – asked where is Midlothian in preventing patients getting a stroke in the first place?

Duncan Miller – reported that in the GMS contract and Qof prevention of strokes is being looked at.

Sue Edmonds – Sue mentioned that there is a difference in care for 65 and over and under 65s.

2.0 Minutes of the Previous Meeting held 31.05.12

Agreed as accurate.

3.0 Matters Arising / Action Plan

Action Log was updated.

4.0 Items for Decision

4.1 Keep Well

Dr Joy Thomlinson attended to discus the national pilot set up by the Scottish Government – on cardiovascular risk factors.

The programme was a pilot and has now been decided that it becomes embedded within all suitable areas.

Initially patients were getting Heart checks at 45 – 60 year olds, this has now been reduced to 35 – 60.

Keep Well is a Scottish Government funded programme that aims to reduce health inequalities by:

a. Providing an intervention focused on preventing cardiovascular disease to those who live in the most disadvantaged areas.

b. Targeting health improvement action and resources at the most disadvantaged areas.
c. Building capacity in primary care to deliver proactive, preventative care.
d. Providing early interventions to prevent escalation of health care needs.

Patients already with a chronic disease are not included in the criteria for the Keep Well Scheme.

Morag Barrow – asked about the use of Telehealth Care. Joy confirmed that this isn’t something that has happened currently but would be interested in discussing this further.

Joy advised that they have increased practice awareness around the proportion of carers.

Decisions

The Committee supported the paper.

5.0 Items for Discussion

5.1 Waiting Times – NHS Lothian
The chair reported that figures had been reported came to the NHS Lothian Board from last year have not been accurate. The NHS Board have been making decisions on data that have not been correct. This had resulted in an increase in patients declared unavailable inappropriately and large numbers exceeding guarantees.

The NHS Board is now addressing the problem. It had previously been reported that the board will catch up in June. Eddie confirmed that this will not happen in this timescale.

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 Discharges

Excellent performance from Midlothian for Delayed Discharge.
Eddie Egan – thanked Council colleagues for assisting with keeping numbers low and getting patients into appropriate facilities.

Integration Agenda

The integration document will be circulated separately from the papers due to the size of this document. Scottish Government is seeking a response by end of July and Midlothian Colleagues have asked for an extension to this.

George Wilson mentioned point 4.4 – David Small replied that it is a key question and one we need to decide soon.
Eddie Egan – in Midlothian we have always had good collaborative working – and we get the patients/members of the public involved sooner rather than later.

Hosted Services Management Arrangements

Jane Hopton has moved temporarily to Strategic Planning and Sally Westwick has moved into Jane’s role temporarily.

Homeopathy Review

The previous review on whether NHS Lothian should fund Homeopathy Services has recommenced. – A Steering Group has now met and are working with other stakeholders on this consultation.

Decisions

The report was noted

6.1 Staff Governance Report

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

The sickness absence rate has shown a disappointing increase. The Senior Management Team is addressing this and may require to increase capacity to provide support for the known areas of concern; Learning Disability, District Nursing and Health Visiting which will have to be looked at. It was agreed to put this back on the CORE SMT agenda for next month.

Some discussion and comments from members took place; Eddie Egan asked for representation from Employee Relations at this meeting.

Decisions

The report was noted.

6.2 Finance Report

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

6.2 End of year month 12

For 11/12 – apart from prescribing, the CHP broke even. All CHPs overspent on prescribing.
GMS – broke even
Overall this represented good performance on the HCH and GMS budgets.

6.2 Revised Month 1

A brief verbal report was given due it being an early month. The
Community Health Partnership was £42K overspent much of which is attributed to GMS. Month 1 prescribing data is not available until month 3.

6.2.1 Finance Plan 2012-13

The purpose of this report is to present the Financial Plan for 2012/13 for the Mid Lothian CHP. The NHS Lothian financial plan which is re-produced in part here has been presented to the May 2012 NHS Lothian Board provides an overview for 2013/14. The second part of the plan provides the local perspective on the outcomes of the financial plan.

More detail can be provided if required or requested by the group at a future meeting.

Key Risks

There are a number of risks inherent in the revenue plan.

Achievement of LRP – this will required focussed and sustained management action with additional schemes being identified to address any slippage.

Prescribing – the uplift has been agreed and a budget has now been set for the CHP. In the event that volume growth or prices exceed the forecast levels an over spend in prescribing could arise.

PMS – the 2012/13 funding model to support GMS services is now being finalised. The current planning assumption is no significant change to the allocations. Premises rental increases will continue to present a financial risk in 2012/13.

AHP budgets have now been funded to the scale point mid+1. There are plans to uplift this to mid+2 in the 2013/14 financial plan. The difference will present a funding gap and hence a financial risk during 2012/13.

There are a number of other ongoing financial pressures that need to be managed through reducing costs, utilising non recurrent slippage or rising through the quarterly forecasting process.

Eddie Egan – asked about the criteria around NRAC funding. Is prisons healthcare being covered in the financial plan?

Proposal for funding from NRAc are being collated for CHPs – David Small is leading on this. In conjunction with Chief Nurses

Based on the General Registers of Scotland – All Lothian CHPs have grown. There is a definite argument for funding. In addition there is the Change fund which is about changing services not for Core Services to work together. Carol Lumsden is working along with Tom Welsh around Frailty Services. Looking at the Lothian Unscheduled Care Service around request for NRAC money.

Prisons – need to review any unmet funding for the services.

Carers Information Monies – Carers have raised their concerns around the proposed savings around this.
Decisions

The reports were noted.

6.3 Clinical Director Report

Note that the Healthcare Governance & Risk management Group Committee supported the recommendation for the disbandment of the Primary & Community Services Healthcare Governance & Risk Management Operational Group (HCGRM).

Note that the Senior Management Teams in the CHPs/CH(C)P should report directly to the NHS Board HCGRM Committee for clinical governance issues. For example, reviewing and monitoring reports on serious adverse incidents and compliance with agreed improvement plans. There will be direct representation on the Board HCGRM Committee from each of the CHPs/CH(C)P through their General Manager/Clinical Director/Chief Nurse.

Note that NHS Lothian Board will need to ratify the changes to the membership of the HCGRM Committee.

Note that a review of the new arrangements should be carried out after a period of at least 6 months.

Clinical governance assurance reporting through the current CHPs/CH(C)P sub committees could be strengthened to evidence how Clinical Governance is managed at CHPs/CH(C)P Board meetings.

It is proposed that the Committee support the Midlothian GP’s proposal that open access X-ray service be available on a regular basis regardless of school holidays. It is proposed that the General manager and Clinical Director pursue the opening of this service 52 weeks per annum. The views of the committee on this inequality of service provision for Midlothian residents would be welcomed. Eddie is keen for Hamish and David to progress this with other colleagues but not for the CHP to fund it.

The Sub Committee confirmed they support the disbandment of the HCGRM committee.

6.3.1 QI Programme 2011 -12 Final V1

For the committee to note.

6.3.2 Pharmacy Report May 2012

For the committee to note.

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.

Eddie Egan reported that Liz has been seconded to this post for the last three years. The previous chief nurse has now moved into a permanent position and the Community Health Partnership will shortly fill the post.

Eddie thanked Liz for all her hard work and input and wished her best of luck in the future.

Liz discussed content of her report. Main topics were:
- Child Protection
- Adult Protection
- Midlothian Community Hospital - Adult Services
- Midlothian Community Hospital - Mental Health Services
- HAI for Midlothian

New figures to be provided to Wendy via Liz to be disseminated to the group.

Decisions

The report was noted.

6.5 AHP Manager Report

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

Eddie Egan reported that Morag is leaving at the end of June 2012 to take up a new post with NHS 24. Eddie thanked Morag for all her hard work and input and wished Morag all the best for the future.

The purpose of this report is to recommend that the Board note the delivery of a new service for Midlothian residents. This service is funded by the Change Fund and is a joint venture between Midlothian Community Health Professionals, Midlothian Council and the Red Cross. The monies fund two Neighbourhood Links service Co-ordinators who have networked extensively with health teams, social work teams and community projects/services and service providers. Each Coordinator works 25 hours per week.

The project will support vulnerable adults in their own community. It was agreed to monitor the work of the post holder to evaluate the effectiveness of the project.

Sue Edmond – said this was an excellent service – it would be important to identify funding for the future since this funding runs out in October 2012.

Tom Welsh supported the programme and the need to ensure it’s delivering and the change fund will be looked at. It doesn’t necessarily mean that the funding will be stopped.

Decisions
The report was noted.

6.6 Hosted Services

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

Hosted Services (Assistant General Manager)
Eddie Egan reported that Jane Hopton was on sick leave from her temporary role and wished her a speedy recovery.

Tracy Sanderson talked to the report. Main items on:

To update Midlothian CHP Committee on performance, clinical governance issues and risk management issues within NHS Lothian Learning Disability (LD) Service.

Delayed Discharges had reduced following the placement of three patients in Midlothian.

Eddie Egan – suggested that the staff injuries could be highlighted or defined as Industrial accidents?

6.6.1 Learning Disability Service Strategy
Rona talked to the report: The purpose of this report is to inform the CHP Sub-committee of the modernisation and strategic development plan for NHS Lothian specialist learning disability services, moving into the next stage of delivery to ensure that the people of Lothian are in receipt of high quality, effective and fit for purpose services.

The Group were asked to note the progress to date in implementing the models of care in respect of each of the four care pathways (mental health, forensic, challenging behaviour/autism and profound and multiple learning disability) and tiers of service identified within the redesign plan as presented to the NHS Lothian Improving Care, Investing in Change (ICIC) Executive Group and previously supported by the Sub Committee.

Note the implications of the report of the work on capacity forecasting requested by the ICIC Executive Group and carried out by Capita Consulting in terms of potential revisions to the redesign plan.

Approve the plan to conclude delivery on the first phase of modernisation and to continue work on the other components to inform full implementation and associated financial framework.

Note the key issues to be addressed in the Work Plan for 2012-13 including:

- Scoping the implications of the proposed forthcoming legislation regarding the integration of community health and adult social care services
- Workforce Strategy for Learning Disability Services
• Site Strategy
• The request from NHS Borders for Lothian to include of NHS Borders in work modelling in-patient capacity requirements.
• Potential development of regional services for learning disabled patients

Eddie Egan – thanked Rona for bringing this report to the group. This topic will have to come back to this group at a later stage when approval is required.

Liz suggested the potential to up skill Nursing Assistants – to be a health and social care assistant.

Rona reported on the Joint LD CAMHS Unit – there was uncertainty on the revenue.

In the last 18th months there had been strong link working and planning of future models of service. Tom added that in Midlothian we are planning appropriate levels of care including for up to 40 people with the highest tariff of services.

Group agreed to the paper and recommendations.

6.6.2 Joint Health Improvement Partnership
Mairi Simpson raised two events that JHIP are planning: - Health and Equalities with Community Planning – extensive house building and how this impacts on health and wellbeing.

Physical activity and Health Alliance event held yesterday – This group are now looking at a new plan and would be happy for anyone to join and assist this group

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.

6.7.1 Dentistry
The increase in access had resulted in an increase in NHS Dental spend. The current spend has to be controlled and a review is being carried out around this. This report will be shared with the PCJMG.

6.7.2 Pharmacy Contract
The current system led to reactive planning and the NHS should plan more proactively.

6.7.3 GP Contract
Cabinet Secretary has advised that she would like to see a more Scottish focused GP Contract. This work is ongoing and in collaboration with Scottish Government and the BMA.
Hamish thanked Duncan Miller saying what a great support he has been and wished him good luck with his secondment to Scottish Government

Decisions
The reports were noted.

7.0 Carers Forum

Julie Gardner raised three point; The launch of the New Carer’s Strategy on the 1st June.

It is proposed there should be a 10% efficiency saving on the funding for the Carers Information Strategy which is unacceptable considering that a new strategy is being progressed. Liz Cregan advised that a meeting is being held within the next two or three weeks around monies and funding.

Alzheimer’s Scotland are still looking for premises. Still no resolutions. Their current lease has now run out, however the funding is still there and new premises that are needed.

Decisions
The update was noted.

8.0 Public Partnership Forum

Sue Edmonds reported on the work ongoing in relation to the discharge/stroke patients. Consultation on Homeopathy and the Integration. A meeting will be held in June for both PPFs for East Lothian and Midlothian to gather their views around the integration agenda.

Transport issue – change in First bus services the knock on effect of local services.

Decisions
The update was noted.

9.0 Community Health Partnership Committee Appointments

Still awaiting the due process for the appointment of Cath Johnstone.

Councillor Aitchison is no longer a councillor. Eddie will be sending a letter on behalf of the committee to thank Mr Aitchison for his contribution over the years to this group.

10.0 AOCB

None were noted.

51. Date and Time of Next Meeting

Thursday 26th July 2012 @ 14.00 in the McSense Centre, Mayfield
1.0 Apologies and Welcome

Apologies were noted as above.

1.1 NHS Lothian Clinical Strategy Update

Libby attended to update the Committee on the above. Hard copies of Libby’s presentation will be sent electronically via Wendy Michael.
The strategy will set out the principles which will govern our future service models, and model how the future will look – with specific service redesign plans then developed for patient groups and conditions incorporating these principles.

The Focus will be on pathways across the whole system, involving primary, secondary care, social care, and 3rd sector. We will prioritise high volume high cost areas of service, engage staff, including clinical leadership of redesign work streams.

We will further develop the capacity and capability of our staff to engage in continuous improvement, pursuit of excellence, recognising that services need to be able to respond to changing needs, new technology and developments.

The Scottish Government 2020 vision is:

By 2020 we will have a healthcare system where we have:

- integrated health and social care,
- a focus on prevention, anticipation and supported self management in order that everyone can live longer healthier lives at home, or in the community as long as possible.
- When hospital treatment is required, day case treatment will be the norm and, whatever the setting, it will be provided to the highest standards of quality, safety and patient experience.
- A focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

NHS Needs of pathway care: Clinical Strategy – 7 Key themes to date:

- Needs-based services
- Effective, seamless, safe care pathways
- Efficient services, outcomes focused
- Innovative learning organisation
- Partnership working
- Health improving
- Addressing health inequalities

Principles of Redesign are:

- Focus on prevention, anticipation and early intervention
  - Shift care interventions to earlier in the patient pathway
- Care delivered in the location best suited
  - Shift what is appropriate from inpatient to outpatient/community
- Care delivered by the professional best suited
  - Staff skills and roles aligned to maximise their contribution and effectiveness
- Care standardised and specified
  - Adopt evidence based pathways; disinvest in services of low clinical value
  - Reduce waste (in its many forms)
- Care and self-care enabled by technology
  - Use information technology and telehealthcare to co-ordinate care
- Planned and reliable elective and emergency care pathways
Focus on delivering both in a planned and reliable way to meet patient needs

- Service models co-designed with patients
  - and outcomes sense-checked with patient experience feedback

Work already carried out in Midlothian:-

- Intermediate care services —community based assessment and step down
- Integrated pathways for long-term conditions e.g. respiratory
- Reduced length of hospital stay, reduced aftercare through more rehabilitation/re-ablement
- Extra-care housing
- Improved support for informal carers
- Telehealthcare
- Community capacity building

Summary:

- Views from stakeholders to inform strategy
- Final document to Health Board meeting September 2012
- Share widely with public and staff
- Use to drive our service redesign

David Small commented on how much this strategy had moved on within the last 12 months. For Midlothian there are some big decisions e.g. Homeopathy reviewing and learning disabilities inpatient units which will be needed and the strategy should provide a framework for these.

Julie Gardner asked about carers being mentioned within the strategy also.

Libby confirmed that the carer’s strategy is incorporated within this strategy. Libby mentioned to the group that Midlothian has already reshaped its care and we now have the Midlothian Community Hospital.

Sally Westwick asked about an overarching/corporate view about decisions that we may have to take in the future.

Eddie Egan asked if Libby will be able attend at a later meeting.

2.0 **Minutes of the Previous Meeting held 31.05.12**

Agreed as accurate.

3.0 **Matters Arising / Action Plan**

Action Log was updated.

4.0 **Items for Decision**

4.1 Lanfine Redesign Feedback

Ciara Byrne attended the meeting to update the Committee. The purpose of the report is to recommend to the Committee the outcomes from the review of the service based at the Lanfine Unit and propose a redesigned service for people with Progressive Neurological Disorders and their families.
A project board has now been set up, chaired by Ian McKay, Clinical Director of Edinburgh CHP.

Sheena Wight thanked Ciara and was supportive of the paper. Sheena asked about the bed numbers being reduced and if there will be a potential to have satellite clinics – this has been discussed and given the nature of the illnesses around fatigue the use of Midlothian Community Hospital would considered although the long term view was to treat patients at home. 14 people from Midlothian use the Lanfine Service. Joanne Boyle from Edinburgh council is linking with her counterparts within the other Council areas.

David Small asked about the Respite beds (Leuchi House) Beds within this area will be helpful for short stay patients for carers. Patients are financially assessed before being able to access Luchie House, which is an added pressure.

Decisions

The Committee supported the paper.

5.0 Items for Discussion

5.1 Progress Report Update – Midlothian Partnership Change Fund

Work streams

Alison updated the Committee. She advised that there was some slippage within the monies due to the recruitment processes.

Some projects still require further work along with checking that existing projects are delivering what they are supposed to.

Eddie said that at the September meeting he would like a more in-depth discussion around the Midlothian work streams to ensure they are delivering what they should.

Hamish also confirmed that due to the Integration of Health & Social Care, he would like to see it made much easier for patients and those referring patients to access these services i.e. one point of contact, one phone number etc.

George Wilson commented and said that a number of very important issues were raised during the discussion. He has concerns whether schemes in place are robust.

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 Discharges

Continued good performance was noted. Alison White advised that the Council are shadowing their four week figures to check these from the council side.

Integration Agenda – joint committee meeting update

The East and Midlothian CHP sub committees held a joint meeting on 27th June to discuss the document and the key questions. At that meeting key issues were raised about whether there should be one or two partnerships covering East and Midlothian, engagement of general practices, how public participation will be secured, whether the partnership (s) should include services beyond older people’s services.

A joint meeting of the East and Midlothian Public Partnership Forums was also held to discuss the consultation.

Some discussion and comments we made by Eddie around Premises and Integration.

Premises

The CHP has been advised that the landlord of Malta House in Edinburgh which accommodates the Lothian and Edinburgh Abstinence Programme (LEAP) wishes to dispose of the property. Work has begun to identify possible alternative locations and to open discussions with the landlord on options. Sally Westwick advised that currently the local community are not aware that the facility will be closing and a communication will be issued to individual service users in the near future.

Homeopathy Review

The stakeholder group has met twice to plan the consultation process and a third meeting is to be held to finalise the details. Details will be brought to the September meeting.

Decisions

The report was noted

6.0.1 UHD Monthly Report

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

Eddie Egan reported that the Board has decided to remove the post of Chief Operating Officer, from UHD Services. Chief Executive interviews are taking place next week.

Waiting Times
Some discussion and comments were made by Eddie and the committee around waiting times and the 12 week waiting time. Sue Edmond asked about more local based follow up clinics.
The Royal Victoria guarantee building at the Western General Hospital is now open. The new facility provides modern, single room accommodation for Medicine of the Elderly and rehab patients.

The first tranche of enabling works for the new RHSC/DCN building are planned to start on in August 2012, and relate to work required at the Emergency Department at the Royal Infirmary of Edinburgh. The developments will include significant internal work within the A&E, and plans are being developed to supplement capacity with a mobile unit. The developments will also affect the road layout, ambulance entrance points and resuscitation facilities.

Legionnaires Disease Outbreak is officially over.

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.

For May Midlothian is 4.58% slightly up from April but a review panel has now been set up for both East & Midlothian on the 24th August 2012.

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 from off patent. This will assist in helping us achieve the LRP for Prescribing.

The GMS plan overall had a £1 million pound premises pressure. This has now been funded.

Lynne confirmed that Midlothian is on target to achieve their LRP and to break even.

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.

The committee was asked to:

Note the annual update from the Challenging Behaviour Practice

Note the annual update from Dr Hazel McCutcheon and Shirley Fife on Cancer and Palliative Care activity across Lothian.

Note the PMS Expenditure by CHP for 2011/12 from Mark Hunter, Head of Finance for the PCCO.

6.3.1 Challenging Behaviour Practice Annual Report

For the committee to note.

6.3.2 Cancer & Palliative Care Update

For the committee to note.

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.

Liz discussed content of her report. Main topics were:

Child Protection
Adult Protection
Midlothian CHP Nursing Services
HAI for Midlothian

Public Health Nursing Clinical Nurse Manager Appointment
Annemarie Burgess has been appointed to the Clinical Nurse Manager/Integrated Children Services post for East & Midlothian CHPs for a 6 month period from 1 June 2012. Interviews for Public Health Team Manager post for Midlothian CHP for a 6 month period were held on 18th July 2012.

HV Staffing
A meeting was held with East Lothian and Midlothian health visitors, staff side and managers in June 2012. Discussions centred around the high number of cause for concern cases in Midlothian and the need for more equitable caseloads across both areas. It has been agreed that a review of Health Visiting Services across East Lothian and Midlothian will be undertaken. The first meeting which will involve representatives from practitioners, staff side/ partnership and manager is planned for early September.
Infection Control – Healthcare Associated Infections
Staphylococcus Aureus Bactereamias as at 30 April 2012 - nil cases in both hospital and Community.
Clostidium Difficile as at 30 April 2012 - 4 cases identified in the Community nil in hospital.
Norovirus – Glenlee Ward has been closed from 11 July 2011 due to a number of symptomatic patients and staff and remains closed as at Mon 23rd July.

HAI Audits
Monthly hand hygiene audits continue to be submitted and compliance with the audit programme continues to improve across core and hosted services. Compliance is 98% for Midlothian Community Hospital and 95% for Hosted In-patient Services as at 31 March 2012.

Decisions
The report was noted.

6.5 AHP Manager Report
Sheena Wight attended on behalf of Rob Packham.

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 Learning Disability Service Strategy
Sally talked to the paper and was happy to take any comments.

Danny discussed the remaining two patients.

Eddie Egan is going to liaise with ER Director to ask for sickness absence figures to include industrial accident. A new field option especially for LD Staff dealing with complex patients.

6.6.2 Joint Health Improvement Partnership
Steven Wray attended to talk to the paper previously circulated to the Committee.

The Midlothian CHP Sub Committee is recommended to:

Note the evaluation report and the potential contribution that improving ‘readiness to learn’ in the early years can make to long term reductions in poor health outcomes
Note that although the Midlothian Equally Well test site formally ended in March 2012 a learning event will be held in the autumn of 2012 to disseminate the good practice developed in improving readiness to learn.
The test site for Midlothian Equally Well has now come to an end in March 2012. Prior to further action planning and discussion how it’s being taken forward in the future the Committee were asked to note the report. Eddie would like to see this taken to NHS Lothian Board. It’s been down through the National Equally Well Site.

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.

6.7.1 PCFG note of Meeting 01.06.12
David highlighted point 5.1 PCFG members supported the PCJMG recommendation to take forward the Enhanced Warfarin Management service which is supported by CH(C)Ps and LMC.

6.7.2 PCJMG Minutes 10.05.12

6.7.3 Late Distribution item 12b-GMS Q4

Decisions

The reports were noted.

7.0 Carers Forum

Julie Gardner gave a verbal report.

Efficiency savings on funding streams
Funding of GP Survey – to look at “GPs supporting Carers” Welfare Reform issues

Julie referred to the discussion around the Lanfine Unit and asked if it would be useful for the carers Bed Bureau paper to be circulated to the Committee.

Decisions

The update was noted and the committee would like to see the bed paper.
8.0 **Public Partnership Forum**

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

**Podiatry**
Danderhall/Pathhead clinics have now closed.

**GP Survey**
Confidentiality issues seems to have been raised around discussions at GP Receptions along with dignity questions and waiting times for other areas.

Sue will liaise with Hamish around the results and how to take them forward.

**Decisions**

The update was noted.

9.0 **Community Health Partnership Committee Appointments**

Still awaiting the due process for the appointment of Cath Johnstone.

Councillor Aitchison is no longer a councillor. Eddie will be sending a letter on behalf of the committee to thank Mr Aitchison for his contribution over the years to this group.

10.0 **AOCB**

10.1 Having the meeting the day after the NHS Board – Eddie asked for the Committee to possibly consider having the Sub Committee Meeting the week before the NHS Board.

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

27th September 2012 @ 14.00 in the Council Chambers at Midlothian House.
Minutes of the West Lothian Sub Committee held on 30 August 2012 at 2 – 4 pm in Strathbrock Partnership Centre.

Present

- Frank Toner (FT) Chair, West Lothian CHCP
- John Richardson (JRi) Public Involvement Representative
- Julie Cassidy (JC) Public Involvement Co-ordinator
- Annabel Ross (AR) GP Rep
- James McCallum (JMc) Clinical Director
- Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
- Jane Houston (JH) Partnership Rep
- John Reid (JRe) Housing Policy and Development Manager
- Pat Donald (PD) Acting AHP Manager, West Lothian CHCP
- Lindsay Seywright (LS) Assistant Principal, West Lothian College
- Jane Kellock (JK) Manager, C&F/Health Improvement
- Debbie Eccles (DE) Clinical Nurse Manager
- Scott Robertson (SR) Police Inspector
- Jennifer Scott (JS) Head of Social Policy, WLC
- Alan Bell (AB) Senior Manager Social Policy
- David Williams (DW) Policy Officer
- Jim Forrest (JF) CHCP Director
- David Chandler Acting Consultant in Public Health

Apologies

- Lorraine Gillies (LG) Community Planning & Development Manager
- Moira Niven (MN) Depute Chief Executive
- Claire Kenwood (CK) Assoc. Clinical Director
- Marion Christie (MC) Head of Health / General Manager, WLCHCP
- Gill Cottrell (GC) Chief Nurse

In Attendance

- Marjory Simpson (MS) Administrative Manager (Minutes)

1. APOLOGIES
   As above.

2. ORDER OF BUSINESS INCLUDING NOTICE OF URGENT BUSINESS
   As agenda.

3. ANY OTHER BUSINESS FOR TODAY
   No other business notified

4. DECLARATION OF INTEREST
   There were no declarations of interest made at this point that were relevant.

5. DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE
   The minutes of the meeting held on 21 June 2012 were approved as being an accurate record

6. MATTERS ARISING FROM PREVIOUS MINUTE
   There were no matters arising from the previous minutes.
7. CONFIRMATION OF ACTION POINTS
Action note was circulated and discussed.

8. MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING
The minutes of the PPFHC from the 7/06/12 and 16/08/12 were noted

9. MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP
JH asked for information re the Warfarin Management Enhanced Service.

JM to send JH this information

10. MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT
JS pointed out that these were a duplicate of the minutes previously sent to the Sub Committee at the June meeting.

JS gave an overview of the remit of the Children and Families Management Group for the purpose of the new chair.

11. SINGLE OUTCOME AGREEMENT 7 (SOA7) We have tackled the significant inequalities in West Lothian society

AB explained the previous report format was felt to be a bit cluttered and confused. A new design has now been developed, with ‘drill down’ facility. Technology prevented the use of this today, so the report was presented (for the last time) in the old format today.

Various relevant performance indicators that relate to CHCP work-plan, and to various high level initiatives and programmes, were reported

Rate of suicide per 1,000 population (3 year average). This is relatively static, numbers are low, but the target is to be lower. A detailed report will be brought to the next CHCP Subcommittee meeting.

Last weekend a small spike in suicide numbers was raised by the local chief superintendent. This led to meetings to discuss the need for and nature of an emergency response which demonstrates the value of the ability to react to information in a timely manner. The spike in suicides for the current year, and adverse associated publicity, was noted. It will be further analysed and reported on.

Teenage pregnancy rates. See paper later in this meeting.

Smoking during pregnancy: there is an overall positive trend.

Rate of homeless presentations: performance improved last year and compared to a few years ago but homelessness remains a problematic area for West Lothian (and most LAs). Shortage of housing was commented on as being a key cause, and this is being addressed in the L.A. Increasing preventative work is also happening. Health and other issues associated with homelessness go beyond pure bricks and mortar and this is the remit of Moving Into Health team. The issues remain subject to partnership work. Performance on emergency housing provision has plateaued.

Increase in personal income after receiving advice from the Advice Shop: West Lothian performance is very good compared to other areas (although there was an unexplained slight
dip last year). Big question mark here was felt to the impact of welfare reforms – likely to lead to increased demand for service.

Young carers accessing peer and statutory support reporting improvements in confidence, self esteem etc, satisfaction. 52 out of 54 young carers last year reported improvements (2 were lost to follow-up). Another 33 young carers / families received information but were not included in evaluation. The service works closely with schools to get the most of its referrals and to evaluate educational performance of service-users after they have received input.

A young carers strategy working group has been established and is looking into schemes to provide ‘awards’ to acknowledge achievements of the young carers.

Employment support for people learning disabilities. Performance generally is considered to be improving and positive. A topic for a more detailed future presentation.

Proportion of mental health / addictions cases allocated within 12 weeks: remains 100% so the plan to reduce and tighten the target to 6 weeks.

Adults with severe chronic alcohol misuse improving / sustaining well-being: the proportion varies widely due to low numbers of service users.

People with physical needs receiving 10 hours care at home (Scottish Government measure): this is increasing, but it does overlook other types of support/service that are provided for people with various needs.

**BREAKAWAY RECOVERY DROP-INS**

Debbie Eccles gave a presentation on the Breakaway Recovery Drop –Ins service. Target waiting times have steadily reduced from 18 weeks to 3 weeks (for at least 90% of referred individuals); all have been achieved in West Lothian along the way.

There are 6 core drop ins across West Lothian where sites were picked on the volume of referral patterns and tend to be in areas of high deprivation. There is scope to establish more centres if they are felt to be working well. The centres are managed by NHS Lothian admin team. The key partners are social work and NHS addictions services, plus 3rd sector West Lothian drug and alcohol service. All are well used to working with each other, and support attainment of the NHS target. The Tobacco drug and alcohol partnership provide monitoring of performance against the HEAT 11a target. EQIA is carried out annually. The drop-ins are financed from existing budgets. Capacity issues persist, and demand for treatment outweighs resources. 4 years ago had there was an 18 months-long waiting list so things are improving.

90 clients (of which 1/3 women, but this is increasing) presented at the Breakaway drop-ins last year compared to 256 who were referred. This was felt to be a good start. The most frequent age categories were between 31-50. Other stats: Alcohol issues 48; drugs 29; both 13

The 90 were spread roughly evenly between the Bathgate Broxburn, Howden, Linlithgow, St Johns and Whitburn. Allocations to services: 50 3rd sector, 26 NHS, 14 social work 2/3 of the 90 service users reported a satisfaction rating 5 out of 5. No-one scored 0 or 1.

**TEENAGE PREGNANCIES WEST LOTHIAN**

JK talked to the paper informing the Sub Committee that there is good evidence that Teenage Pregnancy / early motherhood is associated with various difficulties for the child and parent including social isolation, poverty, poor educational attainment, and health. National target is to reduce the rate by 20% especially for under 16s. Under 16s, 18s and 20s are the three key groups. Under 16s pregnancy is associated with deprivation and terminations, and there is little change in the trends.
However West Lothian compares well with other Lothian regions and is currently meeting the 6.8 target. There is good partnership working, including good efforts in disseminating educational programmes. Reductions in pregnancies have resulted from targeted work for the most vulnerable young people. Healthy Respect drop ins are seen as responsive to young people’s expressed needs. In summary there is a robust strategy in West Lothian.

The chair asked a question about contraception teaching and any differential pregnancy rates in Catholic schools, but no information is available with which to answer this.

13. COMMUNITY HEALTH DEVELOPMENT OFFICER – YOUNG PEOPLES MENTAL WELL-BEING POST

JK talked to the paper detailing the background to the post. The post reflects focus on children’s mental well being. It is a 3 year fixed term Health Improvement Team post and concerns a range of interventions. The appointed officer has been in post since the beginning of August. Her role is to work with young people and staff to help support services. This is not about people with diagnoses but more about early intervention for people with high risk circumstances and to reduce barriers to engage with support.

There was a suggestion that the officer making use of social media in her role – it was agreed that this should be followed up. JK

14. WEST LOTHIAN BUTTLE UK AWARD – SUPPORT CHILDREN LEAVING CARE

LS talked to the paper giving details of the Buttle UK Award. This is a quality mark to support success in education for care leavers. It is usually issued to higher education institutions.

An initial action plan has been submitted, with resubmission scheduled for next month. The submission highlights the good local partnership working with NHS, Looked After Children (LAC) strategy group. The award is expected by year end.

15. TOBACCO, ALCOHOL AND DRUGS PARTNERSHIP (TADP) - UPDATE

David William talked to the paper describing the drive to shift the support to help people to move on with life and achieve abstinence. This requires issues of housing, meaningful activities, breakdown of social isolation and employability to be addressed. Different services have been doing different aspects of these; the project now is to establish a combined service.

There will be a 3 year delivery plan following on from the joint commissioning plan. This has been drafted and submitted to Scottish Government. The key element of the alcohol strategy is reducing the availability of alcohol. The group has looked into local attitudes. They are generally supportive of reduced licensing with 81% living within 500 yards of an outlet selling alcohol. Comments were made in favour of restricting licensing in relation to associations with antisocial behaviour and health impacts.

The chair commented that applications received by the licensing board, that meet the criteria, are approved as this is set by law.

Debbie Eccles discussed the Methadone/Suboxone programme stating the recovery programme can take years, but there is a lot of evidence recorded (Pan Lothian figure) showing this has made a positive impact.

JMc informed the group alcohol has a massive impact on hospital admissions and life expectancy and price and access both have an impact on consumption.
16. REVIEW PUBLIC PARTNERSHIP FORUM FOR HEALTH & CARE
ACTION PLAN 2010-12

JC talked to the paper stating 2010 / 2012 action plan is undergoing review and coming to a close. A 2 year action plan will continue due to the Integration Strategy.

17. DRAFT PUBLIC PARTNERSHIP FORUM FOR HEALTH & CARE
ACTION PLAN 2012-14

JC talked to the paper stating there are amalgamated actions between the 2 action plans. The action plan will need CHCP support to meet its outcomes. Comments were that the Forum is a very active and hard working group, linking in increasingly well with the CHCP Sub Committee and other relevant groups. JF recognises the work that is being carried out and is keen to support this activity. Health Improvement Health Initiative links have improved and became stronger over the last 12 months. JRi commented that the forum could be utilised more to facilitate information to the public but requires a 2 way communication channel. LG is looking at an engagement process and will seek opinions of other group.

A 3 month reporting cycle for the Forum was agreed.

18. ANY OTHER COMPETENT BUSINESS

No other business was discussed.

19. DATE, TIME OF NEXT MEETINGS 2012

CHCP Sub Committee meetings at 2pm – 4pm in Strathbrock Partnership Centre

18.10.2012
06.12.2012

Meeting closed at 3.40pm
MINUTE OF MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD held within THE STRATHBROCK PARTNERSHIP CENTRE, BROXBURN, on TUESDAY 14 AUGUST 2012

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

In Attendance – Jim Forrest (CHCP Director), Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), Lynne Hollis (Associate Director of Finance, NHS Lothian), Alpana Mair (Primary Care Pharmacist), Alan Bell (Senior Manager – Communities and Information, West Lothian Council), Sharon Leitch (Senior Internal Auditor, West Lothian Council), Fiona Duffy (Corporate Communications, West Lothian Council); and John Richardson (PPF)

1. ORDER OF BUSINESS

The Board was informed that Councillor Toner had recently been appointed to the Board of NHS Lothian as the council’s nominated Non-Executive Director, and so would now assume the Chair of the CHCP Board and Sub-Committee.

The Chair then advised that Morag Bryce had been appointed to the CHCP Board and Sub-Committee by the Health Board, and that another Health Board appointment was to be made shortly after the conclusion of a recruitment exercise.

The Chair welcomed to the meeting Sharon Leitch to the meeting to make a presentation on risk management in the CHCP.

2. MINUTE OF MEETING OF THE BOARD – 29 MAY 2012

The Board approved the minute of its meeting of 29 May 2012 as a correct record.

3. CHCP BOARD RUNNING ACTION NOTE

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

Decisions

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

2. To agree that Items 3 to 17 were completed and should be deleted.

3. To agree that remaining items should be carried forward.

4. MINUTE OF MEETING OF CHCP SUB-COMMITTEE – 26 APRIL 2012

The Board noted the minute of the meeting of the CHCP Sub-Committee held on 26 April 2012.

5. MINUTE OF MEETING OF THE PRIMARY CARE FORWARD GROUP – 1 JUNE 2012

(a) The Board noted the minute of the meeting of the Primary Care Joint Management Group held on 1 June 2012.

(b) In relation to Item 5.1, the Board agreed that information should be circulated
to members about the Enhanced Warfarin Management Service (copy Lothian specification and briefing on GP contracts and add-ons such as SESP's).

6. **MINUTE OF MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP – 10 MAY 2012**

The Board noted the minute of the meeting of the Primary Care Joint Management Group held on 10 May 2012.

7. **RISK MANAGEMENT IN THE CHCP – PRESENTATION**

The Board heard a presentation by Sharon Leitch (Senior Auditor, West Lothian Council) on the approach to risk management being adopted in the CHCP.

She explained the agreed joint use of the council's software system called Covalent to record and monitor risks, and the way in which risks were identified and scored to reflect the chances of them arising and their consequences for the partners.

She summarised the arrangements in place for regular monitoring and review of risks in the Risk Register by management and the ways in which that information would be communicated to the Board.

**Decisions**

1. To note the contents of the presentation on risk management in the CHCP and to thank Sharon for attending and for the information provided.

2. To note that an annual report would be brought to the Board to review the CHCP Risk Register after it had been reviewed and updated each year by officers.

8. **REDESIGN OF OLDER PEOPLE'S MENTAL HEALTH SERVICES**

The Board considered a report (which had been circulated) by the Head of Health Services updating Board members on the redesign of Older People's Mental Health Services.

The report explained the background to the redesign, and the purposes behind it before summarising the planned service changes and the progress to date against them.

The report concluded by advising that although the project was still in its first phase, good progress was being made, and the outreach model was being well-received by patients and carers and had increased staff satisfaction.

**Decisions**

1. To acknowledge the progress being made to address the challenges facing Older People's Mental Health Services.

2. To support the progress being made in development and implementation of the project.

9. **PERFORMANCE MANAGEMENT IN THE CHCP**

The Board considered a report (which had been circulated) by the CHCP Director updating the Board on performance management within the CHCP, providing
details of the broad suite of key operational performance indicators across activity within the CHCP, and explaining the work ongoing to add measures related to GP practices and community nursing.

The report set out the background to the CHCP's approach to performance management through the use of Covalent, advising of the reporting and monitoring arrangements and the work undertaken to extend the approach to the NHS side of the CHCP.

The appendix to the report provided a detailed report on the 64 key indicators, of which 55 were on target or better, and an explanation of the indicator which was below target.

Finally, the report explained that there were further lower-level indicators used on a weekly basis by operational managers to monitor performance on an ongoing basis.

Decisions

1. To support and note:

(a) the continued progress of the integrated approach to performance management.

(b) the current performance across 64 key indicators, of which 55 are to target or better, with only 1 below target.

(c) that performance in the activity which is below target is being addressed by management action.

2. To agree that ways to make the Covalent reports more accessible and understandable should be explored with the Chair.

3. To agree that whilst future performance reports would include the full suite of CHCP Performance Indicators, the report, presentation and discussion at the relevant Board meetings would concentrate on each Life Stage in turn.

10. INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND - CONSULTATION ON PROPOSALS - REPORT BY CHCP DIRECTOR

The Board considered a report (which had been circulated) by the CHCP Director asking Board members to agree the CHCP response to the Scottish Government's consultation on the integration of adult health and social care services in Scotland, subject to the approval of appropriate governance mechanisms in West Lothian Council and NHS Lothian.

The report set out the background to the consultation, and the key elements in it, before summarising the proposals and the ways in which the draft response had been informed by extensive consultation.

The proposed response, which would still require final approval by both council and health Board, was in the appendix to the report.

Decision

1. To agree in principle the draft CHCP response to the consultation.
2. To agree that the CHCP Director should continue to refine the response following the receipt of further comment.

3. To note that the final response will be subject to the approval of the appropriate governance mechanisms in West Lothian Council and NHS Lothian.

4. To authorise the CHCP Director to seek that approval, to thereafter submit the consultation response, and to report the final version at a future meeting of the CHCP Board.

11. SCOTTISH GOVERNMENT CONSULTATION - GUIDANCE ON THE INVOLVEMENT OF GPS IN MULTI-AGENCY ADULT PROTECTION ARRANGEMENTS - CHCP RESPONSE

The Board considered a report (which had been circulated) by the Head of Council Services providing an overview of the proposed CHCP response to the Scottish Government's consultation on "The Guidance on the Involvement of GPs in MAPPAs".

The report set out the background to the original consultation on the proposal in principle and its outcome, and summarised the draft guidance.

The Board was advised that overall the guidance document was positive and welcomed, but that there remained concerns (a) of a technical nature, (b) about the omission of cases where adults at risk have no GP, and the subsequent difficulty in getting them registered, and (c) the emphasis on local arrangements for fees rather than national arrangements.

The proposed response was contained in the appendix to the report.

Decisions

1. To note the contents of the report.

2. To approve the CHCP Response for submission to the Scottish Government on the Guidance on the Involvement of GPs in Multi-agency Adult Protection Arrangements document.

12. SCHEDULE OF DATES FOR 2013 CHCP BOARD MEETINGS

The Board considered a report (which had been circulated) by the CHCP Director suggesting meeting dates for the CHCP Board for the calendar year of 2013.

The proposed dates, in conformity with the CHCP Standing Orders, were 22 January, 19 March, 14 May, 25 June, 13 August, 8 October and 26 November.

Decisions

1. To agree the proposed dates for meetings of the CHCP Board in 2013.

2. To agree that meetings should continue to be held in the Strathbrock Partnership Centre.

13. CLINICAL GOVERNANCE - QUALITY IMPROVEMENT TEAMS, ANNUAL REPORT

The Board considered a report (which had been circulated) by the Clinical
Director informing the Board of progress of the Primary Care and Community Quality Improvement teams over the last year, and recommending actions to ensure continued effective delivery of the Quality Improvement programme.

The Lothian Quality Improvement Annual Report was attached to the report as Appendix 1 and contained the key issues. The report contained information in its own appendices in relation to the Team structures, the requirements of QI programmes and information on achievements, challenges and priorities.

**Decisions**

1. To continue to support the key principles of the QI process to ensure that the high profile of quality improvement is embedded through operational management.

2. To agree the priorities within the West Lothian QI programmes as contained in the report.

3. To continue to support QI teams in delivery of the programmes and ensure that effective mechanisms are in place to monitor progress.

4. To recommend that officers include a glossary of terms and abbreviations in future reports to assist Board members and the public to understand reports.

**14. CARE GOVERNANCE - CROFTHEAD HOUSE NURSING HOME - DOSON LTD**

The Board considered a report (which had been circulated) by the Head of Council Services updating the Board about Crofthead Nursing Home and the contingency planning arrangements in place to support the continuity of care and the interests of residents in the Home.

The report explained the financial position of the Home's parent company, and the appointment of a Receiver to manage the Home on an interim basis. It confirmed the Receiver's view that the financial difficulties related more to services based in England than to Crofthead and that the expectation was that a buyer would be found for Crofthead as a going concern.

The report concluded by explaining that contingency plans were in place to ensure continuity of care for residents and to safeguard their interests, involving the appointment of a Liaison Officer and a review of all Care Plans. The Contingency Plan was contained in the appendix to the report.

**Decisions**

1. To note the contents of the report.

2. To approve the proposed contingency arrangements outlined in the plan.

**15. STAFF GOVERNANCE**

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

The report provided information about the council's Leadership Programme, the steering group established by NHS Lothian to review management culture, and the new NHS Standards of Business Conduct.
Decisions

1. To note the progress of the leadership programme within West Lothian Council.

2. To note the review of the management culture within NHS Lothian.

3. To note the new guidance on NHS standards of business conduct.

16. POLYPHARMACY PROJECT 2012-13 (PRELIMINARY REPORT)

The Board considered a report (which had been circulated) by the Head of Health Services highlighting the preliminary results of analysed data from poly-pharmacy reviews undertaken to date within Lothian and to inform the Board of the continued work planned for this financial year.

The report set out the background to the project and the ways in which GP practices had been invited to take part, and had taken part in the project to date. It explained the way in which the project was implemented with patients, the methods used to capture and record data, and then the approach taken to analysing the data retained.

It went on to summarise the key messages drawn from that data analysis, the efficiencies identified and the savings which may be anticipated based on the analysis.

The Review's Service Level Agreement with GP practices was contained in Appendix 1 to the report, and Appendix 2 contained a summary of the specifically West Lothian aspects of the project.

Decisions

1. To note the governance in place supporting the polypharmacy project.

2. To note the preliminary results from analysed reviews which will be shared with the national Efficiency and Productivity Workgroup.

3. To note the data specific to West Lothian in Appendix 2 to the report.

4. To note the ongoing recruitment of pharmacists to conduct further polypharmacy reviews and to support continued funding of this workstream.

17. RESOURCE TRANSFER MONITORING REPORT

The Board considered a report (which had been circulated) by the Head of Council Services providing details of the phased expenditure incurred in the period to 30 June 2012, and the achievement of a continued zero delayed discharge position.

Decisions

1. To note the information provided about the investment of resource transfer monies in West Lothian, and the outcomes achieved, in the first quarter of the year.

2. To agree that West Lothian Council should continue to invest the resource transfer monies effectively in the prescribed areas and continue to maintain a
zero delayed discharge position.


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

The report advised that the anticipated draft out-turn for the CHCP as a whole, and for both services, was for a break-even out-turn.

The report outlined the expected pressure areas for the council and NHS Lothian elements of the budget, and advised that the first full monitoring would be in August to be reported to the next meeting of the Board.

Decisions

1. To note the out-turn figures provided for Council and Health Services, and the CHCP as a whole, for the first quarter of the year

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

19. DIRECTOR’S REPORT

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

The Board was provided with information in relation to the position of CHCP Chair, the appointment of Elaine Duncan as the Lead GP for the CHCP, the confirmation of Tim Davison as the permanent Chief Executive of NHS Lothian, and the twenty-first edition of West Life.

Decisions

1. To note the appointment of Frank Toner as CHCP Chair.

2. To note the appointment of Elaine Duncan as CHCP Lead GP

3. To note the appointment of Tim Davison as Chief Executive, NHS Lothian.

4. To note the publication of the twenty-first edition of West Life.

5. To agree that the CHCP Director should explore with the Chair the possibility of organising a CHCP development day once the final CHCP Board member was in place.
CHAIRMAN'S REPORT

1. Internal

1.1 Board Vice Chair - Expressions of interest

Expressions of interest for the post of Board Vice Chair were invited in the September Chair's report. At the indicated closing date just one expression of interest was received, from Mrs Shulah Allan. The Chair fully supports this expression of interest, and now seeks the Board's confirmation of her appointment to this role. This appointment will be effective until the end of her term on the Board.

1.2 Council Leaders

In this period, I had meetings with the Leaders of Midlothian and East Lothian Councils. This was as part of the liaison process following the May elections (the delay reflected diary pressures). The main topic in both meetings was the integration of health and social care.

1.3 Teapot Trust

On 26 September, I hosted a visit by the Health Minister, Mr Michael Matheson, to the Teapot Trust. This relatively new charity provides art resources for patients at the Royal Hospital for Sick Children.

2. External

2.1 Parliamentary Receptions

In this period, I represented the Board at parliamentary receptions for Nourish (sustainable food) and for ‘Walk the Walk’ (the cancer charity).

2.2 Institute of Health Managers

As Chair of Chairs, I gave some introductory remarks at the IHM conference on 2 October, marking the renewal of the involvement of the Chairs’ Group in this annual event.
2.3 Daily Record Health Awards

On 3 October, I sat as a member of the judging panel for the Daily Record annual Health Awards.

2.4 Midlothian Community Gardens

On 3 October the Provost of Midlothian opened the Midlothian Community Gardens, NHS Lothian’s second community garden. It is located alongside the Midlothian Community Hospital, and will be for the use of community groups, patients, and staff. The site gives emphasis to access for those with limited mobility.

2.5 Other Events

In this period, I also attended a reception of the Crisis charity and the Baker Tilly Leadership lunch.

Charles Winstanley
Chairman
12 October 2012
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for October 2012.

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 5. 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 measures at every other Board meeting.

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 has recently commenced production of a Hospital Scorecard. 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. The next scorecard will be considered at the October meeting of the Government Health and Social Care Management Board.

3.7 Clinical Effectiveness Measure - Diabetes

3.7.1 The measures are as follows:

- Diabetes mortality;
- Blood pressure control for people with Type 1 and Type 2 diabetes;
- Control of blood sugars for people with Type 1 and Type 2 diabetes;
- Diagnosis of end stage renal failure in people with Type 1 and Type 2 diabetes;
- Recording of smoking status for people with Type 1 and Type 2 diabetes;
- Percentage of eligible diabetic population successfully screened for retinopathy.

The data presented are from the Scottish Care Information Diabetes Collaboration (SCI DC information system). The latest data were released in August 2012 and have also been the subject of a response to the Scottish Government about the Board’s performance in comparison to elsewhere in Scotland.

Mortality
Diabetes mortality remains similar in Lothian (3.4%) to that across Scotland overall (3.5%).

Blood pressure control
Of those for whom data is available, 46% of people with Type 1 diabetes and about a third of people with Type 2 diabetes have their systolic blood pressure controlled within SIGN limits; similar to the position across Scotland. It is important to note that tight control of blood pressure may not be appropriate in all cases; particularly those patients with additional medical problems.

Blood glucose control
It is of concern that both in Lothian and across Scotland as a whole approximately one third of patients with type 1 diabetes have poor blood glucose control (31% and 37% over recommended limits respectively) (Table 1).

The Lothian Diabetes Managed Clinical Network (MCN) is prioritising redesign of services for patients with type 1 diabetes. This process has just been initiated; work will take place over the next 6 months and will include feedback from patients and liaison with colleagues in telehealth and telecare to support improved monitoring of the patients’ condition. Type 1 patients in Lothian also have access to DAFNE (Dose Adjustment for Normal Eating) structured educational courses which support better understanding of the condition and hence improved control. Work is taking place to ensure a sustainable funding stream is available so these courses will continue to be accessible across Lothian in future at a frequency to meet patient need.
Blood glucose control for patients with type 2 diabetes in Lothian is similar to that across Scotland. The Lothian Diabetes MCN has been working to redesign the pathway for newly diagnosed patients with type 2 diabetes. This will shortly be going out for wider consultation with primary and community care partners. Patients with Type 2 diabetes can also access DE SMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) structured education to support improved control. The appointment of a Scottish Diabetes Group funded diabetes patient education co-ordinator will allow current variable provision of DE SMOND to be addressed and the needs of specific groups, such as people from Black and Minority Ethnic communities to be responded to.

End stage renal failure
The proportions of those with types 1 and 2 diabetes who develop end stage renal failure are similar to Scotland overall (Table 1). RIE, WGH and St John’s have well-established joint diabetes renal clinics, co-staffed by diabetes and renal physicians.

Table 1: Blood pressure control, blood glucose control and development of end stage renal failure for patients with type 1 and type 2 diabetes for Lothian and Scotland (2011)

<table>
<thead>
<tr>
<th>Systolic blood pressure controlled within SIGN guideline limits</th>
<th>Lothian % (n)</th>
<th>Scotland % (n)</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>46.3 % (1729)</td>
<td>46.5% (11238)</td>
<td>10.5% (439)</td>
</tr>
<tr>
<td>Type 2</td>
<td>32.6% (9238)</td>
<td>31.7% (64893)</td>
<td>4.2% (1244)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood glucose level over recommended limits (75 mmol/mol, 9%)</th>
<th>Lothian</th>
<th>Scotland</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>31.1% (1058)</td>
<td>37.3% (9071)</td>
<td>771</td>
</tr>
<tr>
<td>Type 2</td>
<td>12.7% (3249)</td>
<td>14.6% (199626)</td>
<td>4048</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis of end stage renal failure</th>
<th>Lothian</th>
<th>Scotland</th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>0.9% (36)</td>
<td>1% (292)</td>
<td>-</td>
</tr>
<tr>
<td>Type 2</td>
<td>0.6% (171)</td>
<td>0.5% (1009)</td>
<td>-</td>
</tr>
</tbody>
</table>

Blood pressure control = percentage of patients with Systolic BP <130 mmHg recorded in previous 15 months (within SIGN guideline limits)
Source: Scottish Diabetes Survey 2011, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care

Smoking
Smoking status is well recorded in diabetic patients in Lothian. Lothian has a higher proportion of smokers than in Scotland overall (Table 2); the MCN is linking with smoking cessation services to address this.

Table 2: Recording of smoking status for patients with type 1 and type 2 diabetes for Lothian and Scotland (denominator = those with recording of smoking status)

<table>
<thead>
<tr>
<th>Smoking status recorded</th>
<th>Lothian</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker (%)</td>
<td>31.3</td>
<td>25.1</td>
</tr>
<tr>
<td>Ex-smoker (%)</td>
<td>31.3</td>
<td>20.3</td>
</tr>
<tr>
<td>Never smoked (%)</td>
<td>37.1</td>
<td>52.4</td>
</tr>
<tr>
<td>Recorded (%)</td>
<td>99.3</td>
<td>95.9</td>
</tr>
</tbody>
</table>

| **Type 2**              |         |          |
| Current smoker (%)      | 20.7    | 18.5     |
| Ex-smoker (%)           | 38.2    | 36.2     |
| Never smoked (%)        | 41.1    | 45.3     |
| Recorded (%)            | 99.9    | 99.6     |

Source: Scottish Diabetes Survey 2011, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care
Diabetic retinopathy
Lothian successfully screened 82% of type I patients and 87% of type 2 patients eligible for diabetic retinopathy over a 15 month period, similar to Scotland overall (Table 3).

This year the service in Lothian carried out a small survey exploring reasons for non-attendance. A variety of reasons were given, including caring commitments, travel, not realising the difference between an optician and eye screening. NHS Lothian is part of the national work to redesign the information provided pre-screening and is also testing use of telephone reminders in some hard-to-reach groups.

Table 3: Percentage of people with diabetes (type 1 and type 2) who were recorded as having had diabetic retinopathy screening within the previous 15 months for Lothian and Scotland (2011) (includes those screened by the Diabetic Retinopathy Screening Programme, those attending ophthalmology clinics and those clinically suspended)*

<table>
<thead>
<tr>
<th>Retinal screening</th>
<th>Lothian % (n)</th>
<th>Scotland % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>82 (3329)</td>
<td>80.6 (21991)</td>
</tr>
<tr>
<td>Type 2</td>
<td>87.1 (25745)</td>
<td>87.2 (189750)</td>
</tr>
<tr>
<td>Total screened or suspended</td>
<td>29,074 (86.5%)</td>
<td>211,741 (86.5%)</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>13.5 (4535)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Scottish Diabetes Survey 2011, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care.
†Note children under the age of 12 are excluded from screening.
Patients can be suspended temporarily or on a permanent basis. Reasons for temporary suspension include people who are out of the country or unavailable for a limited period. People may be permanently suspended if they are unable to tolerate screening; permanent suspension also includes patients who have died.
National screening uptake figures produced by the Diabetic Retinopathy Screening service are not directly comparable to those included in the Scottish Diabetes Survey (shown below). This is because the national service looks at everyone attending a screening centre, rather than residents of a particular Board area.
Quality Dashboard September 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.

### Quality Ambition: Person-centred

#### Process Measures
- 20-day Complaints Response Rate
- 3-day Complaints Response Rate

#### Outcome Measures
- Number of complaints

### Quality Ambition: Safe

#### Process Measures
- Incident Management Key Performance Indicator *
- Hand Hygiene Compliance
- Peripheral Vascular Catheter Compliance *
- Early Warning Score Compliance *
- Medicine Reconciliation Compliance *

#### Outcome Measures
- Hospital Standardised Mortality Ratios for RIE, WGH & St. John’s
- Incidents with harm *
- Adverse Event Rate *
- *C. Difficile* Rate *
- *Staph. Aureus Bacteraemia* Rate *

### Quality Ambition: Effective

#### Process Measures
- Falls Prevention Compliance *
- Pressure Ulcer Compliance *
- Admission to stroke unit on day or day after admission *
- Stroke Treatment Measure: CT Scan *
- Stroke Treatment Measure: Swallow Screen *

#### Outcome Measures
- Inpatient Falls with Harm *
- Inpatient Pressure Ulcers Grade 2 or above *
- Nursing Medication Administration Incidents *

### Additional Quality Measures

**Hospital Scorecard: Jan-Dec 2011 (Next release October 2012)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate Per 1000 admissions</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>21.15</td>
<td>20.30</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>41.96</td>
<td>38.82</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>50.63</td>
<td>47.15</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>114.92</td>
<td>105.85</td>
</tr>
</tbody>
</table>

**Lothian**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</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>0.96</td>
</tr>
</tbody>
</table>

**Scotland**

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

1 Note that these arrows have not been assigned following a formal set of rules; they are more of a general indication of the last period’s data. For example HSMR is shown to be remaining stable across Lothian, although the actual ratios for the last quarter 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</th>
<th>Title: Number of Complaints</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-Jun 2012)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Jun '09</td>
<td>83%</td>
</tr>
<tr>
<td>Jul - Sep '09</td>
<td>94%</td>
</tr>
<tr>
<td>Oct - Dec '09</td>
<td>83%</td>
</tr>
<tr>
<td>Jan - Mar '10</td>
<td>86%</td>
</tr>
<tr>
<td>Apr - Jun '10</td>
<td>81%</td>
</tr>
<tr>
<td>Jul - Sep '10</td>
<td>79%</td>
</tr>
<tr>
<td>Oct - Dec '10</td>
<td>70%</td>
</tr>
<tr>
<td>Jan - Mar '11</td>
<td>61%</td>
</tr>
<tr>
<td>Apr - Jun '11</td>
<td>80%</td>
</tr>
<tr>
<td>Jul - Sep '11</td>
<td>78%</td>
</tr>
<tr>
<td>Oct - Dec '11</td>
<td>78%</td>
</tr>
<tr>
<td>Jan - Mar '12</td>
<td>76%</td>
</tr>
<tr>
<td>Apr - Jun '12</td>
<td>75%</td>
</tr>
</tbody>
</table>

Data Source: Datix

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Jun '09</td>
<td>374</td>
</tr>
<tr>
<td>Jul - Sep '09</td>
<td>267</td>
</tr>
<tr>
<td>Oct - Dec '09</td>
<td>283</td>
</tr>
<tr>
<td>Jan - Mar '10</td>
<td>293</td>
</tr>
<tr>
<td>Apr - Jun '10</td>
<td>243</td>
</tr>
<tr>
<td>Jul - Sep '10</td>
<td>224</td>
</tr>
<tr>
<td>Oct - Dec '10</td>
<td>109</td>
</tr>
<tr>
<td>Jan - Mar '11</td>
<td>224</td>
</tr>
<tr>
<td>Apr - Jun '11</td>
<td>243</td>
</tr>
<tr>
<td>Jul - Sep '11</td>
<td>257</td>
</tr>
<tr>
<td>Oct - Dec '11</td>
<td>303</td>
</tr>
<tr>
<td>Jan - Mar '12</td>
<td>321</td>
</tr>
<tr>
<td>Apr - Jun '12</td>
<td>344</td>
</tr>
</tbody>
</table>

Data Source: Datix

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Jun '11</td>
<td>99%</td>
</tr>
<tr>
<td>Jul - Sep '11</td>
<td>97%</td>
</tr>
<tr>
<td>Oct - Dec '11</td>
<td>97%</td>
</tr>
<tr>
<td>Jan - Mar '12</td>
<td>93%</td>
</tr>
<tr>
<td>Apr - Jun '12</td>
<td>68%</td>
</tr>
<tr>
<td>Jul - Sep '12</td>
<td>93%</td>
</tr>
<tr>
<td>Oct - Dec '12</td>
<td>0%</td>
</tr>
</tbody>
</table>

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 15% reduction against 2006/07 baseline by 2012.</td>
</tr>
</tbody>
</table>

#### Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – March 2012

Data Source: ISD (Quarterly)

Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – March 2012

Data Source: ISD (Quarterly)

### Safe: Reduction in Incidents with Harm and improved Incident Management

<table>
<thead>
<tr>
<th>Title</th>
<th>Incident Management Key Performance indicators (KPIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Incidents with harm</td>
</tr>
</tbody>
</table>

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%

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.

Process Measure

Outcome Measure

Data Source: Datix

Title: Adverse Event Rate (NHS Lothian Acute Hospitals)

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

Outcome Measure

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

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

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

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

**Goal:** 95% Compliance

---

**C. difficile associated disease rate against HEAT Target 2011-12**

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

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

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

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards’ rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less. **Rate at August 2012 – 0.33**

---

**Process Measure**

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

**Outcome Measure**

- **Data Source:** Health Protection Scotland

---

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

- **Month-Year**
  - Apr 10
  - May 10
  - Jun 10
  - Jul 10
  - Aug 10
  - Sep 10
  - Oct 10
  - Nov 10
  - Dec 10
  - Jan 11
  - Feb 11
  - Mar 11
  - Apr 11
  - May 11
  - Jun 11
  - Jul 11
  - Aug 11
  - Sep 11
  - Oct 11
  - Nov 11
  - Dec 11
  - Jan 12
  - Feb 12
  - Mar 12
  - Apr 12
  - May 12
  - Jun 12
  - Jul 12
  - Aug 12
  - Sep 12
  - Oct 12
  - Nov 12
  - Dec 12
  - Jan 13
  - Feb 13
  - Mar 13

- **Number of CDI Episodes**
  - 0
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10

- **HEAT Target**
  - 0.39

- **Trend**
  - Results above the dotted line not on HEAT Target

---

**Month-Year**

- Apr 10
- May 10
- Jun 10
- Jul 10
- Aug 10
- Sep 10
- Oct 10
- Nov 10
- Dec 10
- Jan 11
- Feb 11
- Mar 11
- Apr 11
- May 11
- Jun 11
- Jul 11
- Aug 11
- Sep 11
- Oct 11
- Nov 11
- Dec 11
- Jan 12
- Feb 12
- Mar 12
- Apr 12
- May 12
- Jun 12
- Jul 12
- Aug 12
- Sep 12
- Oct 12
- Nov 12
- Dec 12
- Jan 13
- Feb 13
- Mar 13
Safe: Compliance with Peripheral Vascular Bundles

Title: Percent compliance with PVC Bundle (NHS Lothian Acute Hospitals)

Numerator: Total number of patients who have all elements of the PVC bundle in place

Denominator: Total number of patients reviewed per month. \( n=1000 \)

Goal: 95% Compliance

---

Staph. aureus bacteraemias (SABs) rate against HEAT Target 2011-12

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

Numerator: The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)

Goal: Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less. Rate at August 2012 – 0.29

---

Process Measure

Outcome Measure

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

Data Source: Health Protection Scotland

Source Data: Local Audits (QIDS)
Safe: Improved management of the deteriorating patient. Compliance with Early Warning Score Bundle

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

Numerator: The total number of SEWS observations completed correctly

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

Goal: 95% Compliance

Process Measure

Source Data: Local Audits (QIDS)

Outcome Measure

OUTCOME MEASURE TO BE DETERMINED
<table>
<thead>
<tr>
<th>Month</th>
<th>Process Measure</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb-11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-11</td>
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<td></td>
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<tr>
<td>Apr-11</td>
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<tr>
<td>May-11</td>
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<tr>
<td>Jun-11</td>
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<td>Jul-11</td>
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<tr>
<td>Aug-11</td>
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<tr>
<td>Sep-11</td>
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<td>Oct-11</td>
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<td>Apr-12</td>
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<td>May-12</td>
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<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></td>
<td></td>
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<tr>
<td>Nov-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: QIDS
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)</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>

**Outcome Measure**

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

**Process Measure**

Compliance with Clinical Quality Indicator: Falls

**Data Source:** QiDS

---

**Title:** Patient Falls with Harm

| Numerator: | Number of falls reported with harm, moderate, major/ death |
| Goal: | 20% reduction in inpatients falls and associated harm by March 2013 |

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

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

**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

**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**

Data Source: QiDS

---

**Outcome Measure**

Data Source: Datix

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

Target = Zero by March 2014
Effective: Delivering Better Care - Reduction in Nursing Medication Administration Incidents

Title: Number of Nursing Medication incidents per month

Numerator: Number of all medication incidents

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

Outcome Measure

All NHS Lothian

Number of Nursing Administration of Medication Incidents:
All incidents

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

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

**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

---

**Title:** Stroke Treatment Measures

**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 admitted to acute stroke unit within one day of admission**

- **HEAT target:** 90%
- **2012 Target:** 80%

**Process Measure**

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

- **Target:** 80%

**Data Source:** Scottish Stroke Care Audit

---

**Process Measure**

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

- **Target:** 100%
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.

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Clinical Governance & Risk Manager  
11 October 2012  
jo.bennett@nhslothian.scot.nhs.uk

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

List of Appendices

Appendix 1: Supporting Technical Appendix
APPENDIX 1

Technical Appendix

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

Adverse Events
Adverse events are currently measured at the three main acute sites using retrospective case note reviews using the ‘Global Trigger Tool’. An external review by the Institute for Healthcare Improvement (IHI) in February 2010 confirmed that NHS Lothian’s case note review process was robust and set the baseline for adverse event rates at 52 adverse events per 1,000 patient days. For Patient Safety Measures, please refer to measurement plan on the NHS Lothian Intranet - http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGovernanceinNHSLothian/SPSP/Workstreams/Documents/SPSP%20Measurement%20Plan.pdf

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

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

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

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

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

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

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

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

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations. [http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs](http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs)
HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

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

2 Recommendations

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

• Maintain enhanced weekly surveillance of Meticillin Resistant Staphylococcus aureus and Meticillin Sensitive Staphylococcus aureus Bacteraemia to target resources for a sustained reduction.

• Support the reduction of healthcare associated Clostridium difficile Infection by promoting compliance with the antimicrobial stewardship recommendations.

• Support the development of an escalation process for failure to comply with hand hygiene policy and support progress for approval.

• Support the ongoing work with mandatory surveillance.

• Increased compliance with best practice, as recommended by the Antimicrobial Management Team.

3 Discussion of Key Issues

3.1 Staphylococcus aureus Bacteraemia: there were 24 episodes of Staphylococcus aureus Bacteraemia in September 2012 (2 Meticillin Resistant Staphylococcus aureus, 22 Meticillin Sensitive Staphylococcus aureus), compared to 15 in August 2012 (0 Meticillin Resistant Staphylococcus aureus, 15 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 0.30 (updated to September 2012). In order to achieve the target, NHS Lothian has to average no more than 17 episodes per month for the twelve month period, with a current average of 19 episodes per month.

3.2 Clostridium difficile Infection: there were 25 episodes of Clostridium difficile Infection in patients aged 65 or over in September 2012, compared to 29 in August 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 September 2012). In order to achieve the target, NHS Lothian has to average no more than 27 episodes per month for the twelve month period.
3.3 Norovirus outbreaks: a modified point prevalence report that includes data on wards with one or more bays closed to admissions is submitted weekly to Health Protection Scotland and published on their website. Within NHS Lothian, outbreaks in the hospitals and community have already been investigated for the current season.

3.4 The 21st bi-monthly national hand hygiene audit report was published by Health Protection Scotland on 26/9/2012. This indicated NHS Lothian was achieving a hand hygiene compliance of 97%, which exceeds the national compliance rate of 96%.

<table>
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<tr>
<th>Table 1: National and NHS Lothian hand hygiene compliance by staff groups</th>
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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 draft escalation policy for non-compliance with hand hygiene is currently awaiting approval by Partnership and the Local Negotiating Committee. A meeting is planned at the end of this month to discuss further.

3.5 Mandatory Surgical Site Infection Surveillance: monthly and quarterly reports are compiled and distributed to the clinical areas and any actions required discussed. These reports/figures are placed on the information display boards for staff, patients and visitors. For April-June 2012, there were 1120 procedures performed and 8 Surgical Site Infections detected. The Surgical Site Infections rate for all the procedures within NHS Lothian were below the national rate. Table 2 shows Surgical Site Infections for abdominal hysterectomy (inpatient), Caesarean section (inpatient and post-discharge surveillance to day 10), hip arthroplasty (inpatient and readmission to day 30) and repair of neck of femur (inpatient) within NHS Lothian.

<p>| Table 2: National and NHS Lothian surgical site infection rates 1/4/2012-30/6/2012 |
|-------------|-------------|-------------|-------------|</p>
<table>
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<tr>
<th>Procedures</th>
<th>NHS Lothian Number of Procedures</th>
<th>NHS Lothian Surgical Site Infections</th>
<th>NHS Lothian Surgical Site Infection rate (%)</th>
<th>National Surgical Site Infection rate (%)</th>
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</thead>
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<tr>
<td>Abdominal hysterectomy</td>
<td>120</td>
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<td>0.8</td>
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<td>Caesarean Section</td>
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<tr>
<td>Hip Arthroscopy</td>
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<tr>
<td>Repair of Neck of Femur</td>
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3.6 The Healthcare Environment Inspectorate: NHS Lothian updated their Healthcare Associated Infection Self Assessment, returned to the Healthcare Environment Inspectorate by the deadline of 21/9/2012. The Healthcare Environment Inspectorate have also issued a revised Inspection Methodology, which notes from October 2012 the Inspectorate plan to undertake a minimum of thirty inspections
per year in both acute and community hospitals, announced and unannounced. There will also be changes to the escalation procedures of the Inspectorate.

3.7 Incident updates for October 2012: the Infection Prevention and Control Team have been involved in investigating several incidents, including: *Clostridium difficile* Infection at the Western General Hospital; *Clostridium difficile* Infection at St John’s Hospital; an increased number of patients with *Clostridium difficile* Infection in NHS Lothian; norovirus outbreaks.

3.8 Antimicrobial Management Team:
3.8.1 Alert antibiotic pilot-study: the Alert Antibiotic Policy Pilot-Study has been running at the Royal Infirmary Edinburgh site since the beginning of February. It has been approved by the Clinical Management Group for implementation at the Royal Infirmary Edinburgh on a permanent basis, with extension to the Western General Hospital and St John’s Hospital. This policy supports the appropriate use of selected broad-spectrum antibiotic agents (termed ‘alert antibiotics’) to reduce the development of antibacterial resistance. It is planned that the policy will be extended to St John’s Hospital in November and the Western General Hospital shortly afterwards.

3.8.2 Antibiotic Prescribing indicators: the target level for compliance with the guidelines and documentation of indication is 95%. In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is above the target level for the Western General Hospital and the Royal Infirmary Edinburgh (with 100% compliance) and below target level for St John’s Hospital (with 75% compliance). All the sites are above the target level for documentation of indication for antibiotic treatment (with 100% compliance). For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy has remained above target at 100% compliance in the last month; administration of single dose antibiotic prophylaxis has also remained above the target level at 100% compliance. The target level for both prescribing indicators is 95% compliance with Surgical Prophylaxis Guidelines and administration of a single dose of surgical prophylaxis.

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Failure to comply with hand hygiene increases the potential risk of transmission of infection.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Increased numbers of Healthcare Associated Infections leads to adverse patient harm as well as failure to comply with 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 was reviewed in April 2012 and adjusted to medium to reflect ongoing work with infection prevention and control and the Patient Safety team. 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 The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection is variable, depending on increased length of stay and additional treatment requirements.

Fiona Cameron
Head of Service, Infection Prevention and Control
11 October 2012
fiona.cameron@nhslothian.scot.nhs.uk

List of Appendices

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

SAB There were 24 SAB recorded during September 2012 (2 MRSA & 22 MSSA). The lowest number recorded in the last 12 month period is 15 (August 2012).

CDI There were 33 CDI recorded in September 2012, 25 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.

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

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

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Royal Infirmary of Edinburgh

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

Clostridium difficile Infection (CDI)
There were 11 CDI recorded during September 2012.

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

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

Total Staphylococcus aureus Bacteraemia (SAB) Cases

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MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**

There were two SAB recorded during September 2012.

**Clostridium difficile Infection (CDI)**

There were 10 CDI recorded during September 2012.

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

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

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

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**MRSA Bacteraemia Cases**

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

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during September 2012.

---

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

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

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**Liberton Hospital**

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

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

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

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

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**Staphylococcus aureus Bacteraemia (SAB)**

There were no SAB with the onset greater than 48 hours after admission recorded during September 2012.

**Clostridium difficile Infection (CDI)**

There were no CDI recorded during September 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**

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

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**MRSA Bacteraemia Cases**

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**MSSA Bacteraemia Cases**

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Royal Victoria Hospital

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

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

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

**Staphylococcus aureus Bacteraemia (SAB)**
Patients who are identified with a SAB within 48 hours of admission to Hospital are included in this report card. During September 2012 there were 16 SAB recorded.

**Clostridium difficile Infection (CDI)**
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice’s. During September 2012 there were 9 CDI recorded.

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<td>9</td>
<td>11</td>
</tr>
<tr>
<td>M-12</td>
<td>14</td>
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</tr>
<tr>
<td>A-12</td>
<td>13</td>
<td>16</td>
</tr>
</tbody>
</table>

---

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

- **MRSA Bacteraemia Cases**

- **MSSA Bacteraemia Cases**

---

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

- **MRSA Bacteraemia Cases**

- **MSSA Bacteraemia Cases**

---

This is the new Report Card Format introduced by Scottish Government July 2011.
WAITING TIMES PROGRESS AND PERFORMANCE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on waiting times performance and progress 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 ongoing reductions in inpatient waits and particularly in outpatient numbers with both the number of outpatients and inpatients over 12 weeks falling by over a quarter in a month;

2.2 Recognise both the possibility of inpatients over 12 weeks at the end of December and the steps being taken to address that risk;

2.3 Note the work ongoing to reduce the long delays experienced by patients waiting for surveillance and other “repeat” endoscopies; that steps are being taken to see those of highest clinical priority, and also note the pressure on the diagnostic arm of the same service;

2.4 Acknowledge ongoing work being undertaken to standardise waiting list management in light of the Treatment Time Guarantee, which came into force earlier this month, and to provide assurance of practice in this regard.

2.5 Note the work progressing following release of national guidance relating to the Treatment Time Guarantee and the intention to reflect these new definitions and measurement in future reports as the guarantee comes into force; and

2.6 Recognise the variables, risks and areas of uncertainty around these actions;
3 Background

3.1 As reported to the Board and its subcommittees previously over recent months, additional activity has been 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 earlier this 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 1st 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.

<table>
<thead>
<tr>
<th>Table 1 - Inpatient and Daycase Waiting List Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Over 12 Weeks</td>
</tr>
<tr>
<td>Over 9 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>

Source: MMI returns; Performance Review

4.2 The position for inpatients and daycases over 12 weeks at the end of September fell by over a quarter on the month previously and at the upper end of the range outlined to the Board at its previous meeting.

The trend since April 2011 is shown in

4.3 Figure 1.

\(^1\) For more information see [http://www.scotland.gov.uk/Resource/0039/00390166.pdf](http://www.scotland.gov.uk/Resource/0039/00390166.pdf)
Figure 1 – Inpatient and Daycase Waiting List

INPATIENT/DAY CASE WAITING LIST - MONTH END

![Bar chart showing inpatient and daycase waiting list over time with source: Management MMI; ISD Data Warehouse]

Figure 2 – Inpatient and Daycases over 12 weeks

INPATIENTS/DAY CASES OVER 12 WEEKS - WEEKLY MONITORING

![Line chart showing inpatient and daycases over 12 weeks with source: Performance Review (report issued for operational management), 18th October]

2 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
4.4 Operational information suggests that the reduction is slowing slightly (Figure 2) during October, and this appears to be within the General Surgery Clinical Management Team. This stabilisation is also evident in the changes in total list size for these areas, shown in Figure 3.

4.5 Board members will recall that this Clinical Management Team is one where significant outpatient activity was being undertaken. The stabilisation of the list size suggests that the additional activity being undertaken to treat inpatients and daycases in the area is being counterbalanced by the additional outpatients being seen who are then added to the waiting list for an inpatient or day case treatment.

Figure 3 – Inpatient Waiting List Size – General Surgery and Head & Neck CMTs

![Graph showing inpatient waiting list size for General Surgery and Head & Neck CMTs over time.]

Source: Performance Review (report issued for operational management), 18th October

4.6 Given the importance of appropriately using theatre capacity, recent reports have included information on utilisation of this asset. The improvement suggested in ENT and Plastic Surgery last month as a result of ensuring patient attendance does not appear to have been maintained during September, consequentially it has been agreed that the current process for scheduled theatre cases at St Johns will be realigned to both surgeon availability and the casemix to be seen. This could produce an improvement of around 10% utilisation in a list.

3 Board members will recall from the June board paper that ophthalmology was excluded from the figure due to inconsistent recording of “second eye” cataract patients. The reported position for the specialty is also affected by premature and duplicate listing of patients. Support is being given to staff to address these data quality issues.
5 Current Position - Outpatients

5.1 At the last board meeting, board members were briefed on the likely reduction in outpatient numbers by the end of September. This was focussed in areas where the see and treat proposals outlined to board members previously had been targeted.

5.2 Figure 5 shows the change in the numbers over 12 weeks in the see and treat specialties. All five specialties have seen a reduction, with the most marking being in general surgery, urology and gastroenterology.

5.3 The table below outlines the number of outpatients over 12 weeks, unavailability and overall list size since April 2012. In the most recent month, the total number over 12 weeks has fallen by over a quarter. Figure 6 presents a longer time period graphically.

Table 2 - Outpatient Waiting List Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
</tr>
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<tr>
<td>Over 12 Weeks</td>
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<td>4601</td>
<td>5177</td>
<td>5069</td>
<td>4962</td>
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<td>38887</td>
<td>39346</td>
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<tr>
<td>Unavailable</td>
<td>963</td>
<td>1044</td>
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<td>1204</td>
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<tr>
<td>Total List Size</td>
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<td>39585</td>
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<td>40066</td>
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<tr>
<td>Percentage Unavailable</td>
<td>2.4%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>3.0%</td>
<td>2.3%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Source: MMI returns; Performance Review
5.4 The focus on outpatient reduction has resulted in the list size falling across the specialties with the highest number of long waiters and this is illustrated in Figure 7.

4 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
As indicated in 4.5, this additional activity looks likely to be impacting on the inpatient list size as patients requiring treatment are identified in outpatient clinics. It is also, with regard to gastroenterology and general surgery patients, increasing the number of referrals to endoscopy, as highlighted last month and later in Section 7.

Figure 7 - Outpatient Waiting List in specialties with largest variances

Source: Performance Review (report issued for operational management), 15th October

6 Timescales and Routes to Recovery of Inpatient and Outpatient Waits

6.1 As indicated at previous board meeting, work has been focussed on reducing the number of inpatients and daycases over 12 weeks with the aim of no patient being over this threshold by the end of the calendar year.

6.2 Discussions internally suggest that this will happen across many specialties that have had long waits over the last year. However a small number of areas are finding it difficult to find the necessary capacity to accommodate this volume of patients.

6.3 As board members will be aware, there has been significant additional activity, both internally and externally, and rearrangements made to consultant’s work programmes to enable these patients to be seen. However a the time of writing, even with further patients having been identified for treatment in the independent sector, between approximately 400-500 patients in 4 areas are at risk of being over 12 weeks at the end of year – these are almost exclusively highly complex patients in plastic surgery, urology and colorectal surgery as well as some paediatric patients.

6.4 This contrasts to the current position, shown in appendix 1, where more than a dozen specialties are currently exceeding 12 weeks, potentially bringing to an end
the recent history of patients waiting longer than they should in orthopaedics, oral surgery, adult ENT and ophthalmology amongst others.

6.5 As would be expected, work is continuing to ensure that these patients are treated as soon as possible with opportunities for complex, tertiary level treatment for procedures such as complex breast surgery and complex bladder surgery being provided elsewhere in Scotland and beyond continuing to be pursued as well as consideration of alternatives internally. This is being progressed in the manner described in legislative regulations supporting the Act. Section 8 of these regulations\(^5\) outlines the expectation that where Boards are unable to meet the guarantee in their own area, they must take all reasonable steps for treatment at another Scottish Health Board, in the NHS elsewhere in the UK or at another suitable provider either in the UK or within another state of the European Economic Area or Switzerland.

6.6 As these patients were added to the waiting list prior to the 1\(^{st}\) October, they do not fall under the Treatment Time Guarantee, which requires treatment within 12 weeks. Discussion however at the Chief Executive’s Waiting Time Group reconfirmed that it was absolutely appropriate that clinical priority determined the order of treatment of the patient, despite the risks this may present in early 2013 in lack of compliance with the guarantee.

6.7 The Scottish Government Health Department are aware of both this risk and the decision of appropriate prioritisation.

6.8 As highlighted earlier in the paper, the outpatient position has improved in recent months. This is expected to continue with additional clinics organised across the same clinics. This is expected to show significant reductions again over the next few months, with the outpatient situation being largely addressed in some specialties, such as gastroenterology where until recently there were significant numbers waiting over 12 weeks.

6.9 At the end of August almost 5000 patients were waiting more that 12 weeks. This is likely to have more than halved by the end of the calendar year.

6.10 Board members will therefore be conscious that although significant improvements are continue to be made, it is apparent that significant challenges remain. There is thus a requirement for ongoing careful management and close attention on this issue.

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 At the end of September, 609 patients were waiting longer than six weeks for a diagnostic endoscopy; a rise from 372 the month before. The trend in endoscopy numbers over the 6 week standard is shown in Figure 8.

7.3 No patient was waiting beyond 4 weeks for cystoscopy or any the radiological tests covered by the standard.

7.4 As indicated in 5.5 above and in last month’s board paper, the position has exacerbated by the identification of a number of people on the outpatient waiting list as requiring diagnostic endoscopies. Furthermore discussion with the Clinical Director over the plan to address the surveillance patients (Section 8) has led to some routine diagnostic capacity being reallocated to those of a higher clinical priority.

7.5 Given that both diagnostic and surveillance patients make use of the same facilities, solutions to these challenges are being considered together. This is covered in further detail in the following section.

Figure 8 - Endoscopies over Diagnostic Standard (April-September 2012)

8 Current Position – Other Waits

8.1 Last month’s paper outlined the waits being experienced by some patients returning for an endoscopic examination. At that point, 2389 patients were overdue a colonoscopy with 811 awaiting other endoscopic examinations.

8.2 Over the last month, there has a small reduction in the number outstanding, and – as of the 19th October – this is 2278 and 787 respectively. Unfortunately progress was not anticipated to be fast, as was outlined at the last Board meeting the demand of endoscopy is growing significantly and demand is exceeding available sessions within NHS Lothian. Board members will recall from last month’s paper that investment has been approved for additional diagnostic, rather than surveillance, capacity and it is anticipated that this will be in place through substantive arrangements by the spring.
8.3 Details are currently being worked through on equivalent necessary steps for those surveillance and other patients returning to endoscopy. It is currently estimated that it could take between 18-24 months to address this issue, although a shorter timescale is being sought as options are being considered, and the advice of the Clinical Director of the scheduling of the most clinically appropriate groups is being followed. Additional endoscopic capacity in private hospitals in Glasgow is available to Lothian patients but the extent to which this will materially assist in reducing the time taken to clear the backlog of patients waiting will be determined by the willingness of patients to travel and the requirement to identify sufficient additional clinically appropriate patients to compensate. As occurs with other treatment to address waiting times which occurs outside Lothian, support with travel and hotel accommodation will be provided.

8.4 Agreement is also being brokered for independent sector capacity within Edinburgh and patients are being identified to make use of this additional capacity this month. An update on this will be provided at the meeting.

9 Recording and Management of Patient Waiting Times

9.1 As Board members were informed at the last meeting, national guidance was on the treatment time guarantee was released in early August. The standardised operational procedures released in March, and supported with awareness sessions conscious of this anticipated guidance, have been updated and training on these commenced.

9.2 An equality impact assessment has been undertaken on the local access policy, which is required by the guidance to outline the Board’s management of waits. The assessment determined that the policy was neutral in its impact on equality although the importance of communication with patients was evident. Work on this document continues with discussions ongoing with both the Scottish Government Health Department and NHS Scotland’s Central Legal Office.

9.3 Communication is a key part of the Patients Right Act. Government guidance specifies a number of situations where patients are to be informed in writing of adjustments to their waiting time clock, for example when they become unavailable or do not attend an appointment. Standard letters for these instances have been put in place.

9.4 For many instances these letters are being produced automatically from the patient information system, Trak. On some occasions however, automatic production will not be possible until the system was been upgraded to accommodate the changes required. In the interim, arrangements are being put in place to enable these letters to be produced centrally using IT functionality outside of Trak.

9.5 Alongside the training underway, the “forensic dashboard” now in place is an important aspect of assuring appropriate management of patient waits. This dashboard, considered as a prototype at July’s Board meeting, forms a weekly cycle where information on unexpected transactions on trak are highlighted to management teams for investigation who feed back their results for presentation to the Medical Director.

9.6 This process has identified small numbers of changes akin to those identified in Head and Neck earlier this year and referred to in June’s board paper. In the most
recent week there were a total of 91 instances requiring investigation in the context of approximately 10,000 transactions in the average week. Furthermore where fault has been found it has tended to be a reflection of inadequate practice rather than misuse highlighting the importance of training as well as ongoing monitoring.

9.7 Reassurance on the use of unavailability from national statistics. At the end of June, inpatient unavailability in Lothian was the fourth lowest of Scottish Health Boards, less than two-thirds of Scotland overall, see Figure 9, and the proportion of inpatients treated that quarter without any unavailability applied was 80.7% against the Scottish figure of 69.6%.

9.8 As Table 1 indicates unavailability for these patients has remained static over the recent period.

Figure 9 - Inpatient Unavailability - June 2012

Figure 10 – Proportion of Inpatients admitted with No history of Unavailability – June 2012

Source: ISD
9.9 As mentioned last month, the presentation of reports in the future will alter as patients covered by the treatment time guarantee are seen, informed by changes in national presentation of data, which is currently being consulted on by ISD\(^6\). In addition to slight changes in definition, one anticipated change is a focus on 12 weeks for admission for inpatient and daycase admission rather than 9 weeks.

10 **Key Risks**

10.1 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.

10.2 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.

10.3 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.

10.4 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.

10.5 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. 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.

10.6 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.

10.7 Seasonality will also have an effect as staff will wish to arrange leave over the winter holiday periods. To counter this external agencies are being used to

\(^6\) [http://www.isdscotland.org/Health-Topics/Waiting-Times/Consultation-on-Stage-of-Treatment-Statistics.pdf](http://www.isdscotland.org/Health-Topics/Waiting-Times/Consultation-on-Stage-of-Treatment-Statistics.pdf)
maximise the level of core capacity retained. This is also being factored into the Boards winter/resilience planning.

10.8 Seasonality will also 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.

10.9 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 October 2012
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.
Historical figures relating to levels of attainment of the waiting times standard and levels of patient unavailability are known to be inaccurate.

Further information can be found in the Pricewaterhouse Coopers report published in March 2012. (http://www.scotland.gov.uk/Resource/0039/00390166.pdf)

Source: MMI returns
Time since added to the Inpatient List for those Currently Waiting

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<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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<td>44</td>
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</table>

September 2012 Extract
Takes no account of periods of unavailability nor clock resets
Figures should not be added – eg 501 patients were waiting longer than 6 months, of whom 204 were waiting longer than 9 months

Source: Performance Review 18 October 2012
**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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</thead>
<tbody>
<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
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<td>6</td>
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<td>4</td>
<td>1</td>
</tr>
<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
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September 2012 Extract
Takes no account of periods of unavailability nor clock resets
Figures should not be added – eg 658 patients were waiting longer than 6 months, of whom 255 were waiting longer than 9 months

Source: Performance Review 18 October 2012
UNSCHEDULED CARE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on plans and actions to safely meet the unscheduled care needs of patients and achieve sustained improvement against the national 4 hour access standard.

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 current performance as described against the 4 hour emergency access/target.

2.2 Recognise the variables and risks around unscheduled care.

2.3 Note the progress with the Improvement Plan.

2.4 Note the progress with Resilience & Winter Framework

3 Discussion of Key Issues

3.1 Performance for NHS Lothian against the 4 hour standard in September was 93.1%. The performance for Lothian (YTD) is 92.9%. There were 110 8-hour and 12 12-hour breaches during September. Graph 1 shows NHS Lothian trend performance against the 4 hour standard on a weekly basis since January 2012 along with the number of attendances at emergency departments and the number of 12 hour breaches. Graph 2 indicates the number of patients boarding across NHS Lothian and individually on the acute sites with additional information since August highlighting the level of front door boarding at the Royal Infirmary.
**Graph 1** NHS Lothian Emergency Department attendances, 4hr emergency care standard compliance, 12hr breaches (weekly)

**Definition**
Weekly compliance with 4h emergency access standard (%); average daily attendances; and ED Length of stay patients >12h. ED refers to RIE, SJH, RHSC emergency departments and ARAUT/MIC at WGH. Process limits are unadjusted XmR-based control limits.

**Data Source**
TRAK data via BOXI; excludes planned returns.

**Constraints**
Accuracy of TRAK data is dependent on ‘real time’ use by clinical / front line staff.

**Expected Trend**
It is expected that the 4h compliance (%) will increase to the national standard of 98%. 12h breaches should reduce to the target of 0. Attendances are likely to rise due to population growth; but growth will be dependent on T10 workstreams.
**Graph 2**  Daily numbers of boarding patients across NHS Lothian acute hospital sites

![Graph showing daily numbers of boarding patients](image)

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<table>
<thead>
<tr>
<th>Definition</th>
<th>Daily number of total boarders across NHS Lothian acute sites. CAA boarders as a sub-set of RIE boarders (‘front door’ boarders). Boarding is defined as any patient in a clinical area outwith their assigned primary care provider’s (consultant’s) specialty.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>TRAK data via BOXI from 1 January 2012 onwards; prior to that data was taken from manually collated daily ‘boarding lists’ – those patients advised to the Capacity and Site Management Team to be boarders.</td>
</tr>
<tr>
<td>Constraints</td>
<td>Accuracy of TRAK data is dependent on ‘real time’ use by clinical / front line staff. Where specific care providers operate across one or more specialisms, boarders will not be counted. No ‘front door’ boarding data is available for WGH or SJH at present.</td>
</tr>
<tr>
<td>Expected Trend</td>
<td>Boarding is considered a symptom of poor system management; therefore it is expected that all measures will decrease with progress of improvement actions.</td>
</tr>
</tbody>
</table>

3.2 The Unscheduled Care Group has sought to focus on much more integrated working across primary, secondary and health and social community care.
3.3 The Nurse Director and Director of Health and Social Care, Edinburgh CHCP, have been appointed as joint leads for delivery of the Improvement Programme to achieve sustained improvement towards the 98% target.

3.4 The aims of the Unscheduled Care Improvement Programme (UCIP) are:

- to achieve safe effective person centred unscheduled care for patients
- to achieve sustainable improvement of performance towards the whole system indicator of 98% of the 4 hour access standard
- to develop and implement a plan to secure sustained reduction in patient boarding, without compromising patient safety or the 4 hour performance standard
- to develop a costed capacity plan to reach demand/capacity equilibrium for unscheduled care across primary, secondary and social care, for a mixed economy of home care, care home and NHS beds for predicted and surge demand.

3.5 Performance reporting for Unscheduled Care is being revised to reflect the agreed priorities for improvement of the Unscheduled Care Group. These priorities are:

- 7 day working and 7 day discharge
- reducing boarding levels and
- care of older people in unscheduled care
- increasing capacities.

3.6 The revised performance report is currently under development and will be reviewed at the Unscheduled Care Group on 16 October. Once agreed it is anticipated that this report will be used as part of future updates on performance to the NHS Lothian Board.

3.7 Initial priority actions have already been agreed to support the development of models of care to support older frail patients whose pathway of care can be improved through the provision of alternatives to acute hospital admission. Within Edinburgh the current COMPASS pilot in SE Edinburgh will be extended to the north west of the city. Within West, East and Mid Lothian, similar schemes have also been agreed. These are now being progressed towards implementation with recruitment of key staff being taken forward by the clinical teams involved.

3.8 The other priority area initially supported by the Unscheduled Care Group has been the agreement of a model of care for Front Door areas of the acute hospitals. The model extends the presence of senior decision-making into the evenings and weekends to reduce time to assessment on admission. This senior decision-making is provided through a mixture of consultant medical staff, specialty grade doctors and advanced nurse practitioners. In addition, the model will provide the ability to manage additional patients through an ambulatory care pathway as an alternative to admission through providing GP’s with the opportunity to speak to senior clinicians for advice if the GP wishes. The development of further ambulatory care pathways for other conditions which are currently admitted is part of longer term plans.

3.9 The Unscheduled Care Group will continue to identify and implement improvements to patient flow either through redesign in primary care, enhancing front door capacity and efficiency or down stream rehabilitation capacity.
3.10 There are already a range of ongoing activities which are supporting improvement in unscheduled care and do not require additional financial support other than staff time, leadership and commitment.

Some examples of this work include:

- a reduction in the time-to-fill a bed from the assessment area to ward, supporting reduction in 4 hour breaches associated with bed waits at RIE
- proposal to develop a single bed management system to support improved patient flow across the whole of NHS Lothian and with partner organisations
- increased system awareness of impact of complex patients with delays on acute sites through monitoring of over 28 day stays
- developments to improve access to neuro-rehabilitation, to reduce delays for patients waiting for transfer
- developments to reconfigure general and ortho-rehabilitation wards, to maximise capacity and provide opportunities for reduced boarding and shorter length of stay at SJH

3.11 Social Care Services to Support Discharges from Hospital and to Prevent Admission to Hospital

3.11.1 The City of Edinburgh Council’s investment of £2m for demography and the Change Fund have enabled an increased investment in community-based services. The additional investment in reablement, home care and intermediate care has increased the overall capacity in the system. Between week ending 29 April 2012 to week ending 30 September 2012 (23 weeks), there were 1,650 supported discharges from hospital. This compares to a previous baseline of 1,449 for a similar period. There has been an increase of 201 discharges over the 23 week period.

3.11.2 The chart below shows the increased activity in home care/care at home since April and the projected increase to the end of March. The number of hours has increased by 2,431 hours (7.5%) and is projected to increase by a further 2,943 hours (8.4%) by the end of March 2013.
3.11.3 Discussion has commenced with providers around a mini-tender for a block contract of 500 hours per week for the period December 2012 to the end of April 2013. This proposal is to deal with potential increased demand over this period.

3.11.4 An in-house project to bring in more agency staff is being developed for a six month period to deal with surge capacity. This scheme should be up and running by mid-November and should deliver an additional 304 hours.

3.11.5 The availability of care home beds, particularly for those with challenging behaviour is impacting on the length of stay in hospital. New beds will be coming on stream between February and July 2013. Discussions are taking place with Care providers around the development of Step Up Step Down and challenging behaviour beds. The funding for these beds needs to be considered in our joint planning.

3.12 Resilience & Winter 2012/13 Framework

As well as improving the key standards highlighted above, which will also have an impact on the requirement to improve delayed discharge standards, the 2012/13 NHS Lothian Corporate Objective number 4 indicates that we require to:

- Ensure that winter pressures are effectively managed and that activity to reflect seasonal pressures

In 2011/12, from November onwards, it was noted from formal feedback across the system, that there were additional challenges across the whole system, in particular:

- A net increase of 41 beds for winter from base prior to Local Reinvestment Plan bed reductions
- Older People Change Fund Plans saw a delay in recruitment to community posts, particularly in Edinburgh
- Increased elective activity and demand to address backlogs creating additional pressure within the system
Coherence of plans across health and social care could be improved, to reduce variation and enhance consistency.
- Local plans and escalations not being clear, nor followed as agreed

In 2012-13 there are a number of additional challenges facing our system, which will compound our ability to deal with winter surge activity, including:

- Backlog of elective activity
  - The requirement to meet the new legal requirement for Treatment Time Guarantees, means there will be no running down of elective activity as has been the case in previous years to accommodate the unscheduled surge in activity
  - The lack of availability of additional hospital based surge capacity, which is currently being used on an ongoing basis to allow flow to occur system wide

Key enablers that will lead to a more coherent approach with the system wide developments and changes underway include:

- the work being undertaken by the unscheduled care group, described above
- the whole system approach to ensure surge capacity is available across health and social care community settings
- the development of coherent local plans, including agreed escalation plans, trigger points and responses agreed by the Corporate Management team, and key elements indicated by the Scottish government:
  - Efficient utilisation of Capacity & optimisation of patient flow
    - analysis and planning of elective activity, based on forecasted emergency activity
    - staff rotas
    - improved discharge planning
    - senior decision makers availability
    - enhancements of home care packages
    - improved communications
  - Norovirus plans
    - outbreak control measures
  - Seasonal flu plans
    - vaccination uptake for staff working in high risk areas
  - Management Information of real time activity
- a coherent financial plan being developed

There has been consensus across health and social care this year on the approach to take within Lothian this year through the multi agency Core Group, with the overarching Resilience & Winter Framework being populated with local plans, providing a whole system picture to promote confidence that there are robust plans in place, and that the key milestones, against the Lothian and government requirements are met. The purpose of the framework, therefore, is to;

- outline the processes and procedures available to NHS Lothian to respond effectively when under greater pressure, due to the variations in demand and capacity that are well documented during the winter period and other periods of escalation, which for Lothian, may occur more frequently owing to our elective programme.
make available, in one place, the robust plans for operational readiness throughout holiday periods, and in the event of increases in influenza like illnesses, respiratory ailments, norovirus, and accidents due to adverse weather conditions.

4 Key Risks

4.1 The risks associated with achieving the 4 hour standard, and the management of the surge activity expected throughout the winter period include not meeting the demand for unscheduled care and older people, in particular, being adversely affected by long waits, boarding and extended stay in hospitals and the growing evidence which demonstrates the associated increase in mortality and morbidity. This relates to being unable to finance the proposals for unscheduled care and surge activity plans and being able to implement the proposals, including having timely recruitment to required posts, and finally to the proposals meeting the level of demand required.

4.2 There are also risks to elective activity, if capacity for unscheduled care patients is exceeded, at times of surge activity, and boarding into surgical specialties is required. This could result in elective cancellations, and non compliance with the new treatment time guarantees.

4.3 There are many variables which can affect performance outside the control of the Health Board such as seasonal variation, incidents, and infection outbreaks.

4.4 These risks will be mitigated through the delivery of the UCIP with performance management from the Corporate Management Team. Risks will be managed as part of the partnership approach throughout this process. Alongside this the application of the agreed escalation plans and applying the appropriate responses to surge/winter activity, will assist to mitigate the risks.

5 Risk Register

5.1 The clinical risk to patients and the corporate risks of non delivery associated with unscheduled care are noted on local and corporate risk registers. Mitigation of these risks has been outlined above.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment on the Unscheduled Care Improvement Plan is scheduled for October.

7 Involving People

7.1 The resilience framework and local surge activity plans have been developed by local multi agency teams, with the support of the Corporate Management Team.
8 Resource Implications

8.1 Financial implications of the priority investments for unscheduled care were outlined in the Board paper for September. At this point no further change to the resource implications have been made. Once further priority areas for the Unscheduled Care Improvement Plan are agreed the quantification of the costs of the additional investments proposed and the financial and other benefits arising from them will be reported. This work will be integrated into the financial planning process and future financial risks and benefits will be examined in the 2013/14 financial plan.

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Chris.stirling@luht.scot.nhs.uk

Katie McWilliam  
Strategic Programme Manager  
katie.mcwilliam@nhslothian.scot.nhs.uk
PERFORMANCE MANAGEMENT

1 Purpose of the Report

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

2 Recommendations

The Board is recommended to:

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

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

2.3 Note that work is underway to strengthen the process for collecting and reporting performance information through the Health Intelligence Unit. This will involve information being collected at a fixed point in each month (to be agreed) and the same suite of information being reported to the Corporate Management Team (CMT) and the Board.

2.4 Note that future reports will include routine activity level information for both elective and unscheduled care, and this will be available for the November Performance Report.

2.5 Note that this work to strengthen scrutiny and validation of information being provided to the CMT and Board is under development and will be in place before the next paper to the Board in November.

3 Discussion of Key Issues

3.1 Of the 41 items monitored within Appendix 1, the most recent data indicates NHS Lothian:
Meets the overall target on six occasions (table key: ✓✓)

Is on trajectory to meet, but has not yet met the final target, on nine occasions (table key: ✓)

Is off trajectory on eight occasion (table key: ✗)

Does not meet the overall target on fourteen occasions (table key: ✗✗)

No data available yet (new or revised target) on four occasions (Blank)

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

4 Key Risks

4.1 The following performance measures are those where NHS Lothian are currently off trajectory and therefore are considered risks to the organisation. We are in the process of reviewing the corporate risk register to ensure that each target has been reviewed by responsible Directors actions are being taken to mitigate these risks.

4.1 HEAT Targets

4.1.1 Detecting Cancer Early (Responsible Director: Director of Public Health and Health Policy)

The aim of the NHS Lothian Detect Cancer Early Programme is to increase the population of people diagnosed and treated in the first stage of Breast, Colorectal and Lung cancer by 25%, by 2014/2015.

An interim improvement trajectory has been agreed with the Scottish Government Health Department (based on a 2005-2009 baseline) and is included in the 2012/2013 Local Delivery Plan. By the end of 2012/2013 we aim to have a minimum 17.5% of all Colorectal, Lung and Breast cancers diagnosed at first stage of disease. I.S.D. Scotland however has been tasked by the Scottish Government Health Department with establishing data definitions, a Board-by-Board baseline, and revised 2014/2015 end-point target once data sources and methods have been established. NHS Boards are awaiting indication of the target definitions and construction from I.S.D. and the Scottish Government Health Department. Meantime NHS Lothian is working with local cancer audit data. This local data shows that 21.8% of all Breast, Lung and Colorectal cancers are stage 1 cancers.

4.1.2 Early Access to Antenatal Care (Responsible Director: Director of Strategic Planning & Primary Care)

A quarterly steering group has been established to drive forward early access to antenatal care. The steering group has allocated funding for this financial year, and is regularly reviewing progress against the agreed Action Plan. NHS Lothian is currently meeting the target of early access to antenatal care for 80% for each quintile of the population.

There has been an increase in attendance to early trimester screening and scanning from women who know they are pregnant. However, further work is needed to plan for the most hard to reach women - the 10 - 20% who are still attending services later. We are looking at the use of mobile technology to access the EPR to improve the continuity of care and mobility and flexibility of the
workforce. Additionally, we are working to establish reporting from centralised bookings in relation to call responses.

The baseline information for this target will be reported to the Board in November.

4.1.3 **Provision of insulin pumps for those under and those over 18 years of age**  
(Responsible Director: Director of Strategic Planning and Primary Care)

At the end of August 2012, there were 54 people under age 18 on pumps and 202 adults (22 of these adults are looked after by the Lothian diabetes team, but funded externally for their pumps and associated consumables). This is an increase from 39 for under 18s and 169 for over 18s at December 2011.

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<tr>
<th>Patients under 18</th>
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<td>Number of patients with Type 1 diabetes at Dec 2011</td>
<td>Number of patients with Type 1 diabetes at Dec 2011</td>
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<tr>
<td>363</td>
<td>3,821</td>
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<td>Number of patients with Type 1 diabetes at end Aug 2012</td>
<td>Number of patients with Type 1 diabetes at end Aug 2012</td>
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<td>410</td>
<td>3,863</td>
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<td>Number of patients on an insulin pump at Dec 2011</td>
<td>Number of patients on an insulin pump at Dec 2011</td>
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<td>39</td>
<td>169</td>
</tr>
<tr>
<td>Number of patients on an insulin pump at end Aug 2012</td>
<td>Number of patients on an insulin pump at end Aug 2012</td>
</tr>
<tr>
<td>54</td>
<td>202</td>
</tr>
</tbody>
</table>

In line with the reporting arrangements, the next update on the number of adults and children being provided with insulin pumps will be November.

4.1.4 **Wheelchair: referral to assessment and assessment to fitting**  
(Responsible Director: Joint Director Edinburgh CHP)

The Mobility Service achieved 94.56% compliance within 18 weeks RTT. The non-compliant episodes have been reviewed and a number of the cases will have been progressed since the writing of this report. As previously reported, the service is experiencing a significant reduction in the level of recurring funding available since the completion of the Wheelchair and Seating Services Modernisation Programme. The service continues to work within austerity budgets which have been set to minimise disruption to the service. Patients who are assessed for equipment will be prioritised based on their clinical needs. All non-compliant cases will continue to be reviewed retrospectively and prospectively – that is, cases closed each month which have breached. In addition the service will review cases on an on-going basis which are approaching 6 weeks of breaching. This will ensure that cases which require equipment are ordered and received within a reasonable timeframe and fitting arranged within the 18 week target.

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

Based on the most recently available (August 2012) data NHS Lothian T10 performance has slipped in comparison with the preceding month, which had seen a reduction following three months of gradually increasing activity. August 2012 activity was an increase of 4.1% on the same period in 2011 (700 patient attendances) as shown in the table below.
T10 attendances for 2012/13 compared with 2011/12

NHS Lothian

<table>
<thead>
<tr>
<th>T10 sites</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>17,133</td>
<td>17,946</td>
<td>17,090</td>
<td>17,084</td>
<td>17,216</td>
</tr>
<tr>
<td>2012/13</td>
<td>17,164</td>
<td>18,269</td>
<td>17,629</td>
<td>16,789</td>
<td>17,916</td>
</tr>
<tr>
<td>Change</td>
<td>31</td>
<td>323</td>
<td>539</td>
<td>-295</td>
<td>700</td>
</tr>
<tr>
<td>% Change</td>
<td>0.2</td>
<td>1.8</td>
<td>3.2</td>
<td>-1.7</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Looking at emergency department attendance rates for Lothian, this is moving away from the target trajectory and appears to be adopting an upward trend, though in common with previous months there may be month on month fluctuations.

While not as high as the peak of March 2012, this month’s attendance rate is among the highest since April 2009. In comparison, while NHS Lothian’s attendance rate was 2,141 in August, for the same period, NHS Lanarkshire’s rate was 2,993, Greater Glasgow and Clyde was 2,905 and Tayside was 1,627.

4.2 HEAT Standards

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

Work is continuing on previously agree actions to support this target and the work associated with it. Performance for August was 93.59%, and was 93.07% for September.

4.2.2 12hr Breaches – Month-to-date for September 2012 (Responsible Director: Nurse Director)

The number of reported 12hour breaches for September was 12 in total. The number to date for October (as of the 10th October) stands at 3.

4.2.3 Cancer Waiting Times (Responsible Director: Medical Director)

Overall, cancer waiting times are:

- 62 days – 93.6%
- 31 days – 96.6%

Due to the recent scrutiny in cancer waiting times performance, monthly cancer waiting times will now be included in the performance reports. Monthly performance is submitted to ISD on the 20th of each month detailing the previous month treatments for 62 and 31 day targets. Whilst the monthly reports give a good indication of performance, the quarterly data submission may change following discussion at the quarterly service sign off meetings, for example exclusions due to complexity.
Endometrial cancer performance is submitted to ISD on a monthly basis for developmental reporting only, this data is not published. Endometrial performance will be included in Appendix 1 of future performance reports. In August 2012 endometrial cancer performance was 100% for 62 days and 42.9% for 31 days (4 breaches of 7 cases).

A workshop was held on the 3rd October for cancer trackers, co-ordinators and managers. This has generated a number of actions which will be taken forward and will also mean revisiting timed pathways and escalation policies. There will be a weekly review of all cancer patients to minimise any future breaches.

4.2.4 **Stroke** (Responsible Director: Nurse Director)

An overall increase in number of medical attendances at the Emergency Department (ED) and admissions coupled with continued high numbers of patients waiting onward transfer of care is preventing appropriate admission to all medical specialties. This is more evident in stroke services as it now has a HEAT target. NHS Lothian fell short of achieving the trajectory of 85% of patients being admitted to a stroke unit within one day.

Data for July shows 67% adherence to this target across Lothian, although the mean for the latest 12 months (August 2011 to July 2012) is sitting at 75%. Whilst the current capacity and occupancy rates within RIE, WGH and St John’s acute stroke wards remains very high it is difficult to predict large scale improvements.

Discussion on improvement to the stroke pathway and utilisation of stroke beds was agreed and discussed at the Joint Management Team meeting on the 20th September. The Nurse Director can provide further update on these developments as required.

4.3 **Other National/local Targets**

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

Within the national rules set out by ISD, the Lothian Partnership reported 187 delayed discharge patients in September. This is on a par with the 181 delays in August but 20% higher than the July figure.

The table gives a summary of headline figures from the September census

<table>
<thead>
<tr>
<th></th>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Complex Codes</th>
<th>Delays (excl. x-codes)</th>
<th>Delays 6 Weeks+ (National standard - 0)</th>
<th>Delays 4 Weeks+ (National standard – 0 from April 2013)</th>
<th>Average length of stay as a delayed discharge Days (non- x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>187</td>
<td>44</td>
<td>143</td>
<td>22</td>
<td>49</td>
<td>26</td>
</tr>
</tbody>
</table>

The table below sets out the performance across the Partnership areas for September with August and July for comparison. In line with information
governance guidance, numbers less than 5 are not reported; however detailed figures can be provided to NHS Lothian Board members on request.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Non Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
</tr>
<tr>
<td>Overall</td>
<td>85 104 120</td>
<td>14 16 15</td>
<td>≤5 ≤5 ≤5</td>
<td>0 ≤5 ≤5 ≤5</td>
<td>≤5 ≤5 ≤5 ≤5</td>
</tr>
<tr>
<td>Over6wks</td>
<td>10 16 20</td>
<td>0 0 0</td>
<td>0 0 0</td>
<td>0 0 0</td>
<td>≤5 ≤5 ≤5 ≤5</td>
</tr>
<tr>
<td>Over4wks</td>
<td>23 31 42</td>
<td>≤5 ≤5 ≤5</td>
<td>≤5 0 ≤5</td>
<td>0 0 0</td>
<td>≤5 ≤5 ≤5 ≤5</td>
</tr>
</tbody>
</table>

In City of Edinburgh, the single largest pressure is care homes, with 60% of delays awaiting suitable care home placements, and 30% of these require dementia beds. Patients waiting on packages of care to return to their own home continue to improve in the speed of pick up by City of Edinburgh’s in-house service and its contracted suppliers.

East, Mid, and West Lothian continue to have no delays over six weeks, reflecting the continued effective partnership working locally to ensure timely discharge from hospital. Both Mid and West Lothian are now meeting the impending new National target (April 2013) of having no delayed discharges over 4 weeks.

The number of patients who are coded as complex has come down from the last couple of months and is now at 44. The largest proportion of complex delays is mainly patients aged under 65 years within the Royal Edinburgh Hospital who require varying forms of tenancies/supported accommodation in the community.

The following graph shows the main categories of delayed discharges by length of time

- Assessment-all delayed discharge patients will have a social work assessment to determine need
- Care Home - which could be residential or nursing, specialist provision such as dementia beds
- Own Home - which many have care packages or adaptations to the environment
- Complex - These will include cases where Guardianship is being sought or where patients are considered clinically to frail to move to interim care home placements.
The table below sets out the complex delays across Partnership areas, with the figures for the previous two months also show.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Non Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
<td>Jul Aug Sep</td>
</tr>
<tr>
<td>Complex delays</td>
<td>33 35 25 ≤5 ≤5 ≤5 ≤5 ≤5 ≤5 ≤5</td>
<td>7 12 ≤5 ≤5 ≤5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall number of patients delayed in hospital**

There were circa 330 patients recorded on EDISON whose discharge was delayed; however following the application of ISD reporting rules, Lothian reported the above stated, 187 delays at the September census. NHS Lothian and Council partners continue to work collectively to reduce the overall number of delays, recognising the pressures being placed across the health and social care system, although some more detailed work for the under 65s looking for specialist residential accommodation coming out of the Royal Edinburgh Hospital has been commenced, with 5 being discharged since the last report to the Board.

The Board’s Unscheduled Care Groups has several developments in place to reduced delayed discharges

- Enhancing senior decision makers at the front door
- Frailty Model, enhancing community reposes in East and Midlothian
- West Lothian’s Older People Model
- Roll out of COMPASS (Comprehensive Assessment) in North West Edinburgh
- Consultant Physician/geriatrician liaising directly with GP’s offering amongst other things, assessment at home

The table below presents the information from April 2011, relating to the number of overall delays within the hospital system and the number of delays which are reported to ISD based on the national reporting rules. The gap had increased since March 2012 due to the effect of recording the Hospital OT arranged <14Hrs Packages of Care on the EDISON delayed discharge database, circa 25 at any one time. From May 2012 there is a narrowing of the gap as the inclusion of the 0-3 days delay increase the returnable number to ISD.
However, irrespective of ISD rule changes we are now running with circa 325 patients who have been declared ready for discharge, but remain in hospital. Whilst National targets for ensuing no individual is delayed more than a prescribed time limit, the use of bed days lost across all delayed discharges, gives a more accurate measure of lost capacity.

This is now reported at each quarterly census (Jan, Apr, Jul, Oct) by ISD Scotland, with the data for Lothian for Jan – Jun set out below. This data covers all Lothian delayed discharge, not just those that fit the ISD delayed discharge definitions used at the monthly census points. As such it is more reflective of the actual capacity being used with in the wider hospital system for patients, who are no longer in need of inpatient based care. As data on this area develops, trend charts will be produced to demonstrate performance across the year. Crudely however we have 30% more bed days lost per month in September than we did in January.

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 74 years</td>
<td>1,966</td>
<td>2,658</td>
<td>2,887</td>
<td>2,777</td>
<td>2,754</td>
<td>2,498</td>
<td>2,625</td>
<td>2,724</td>
<td>2,764</td>
</tr>
<tr>
<td>75+ years</td>
<td>5,424</td>
<td>4,930</td>
<td>6,025</td>
<td>5,271</td>
<td>5,145</td>
<td>6,334</td>
<td>6,104</td>
<td>6,366</td>
<td>6,691</td>
</tr>
<tr>
<td>Total bed days</td>
<td>7,390</td>
<td>7,571</td>
<td>8,912</td>
<td>8,048</td>
<td>7,899</td>
<td>8,832</td>
<td>8,729</td>
<td>9,530</td>
<td>9,565</td>
</tr>
</tbody>
</table>

### 4.3.2 Monthly Hospital Inpatient Boarding

Scottish Government has asked Boards to report monthly (broken down by each week) on the number of Borders in their respective acute hospitals. This is an extension to ‘all year round’ on what boards have been doing for the last three years as part of the ‘winter reporting’ suit of data.

Boarding is classified as: “the total number of bed days occupied by patients during the reporting week, who are managed by an individual consultant or team and are out with the main allocated inpatient area for that consultant/team or specialty for their treatment”.

This should include patients who become boarders upon admission or transfer and patients who are boarding in non-inpatient bedded areas. This should include boarders in both medical and acute specialties.

The figures for September are show in the table below
4.3.3 Audiology waits – Adults and Paediatrics (Responsible Director: Medical Director)

As previously reported, within Adult services, plans are in place to ensure sustainable delivery of the target. A Band 5 audiologist has recently been recruited, and will start on 1st October. Furthermore, a Band 6 audiologist has recently returned from maternity leave. It is hoped that these developments will reduce waiting times to a much more acceptable level.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

8.1 There are no resource implications relating directly to the provision of this report. Financial implications are reported as appropriately to the Board, CMT and other committees.
List of Appendices
Appendix 1: Performance Management Scorecard
# Heat Targets, Standards and other Local / National Targets

## 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

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>265</td>
<td></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 this trajectory. This was because 574 interventions were recorded on the national Child Health Surveillances Programme. School system rather than the 571 initially anticipated from locally held data.
- A relatively small number of school-based interventions were completed between April - June in one of the attached nursery schools will be reported in the next quarter.

### Suicide Reduction - % of suicides per yr per 100,000 plpn

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<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 (16.6% of the Scottish total). This is an increase on 2010 (122) but lower than 2008 (136). 2008 was the highest yearly total in the last 25 years. The 2011 total is made up of 96 males and 32 females. Much of the variation in the Lothian figures over the last 5 years appears to be due to changes in male suicide. Female deaths from suicide have been between 30 and 34 in that period.

### Child Fluoride Varnishing - achieve at least 60 per cent of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td>7,011</td>
<td>Jul-12</td>
<td>3,905</td>
<td>Aug-12</td>
<td>4,002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,381</td>
<td></td>
</tr>
</tbody>
</table>

- Target has been simplified; new data still not available due to change of personnel within ISD. All additional Childsmile dental practitioners. A key post, Head of Oral Health Improvement will be filled from redeployment, from 1 October.

### Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 20% are to be diagnosed while in the first stage of the disease

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Details of local trajectories for the three cancers are still being agreed with the Scottish Government

### Early Access to Antenatal Care - at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation by March 2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Detail still being agreed with the Scottish Government. A national event to move this forward is planned for the 29th August.

## Efficiency

### Reduce Carbon Emissions - % reduction year-on-year (Tonnes of CO2)

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 4, 11/12</td>
<td>2.77%</td>
<td>Qtr 1, 12/13</td>
<td>1.88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.91%</td>
<td></td>
</tr>
</tbody>
</table>

### Reduce Energy Consumption - % reduction year-on-year (Energy GJ)

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>-2.97%</td>
<td>Qtr 4, 11/12</td>
<td>2.17%</td>
<td>Qtr 1, 12/13</td>
<td>1.19%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.99%</td>
<td></td>
</tr>
</tbody>
</table>

## 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>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>90%</td>
<td>Jul-12</td>
<td>78.60%</td>
<td>Aug-12</td>
<td>83.20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>81%</td>
<td></td>
</tr>
</tbody>
</table>

### Faster access to CAMHS - deliver 26 wks Referral to Treatment

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>0</td>
<td>Jul-12</td>
<td>87</td>
<td>Aug-12</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>58</td>
<td></td>
</tr>
</tbody>
</table>

### Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Treatment Appropriate for Patient

### A&E Attendances - rate of A&E attendances per 100,000 population

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td>1,911</td>
<td>Juli-12</td>
<td>1,978</td>
<td>Aug-12</td>
<td>2,141</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,951</td>
<td></td>
</tr>
</tbody>
</table>

### MRSA / MSSA Reductions - achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MRSA) cases to 0.28 or less per 1,000 acute occupied bed days

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>0.26</td>
<td>Aug-12</td>
<td>0.30</td>
<td>Sep-12</td>
<td>0.28</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>0.39</td>
<td>Aug-12</td>
<td>0.34</td>
<td>Sep-12</td>
<td>0.39</td>
</tr>
</tbody>
</table>

### Reduction in emergency bed day rates for patients aged 75+

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>5,143</td>
<td>Mar-12</td>
<td>5,177</td>
<td>Apr-12</td>
<td>5,149</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,368</td>
<td></td>
</tr>
</tbody>
</table>

### Delayed Discharges - no people to wait more than 28 days to be discharged from hospital into a more appropriate care setting from April 2013

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Apr-13</td>
<td>0</td>
<td>Aug-12</td>
<td>35</td>
<td>Sep-12</td>
<td>49</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
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</tr>
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</table>

### Delayed Discharges - no people to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-15</td>
<td>0</td>
<td>Aug-12</td>
<td>70</td>
<td>Sep-12</td>
<td>83</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>Target</td>
<td>Mar-13</td>
<td>May-12</td>
<td>Jul-12</td>
<td>89%</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td>90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Data available monthly from SSCA at ISD, one month in arrears. Non validated &amp; may be incomplete data till following month. New eSSCA system has been implemented (July 2012)</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
- ✗ Is off trajectory
- ✗★ 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 Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol Brief Interventions</strong> - 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 July 2012 4,932</td>
<td>✓</td>
<td>AKM</td>
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<td></td>
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</tr>
<tr>
<td><strong>Cancer Waiting Times - 62 day referral to treatment</strong> - achieve 95% of patients diagnosed with cancer starting treatment within 62 days if urgently referred.</td>
<td>Standard</td>
<td>Breast</td>
<td>100.00%</td>
<td>100.00%</td>
<td>✓</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cervical</td>
<td>60.00%</td>
<td>100.00%</td>
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<tr>
<td></td>
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<tr>
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<td>Head &amp; Neck</td>
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<td>100.00%</td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Lymphoma</td>
<td>100.00%</td>
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<td>Melanoma</td>
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<td></td>
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<td>83.30%</td>
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<tr>
<td></td>
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<td>Upper GI</td>
<td>98.20%</td>
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<td></td>
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<td>94.80%</td>
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<tr>
<td></td>
<td></td>
<td>95%</td>
<td>93.60%</td>
<td>92.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer Waiting Times - 31-day decision to treat to first treatment</strong> - achieve 95 per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat.</td>
<td>Standard</td>
<td>Breast</td>
<td>100.00%</td>
<td>100.00%</td>
<td>✓</td>
<td>DF</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Cervical</td>
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<tr>
<td></td>
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<td>Colorectal</td>
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<td>95.20%</td>
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<td></td>
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<td>Head &amp; Neck</td>
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<td>96.60%</td>
<td>97.10%</td>
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<tr>
<td><strong>18 weeks Referral To Treatment</strong> - 90 per cent of patients to wait no longer than 18 weeks from referral to treatment</td>
<td>Standard</td>
<td>Breast</td>
<td>100.00%</td>
<td>100.00%</td>
<td>✓</td>
<td>DF</td>
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<td>92.50%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>12 week Outpatients</strong> - no patient to wait longer than 12 weeks from referral to a first outpatient appointment.</td>
<td>Standard</td>
<td>Breast</td>
<td>100.00%</td>
<td>100.00%</td>
<td>✓</td>
<td>DF</td>
<td></td>
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<tr>
<td></td>
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<td>Cervical</td>
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<td>100.00%</td>
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<tr>
<td></td>
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<td>Head &amp; Neck</td>
<td>96.50%</td>
<td>100.00%</td>
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<td>Lung</td>
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<td>97.00%</td>
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<td>100.00%</td>
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<td>70.00%</td>
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<td>100.00%</td>
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<td>96.10%</td>
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<tr>
<td></td>
<td></td>
<td>95%</td>
<td>96.60%</td>
<td>97.10%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Dementia</strong> - number of people on QOF dementia register - improvements in the early diagnosis and management of patients with Dementia</td>
<td>Standard</td>
<td>BRE</td>
<td>90%</td>
<td>Jun-12 89.00% Jul-12 87.00%</td>
<td>90%</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>JS</td>
<td>90%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>SD</td>
<td>90%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>95%</td>
<td>98.90%</td>
<td>98.60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GP Access</strong> - patients reporting they had GP access within 48 hours</td>
<td>Standard</td>
<td>BRE</td>
<td>90%</td>
<td>10/11 94.3% 11/12 91.8%</td>
<td>90%</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>JS</td>
<td>90%</td>
<td></td>
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<td></td>
<td></td>
<td>SD</td>
<td>90%</td>
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<tr>
<td></td>
<td></td>
<td>95%</td>
<td>98.90%</td>
<td>98.60%</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
- ✗ Is off trajectory
- ✗ ✖ Does not meet the overall target

Due to the recent downward trend in cancer waiting times performance, details of the monthly performance will be included in future performance reports.

**Due to the recent downward trend in cancer waiting times performance, details of the monthly performance will be included in future performance reports.**
<table>
<thead>
<tr>
<th>Other Local / National Target</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Delayed Discharges over 6 weeks (monitor nationally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12 17</td>
<td>Sep-12 22</td>
<td>0</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Total number of Delayed Discharge in Short-Stay setting (monitor locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12 7</td>
<td>Sep-12 8</td>
<td>0</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Inpatient/Day Case Max 12 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jul-12 1658</td>
<td>Aug-12 1432</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Inpatient/Day Case Max 9 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12 2467</td>
<td>Jul-12 2196</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Wait for key diagnostic tests &gt; 4 weeks (Monitor Nationally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Jul-12 0</td>
<td>Aug-12 0</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Cataract Waiting Times - max wait 18 wks outpatient and inpatient combined (Monitor Locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12 146 day cases and 112 outpatients</td>
<td>Jul-12 229 day cases and 186 outpatients</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Hip Surgery - waiting times % of Hip Fracture operations within 24 safe operating hours (Monitor Locally)</td>
<td>Ongoing</td>
<td>98%</td>
<td>Jul-12 98.5%</td>
<td>Aug-12 85.7%</td>
<td>98%</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Wait for cardiac intervention to be &lt; 10 wks (angiography, angioplasty and CABG) (Monitor Locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12 0</td>
<td>Jul-12 0</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Day Case - number of patients waiting over 12 weeks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12 10</td>
<td>Jul-12 8</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Audiology (Adults) - number of patients waiting over 12 weeks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jul-12 124</td>
<td>Aug-12 129</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Audiology (Paediatrics) - number of patients waiting over 12 weeks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jul-12</td>
<td>Aug-12 129</td>
<td>0</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in acute hospital</td>
<td>Dec-15</td>
<td>38%</td>
<td>Qrt 4 2011/12</td>
<td>Qrt 1 2012/13</td>
<td>40.2%</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in community residential settings</td>
<td>Dec-15</td>
<td>39%</td>
<td>Qrt 4 2011/12</td>
<td>Qrt 1 2012/13</td>
<td>37.3%</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>Wheelchair - referral to fitting - Patients still waiting 18 weeks+</td>
<td>Ongoing</td>
<td>100%</td>
<td>Aug-12 90.00%</td>
<td>Sep-12 94.66%</td>
<td>100.0%</td>
<td>PG</td>
<td></td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>Mar-13</td>
<td>4%</td>
<td>Jul-12 4.17%</td>
<td>Aug-12 4.32%</td>
<td>4.0%</td>
<td>AB</td>
<td></td>
</tr>
</tbody>
</table>

**Assessment**

- ✔ ✔ Meets the overall target
- ✔ ✗ On trajectory to meet, but has not yet met, the final target
- ✗ ✗ Off trajectory
- ✗ ✔ Does not meet the overall target

---

Latest data (SWISS) is as August 2012. NHS Lothian’s Year to Date Average (April - Aug '12) = 4.17%. NHS (Scotland) Year to Date Average (April - Aug '12) = 4.60%. Sickness absence figures reported monthly. (SWISS data)
1 Purpose of the Report

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

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 Members of the Board are asked to note:

- The overspend of £1.3m for the six months to the end of September 2012; and
- That a detailed Mid Year review is now being undertaken to ensure year end financial balance is delivered.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an overspend of £1.3m for the first six months of the financial year. This comprises a small operational benefit of £0.2m offset by an under delivery of £1.5m against the efficiency savings target. The position is summarised below with details of the financial position by operational unit included in Appendix 1.

Table 1: Financial Position to 30 September 2012

<table>
<thead>
<tr>
<th>Operational Unit</th>
<th>Total £k</th>
<th>Baseline £k</th>
<th>Efficiency Savings £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Division</td>
<td>(1,120)</td>
<td>(238)</td>
<td>(881)</td>
</tr>
<tr>
<td>CHPs/CHCP/PCCO</td>
<td>2,124</td>
<td>2,222</td>
<td>(99)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>(1,107)</td>
<td>(557)</td>
<td>(550)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(1,180)</td>
<td>(1,180)</td>
<td>0</td>
</tr>
<tr>
<td>Under/(Over) Spend</td>
<td>(1,283)</td>
<td>247</td>
<td>(1,530)</td>
</tr>
</tbody>
</table>
3.2 This position is, however, largely achieved through a number of non-recurring benefits including the prescribing underspend benefit which will be required to offset the residual efficiency gap. This will be actioned at Mid Year review, at which point there will be more certainty on the value of the prescribing price benefit.

3.3 Over and above, this progress on delivering of LRP savings is slow with less than one third of the target delivered at the end of September, whilst expenditure on capacity requirements for both elective and emergency care is likely to be greater than forecast.

3.4 The detailed Mid Year review which is now underway will capture the overall financial impact of these issues. Although it is fully anticipated that financial balance will remain achievable, the balance between the recurring and non-recurring position is of concern, and will clearly have an impact on the financial position going forward. The output of the Mid Year review will be incorporated in the November Board paper.

**Baseline Position**

3.5 There was little change in the operational position in the month, with the continuing underspend on prescribing (£0.5m in the month and £2.5m cumulatively) offsetting increases in clinical costs, ongoing pressures in facilities and the impact of unplanned activity outwith NHS Lothian.

3.6 Prescribing costs continue to reduce in line with the year end projection, an underspend of £5.2m. Proposals to offset this benefit against the residual efficiency savings gap of £4.8m will be presented as part of the mid year review. This LRP deficit is not currently reflected in the reported results, masking the underlying underspend.

3.7 The issues identified during the Q1 review remain evident in the baseline financial position. Many of these are offset by a range of benefits; the exceptions which feature as overspends are under close review and include:

- Facilities costs - including energy, Consort service change orders, and extra ordinary maintenance (£1.3m);
- Equipment, clinical and other supplies costs (£0.9m) - whilst some one off benefits materialised in September, the overall trend is an increase in expenditure across the organisation. A detailed piece of work has been commissioned to identify the key drivers and develop an action plan to address these overspends; and
- UNPACS (£1.2m) – the majority of the overspend relates to a small number of high cost learning disability patients some of which have recently transferred to the care of NHS Lothian.

3.8 The financial implications associated with the system wide pressures on core capacity remain a concern. The Unscheduled Care Board (UCB) continues to work towards finalising the plans for additional capacity requirements for the remainder of the year. This will include an estimate of the likely additional cost. The winter plan will be agreed by the end of October and the remainder of the capacity plan in November.
Efficiency & Productivity

3.9 Non delivery of the local reinvestment plans (LRP) remains one of the key risks for the organisation. Whilst there has been full delivery of the in month target, this was largely a result of local schemes being substituted for non delivery on workstreams. As the majority of these schemes were non recurring, delivery of the recurring targets remains a concern.

3.10 On a full year basis, schemes valued at £28.6m (76% of the annual target) have been agreed. For the six month period to September, efficiencies of £10.0m have been delivered against a plan of £11.5m, an under delivery of £1.5m. The year to date and full year position against plan is set out in Table 2:

Table 2: Efficiency & Productivity 2012/13

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target</th>
<th>Schemes identified</th>
<th>April - September</th>
<th>Full Year Savings Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>Target</td>
<td>Actuals</td>
</tr>
<tr>
<td>Red’d Low Clinical Value Interventions</td>
<td>537</td>
<td>537</td>
<td>142</td>
<td>0</td>
</tr>
<tr>
<td>Primary &amp; Community Care Bed Red’n</td>
<td>650</td>
<td>650</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity Management</td>
<td>3,233</td>
<td>2,767</td>
<td>454</td>
<td>431</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>1,894</td>
<td>801</td>
<td>237</td>
</tr>
<tr>
<td>Prescribing</td>
<td>6,211</td>
<td>6,211</td>
<td>1,682</td>
<td>1,258</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>1,056</td>
<td>580</td>
<td>580</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>687</td>
<td>404</td>
<td>248</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td>1,945</td>
<td>1,945</td>
<td>1,064</td>
<td>732</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,779</td>
<td>1,779</td>
<td>571</td>
<td>341</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>5,171</td>
<td>5,169</td>
<td>2,258</td>
<td>2,242</td>
</tr>
<tr>
<td>UHD Local</td>
<td>3,893</td>
<td>3,899</td>
<td>1,727</td>
<td>2,133</td>
</tr>
<tr>
<td>LAMS</td>
<td>2,000</td>
<td>2,000</td>
<td>1,800</td>
<td>1,800</td>
</tr>
<tr>
<td><strong>Total Planned Savings</strong></td>
<td><strong>32,702</strong></td>
<td><strong>28,594</strong></td>
<td><strong>11,532</strong></td>
<td><strong>10,002</strong></td>
</tr>
<tr>
<td>Residual Gap</td>
<td>4,838</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37,540</strong></td>
<td><strong>28,594</strong></td>
<td><strong>11,532</strong></td>
<td><strong>10,002</strong></td>
</tr>
</tbody>
</table>

3.11 With a shortfall of £11.8m forecast at quarter 1, the level of overall slippage gives cause for concern and urgent action is being taken, with a particular focus on outpatients, acute medicines and nursing. In some instances delivery will provide capacity rather than cash savings and this will require to be reflected in the financial provision for capacity going forward. It does not, however, address the requirement for cash savings in year and other options are being explored.
Agreement of further management action required, particularly for those workstreams where there is little evidence of delivery to date, will continue to be taken forward by the monthly Efficiency & Productivity Group under the leadership of the Director of Finance.

**Waiting times**

3.12 The total cost of delivering additional waiting times activity was £12.2m to the end of September, an increase of £2.5m in the month. This increase was expected given the level of activity that took place during September.

3.13 The review to validate independent sector costs incurred to date highlighted a higher than forecast average cost per case. The impact of this on the forecast outturn is not as great as previously indicated and will be further mitigated by a shift from independent sector to in house provision combined with an increased use of Medinet.

3.14 Whilst a comprehensive review will be carried out as part of the mid year review, it is likely that the total costs will be above the forecast of £20m for the year, although it is not anticipated that there will be a significant overspend.

3.15 Further expenditure is also required to clear the backlog of surveillance scopes. This is currently being assessed and will be reported at the Board meeting.

**Capital**

3.16 The quarter 1 review of capital identified significant slippage in the programme and the Corporate Management Team (CMT) agreed a number of actions. Key amongst these was the development of a Lothian wide prioritised programme to address and resolve key areas of risk in backlog maintenance and ensure compliance with statutory standards. CMT and F&PR have since approved a programme of up to £10m over the next 2 years utilising a combination of in-year slippage and the statutory standards budget this year and next.

3.17 In addition to the slippage identified in the quarter 1 review, the enabling works for the RHSC and DCN Project will cost significantly less than the in year budget. This impact of this on the capital programme for the year is currently being discussed with SGHSCD.

3.18 Expenditure of £9.8m was incurred for the first 6 months of the financial year. Appendix 3 includes details of the programme on a scheme by scheme basis.

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;
• Ongoing monitoring and review of GP prescribing costs, and any changes to the current forecast benefit from price reductions.

• The solution(s) agreed to address the system wide bed capacity pressures across the system, 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
17 October 2012
Susan.goldsmith@nhlothan.scot.nhs.uk

List of Appendices

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

### UNIVERSITY HOSPITALS DIVISION

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Associated Services</td>
<td>122,807</td>
<td>59,999</td>
<td>60,855</td>
<td>(856)</td>
<td>(331)</td>
<td>(525)</td>
</tr>
<tr>
<td>REAS &amp; MOE</td>
<td>67,027</td>
<td>31,916</td>
<td>32,210</td>
<td>(294)</td>
<td>(232)</td>
<td>(62)</td>
</tr>
<tr>
<td>Surgical Directorate</td>
<td>79,636</td>
<td>42,743</td>
<td>42,854</td>
<td>(111)</td>
<td>131</td>
<td>(242)</td>
</tr>
<tr>
<td>Labs, A&amp;T, Critical Care &amp; HSDU</td>
<td>120,475</td>
<td>61,324</td>
<td>60,853</td>
<td>471</td>
<td>572</td>
<td>(101)</td>
</tr>
<tr>
<td>Women, Children &amp; Neuroscience</td>
<td>90,648</td>
<td>43,913</td>
<td>44,770</td>
<td>(857)</td>
<td>(592)</td>
<td>(265)</td>
</tr>
<tr>
<td>Radiology, Cancer, Head &amp; Neck</td>
<td>99,797</td>
<td>49,651</td>
<td>49,294</td>
<td>357</td>
<td>52</td>
<td>305</td>
</tr>
<tr>
<td>Corporate</td>
<td>(637)</td>
<td>(11,626)</td>
<td>(11,797)</td>
<td>171</td>
<td>163</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>579,752</strong></td>
<td><strong>277,920</strong></td>
<td><strong>279,039</strong></td>
<td><strong>(1,119)</strong></td>
<td><strong>(237)</strong></td>
<td><strong>(881)</strong></td>
</tr>
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</table>

### CHPs/CHCP/PCCO

<table>
<thead>
<tr>
<th>CHP/CHCP/PCCO</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lothian CHP</td>
<td>68,944</td>
<td>34,589</td>
<td>34,482</td>
<td>107</td>
<td>146</td>
<td>(39)</td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>240,923</td>
<td>120,520</td>
<td>119,429</td>
<td>1,092</td>
<td>1,090</td>
<td>2</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>70,165</td>
<td>35,325</td>
<td>34,791</td>
<td>534</td>
<td>561</td>
<td>(27)</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>99,400</td>
<td>47,354</td>
<td>46,902</td>
<td>452</td>
<td>487</td>
<td>(34)</td>
</tr>
<tr>
<td>Primary Care Contractor Organisation</td>
<td>10,784</td>
<td>46,239</td>
<td>46,299</td>
<td>(60)</td>
<td>(60)</td>
<td>0</td>
</tr>
<tr>
<td>Corporate</td>
<td>3,633</td>
<td>(7,765)</td>
<td>(7,763)</td>
<td>(2)</td>
<td>(2)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>493,849</strong></td>
<td><strong>276,262</strong></td>
<td><strong>274,139</strong></td>
<td><strong>2,123</strong></td>
<td><strong>2,222</strong></td>
<td><strong>(99)</strong></td>
</tr>
</tbody>
</table>

### CORPORATE BUDGETS

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>653</td>
<td>392</td>
<td>393</td>
<td>(1)</td>
<td>0</td>
<td>(1)</td>
</tr>
<tr>
<td>Consort</td>
<td>45,703</td>
<td>22,113</td>
<td>22,296</td>
<td>(182)</td>
<td>(182)</td>
<td>0</td>
</tr>
<tr>
<td>Communications</td>
<td>1,142</td>
<td>474</td>
<td>458</td>
<td>16</td>
<td>16</td>
<td>(0)</td>
</tr>
<tr>
<td>Ehealth</td>
<td>26,691</td>
<td>9,613</td>
<td>9,647</td>
<td>(34)</td>
<td>(34)</td>
<td>0</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>80,050</td>
<td>38,510</td>
<td>39,925</td>
<td>(1,415)</td>
<td>(1,197)</td>
<td>(218)</td>
</tr>
<tr>
<td>Finance &amp; Capital Planning</td>
<td>10,626</td>
<td>5,073</td>
<td>4,930</td>
<td>144</td>
<td>182</td>
<td>(38)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>11,182</td>
<td>4,715</td>
<td>4,776</td>
<td>(61)</td>
<td>17</td>
<td>(78)</td>
</tr>
<tr>
<td>Medical Director</td>
<td>976</td>
<td>144</td>
<td>108</td>
<td>37</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Nursing</td>
<td>3,768</td>
<td>(201)</td>
<td>(278)</td>
<td>77</td>
<td>77</td>
<td>(0)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12,143</td>
<td>5,862</td>
<td>5,670</td>
<td>193</td>
<td>376</td>
<td>(183)</td>
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<td>Planning</td>
<td>3,619</td>
<td>1,009</td>
<td>800</td>
<td>209</td>
<td>209</td>
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<tr>
<td>Public Health</td>
<td>3,265</td>
<td>1,395</td>
<td>1,485</td>
<td>(90)</td>
<td>(59)</td>
<td>(31)</td>
</tr>
<tr>
<td>Other</td>
<td>155</td>
<td>(13)</td>
<td>(13)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>199,974</strong></td>
<td><strong>89,087</strong></td>
<td><strong>90,194</strong></td>
<td><strong>(1,107)</strong></td>
<td><strong>(557)</strong></td>
<td><strong>(550)</strong></td>
</tr>
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</table>

### STRATEGIC BUDGETS

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLAs/UNPACs/NCA</td>
<td>10,051</td>
<td>5,026</td>
<td>6,227</td>
<td>(1,201)</td>
<td>(1,201)</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation, Capital Grants &amp; Asset Impairment</td>
<td>38,791</td>
<td>19,181</td>
<td>19,449</td>
<td>(268)</td>
<td>(268)</td>
<td>0</td>
</tr>
<tr>
<td>Provisions for Pension Costs &amp; Claims</td>
<td>15,915</td>
<td>1,511</td>
<td>1,523</td>
<td>(12)</td>
<td>(12)</td>
<td>0</td>
</tr>
<tr>
<td>Commissing from 3rd Sector</td>
<td>8,929</td>
<td>6,820</td>
<td>6,760</td>
<td>60</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Reserves &amp; Uncommitted Allocations</td>
<td>9,522</td>
<td>(1,662)</td>
<td>(1,902)</td>
<td>240</td>
<td>240</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>83,208</strong></td>
<td><strong>30,876</strong></td>
<td><strong>32,056</strong></td>
<td><strong>(1,180)</strong></td>
<td><strong>(1,180)</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**Total**                                           | **1,356,782**   | **674,145**   | **675,428**| **(1,283)** | **248**              | **(1,530)**     |
# NHS Lothian Income Summary September 2012

## APPENDIX 2

### YTD Budget Actuals Variance

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from other health systems</td>
<td>(114,582)</td>
<td>(49,270)</td>
<td>(49,496)</td>
<td>225</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(57,658)</td>
<td>(29,385)</td>
<td>(29,424)</td>
<td>39</td>
</tr>
<tr>
<td>National services</td>
<td>(31,232)</td>
<td>(23,005)</td>
<td>(23,046)</td>
<td>41</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,758)</td>
<td>(1,408)</td>
<td>(986)</td>
<td>(422)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(2,401)</td>
<td>(1,201)</td>
<td>(1,201)</td>
<td>0</td>
</tr>
<tr>
<td>Other income</td>
<td>(38,522)</td>
<td>(24,997)</td>
<td>(25,984)</td>
<td>987</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td><strong>(247,154)</strong></td>
<td><strong>(129,266)</strong></td>
<td><strong>(130,136)</strong></td>
<td><strong>870</strong></td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,254,745)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>(1,501,899)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The difference in the total annual income above and the annual expenditure budget in Appendix 1 relates to income budgets which are held within CMTs/CHPs/CHCP and corporate departments. At this local level £0.14bn of income budgets are offset against expenditure.
### SCHEMES WITH SPECIFIC FUNDING

<table>
<thead>
<tr>
<th>Description</th>
<th>Agreed Programme</th>
<th>Actual Expenditure</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committed</strong></td>
<td>(28,665)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>2,234</td>
<td>3,341</td>
<td>(1,107)</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>10,000</td>
<td>17</td>
<td>9,983</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>269</td>
<td>(37)</td>
<td>306</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>2,000</td>
<td>280</td>
<td>1,720</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>3,917</td>
<td>1,289</td>
<td>2,628</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>4,663</td>
<td>2,260</td>
<td>2,403</td>
</tr>
<tr>
<td>Gullane Medical Centre</td>
<td>1,245</td>
<td>0</td>
<td>1,245</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>11</td>
<td>(12)</td>
<td>23</td>
</tr>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>2,245</td>
<td>206</td>
<td>2,039</td>
</tr>
<tr>
<td>Radiotherapy-Other</td>
<td>226</td>
<td>10</td>
<td>216</td>
</tr>
<tr>
<td><strong>TOTAL - SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td>26,811</td>
<td>7,355</td>
<td>19,456</td>
</tr>
</tbody>
</table>

| **Approved, not committed**                                     |                  |                    |                                   |
| West End Medical Practice                                       | 1,467            | 136                | 1,331                             |

| **Programmed, but unapproved**                                   |                  |                    |                                   |
| Hub Enabling Works                                              | 0                | 0                  | 0                                 |
| Gullane Medical Practice                                         | 387              | 0                  | 387                               |

| **TOTAL - SCHEMES WITH SPECIFIC FUNDING**                       | 28,665           | 7,491              | 21,173                            |

<p>| <strong>Over/ (Under) Commitment on Specific Funding</strong>                 | 0                | 0                  | 0                                 |</p>
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<th>£k</th>
<th>£k</th>
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<td>85</td>
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<td>Expansion of renal capacity RIE *</td>
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<td>(297)</td>
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<tr>
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<td>(6)</td>
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<td>Observation Ward A&amp;E RIE *</td>
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<td>13</td>
<td>(368)</td>
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<td>(25)</td>
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<td>185</td>
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<td>Maternity Unit (SJH)</td>
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<td>BCI Mammography Upgrade WGH</td>
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<td>Tranent</td>
<td>389</td>
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<td>387</td>
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<td>500</td>
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<td>31</td>
<td>399</td>
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<td>31</td>
<td>868</td>
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<td>(131)</td>
<td>(21)</td>
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<td>(56)</td>
<td>4,331</td>
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**TOTAL - SCHEMES FUNDED BY FORMULA & OTHER FUNDING**

|                  | 20,203| 2,315| 17,888 |

**Over/ (Under) Commitment on Formula**

|                  | (4,068)|      |        |

**GRAND TOTAL**

|                  | 48,867| 9,806| 39,061 |

**Over/ (Under) Commitment**

|                  | (4,068)|      |        |

* VAT recovery is included in the remaining anticipated expenditure for this project.
NHS LOTHIAN ESTATE: BACKLOG MAINTENANCE ISSUES

1 Purpose of the Report

1.1 The purpose of the paper is to provide the Board with an overview of the backlog maintenance issues in relation to the estate of NHS Lothian and the proposed approach to the management of associated risks in the short term.

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

2 Recommendations

2.1 Board members are recommended to:

- Note the current level of backlog maintenance risks identified through the Property & Asset Management Strategy for 2012-2017 and that a major planning exercise is underway to scope the longer term investment required;

- Note that a robust Programme Management approach will be adopted for the delivery of an investment programme, to address these risks over the next 5 years;

- Note that plans are underway to scope the priority packages of work which can be delivered over the next 2 years;

- Approve a programme of up to £10m over the next 2 years utilising in-year slippage of £4m and the statutory standard budget this year and next;

3 Discussion of Key Issues

Strategic Context

3.1 The strategic agenda for healthcare services in Scotland is set by the NHS Scotland Quality Strategy, which considers the direction, development and delivery of all healthcare services. The Asset Management Policy for NHS Scotland\(^1\) supports this overarching strategy; it establishes the policy environment and key performance indicators for asset management; setting a framework against which the planning, deliver, management and disposal of all NHS Scotland property and other assets is undertaken and assessed.

\(^1\) CEL 35 (2010)
3.2 Over recent years there has been increasing focus on the cost of public sector assets. This recognises the importance of robust asset management, the need to ensure value for money, and the impact of the physical environment on patient care.

3.3 Expenditure on assets and the estate across NHS Scotland is in the region of £640 million per annum, representing 11% of each Board’s total hospital sector operating costs. In 2011 the first State of the Estate Report was produced for NHS Scotland. This report is based on information submitted by each NHS Board, from their individual Property & Asset Management Strategy (PAMS). These returns are submitted annually to the Scottish Government and provide details of the condition of Boards’ estate in accordance with a multi-facet survey of 6 key factors: physical condition, statutory compliance, quality, functional suitability, space utilisation and energy. It is a requirement of each Board to survey 20% of the estate on a yearly basis, to ensure accurate information is available on the condition of the estate and backlog maintenance requirements.

3.4 In 2011 the first State of the Estate Report was produced for NHS Scotland. This report is based on information submitted by each NHS Board, from their individual Property & Asset Management Strategy (PAMS). These returns are submitted annually to the Scottish Government and provide details of the condition of Boards’ estate in accordance with a multi-facet survey of 6 key factors: physical condition, statutory compliance, quality, functional suitability, space utilisation and energy. It is a requirement of each Board to survey 20% of the estate on a yearly basis, to ensure accurate information is available on the condition of the estate and backlog maintenance requirements.

3.5 Following publication of the State of the Estate Report for 2011, there was real concern over the level of backlog maintenance required across the NHS Scotland estate. This brought with it risks for service delivery as well as financial pressures: c. £1.01 billion for Scotland; £140 million for NHS Lothian. This cost estimate excludes VAT and fees, and any associated service cost of remedy.

3.6 The methodology used to estimate these costs was based on an assessment of hospital sites and health centres by independent Surveyors, under the management of Health Facilities Scotland (HFS), and in accordance with the NHS Scotland Asset Management Property Appraisal Manual 2011. This methodology provides an assessment of the backlog maintenance and statutory compliance costs for elements and sub elements of all assets which have a remaining life greater than 5 years.

3.7 The State of NHS Scotland Assets & Facilities Report for 2012 shows a reduction of £62 million in backlog maintenance investment required, with a total bill of £948 million for NHS Scotland. For NHS Lothian however, there has been a slight increase to £141.9 million (15% of the total required across Scotland).

**NHS Lothian Estate**

3.8 NHS Lothian has a large estate comprising a geographically and functionally diverse property portfolio of 600,000 m2, valued at £645 million (directly owned properties) as at 1 April 2012. This encompasses all properties currently used in the support and delivery of healthcare for NHS Lothian and includes NHS owned, leased and privately financed properties.

3.9 The current backlog maintenance requirements are set out in the Property & Asset Management Strategy for 2012-2017. The figure for NHS Lothian is £141.9 million:

- Physical condition £93.6 million
- Statutory compliance £48.3 million

3.10 It is important to note that more than 70% of the investment required represents a high or significant risk. The specific high risk areas are consistent across a number of the older hospital sites, including the Western General Hospital, St John’s Hospital, Royal Edinburgh, Astley Ainslie, Liberton and Roodlands Hospitals. The high risk areas include:

- Fire Precautions
- Legionella Risk (DHW & CWS)
- Estate Infrastructure (including external fabric)
- Window replacements
- Slips, Trips and falls.
- Future Service Development
- Asbestos
- Mechanical & Electrical plant (including HV, LV heating systems)
- Traffic Management

3.11 Whilst notwithstanding the fact that significant investment is required, there are a number of measures already in place to mitigate risks and to manage the likely investment required in backlog maintenance over the coming years. This includes:

- Property disposals;
- Reprovision programme already underway; and
- Other planned investments.

3.12 It is anticipated that the ongoing property disposal programme will reduce the overall backlog maintenance required across NHS Lothian by c. £30 million over the next five years, subject to the conditions of the property and financial markets. The anticipated reduction would be split as follows, and covers c. £24 million of high or significant risk areas:

- Clinical areas including the disposal of the Royal Hospital for Sick Children, the Royal Victoria Hospital, and Edenhall hospital (£20.8 million)
- Non clinical areas (£7 million)
- Vacant properties (£2.2 million)

3.13 In addition, specific reprovision projects will reduce the backlog maintenance cost by a further £43.2 million. This is primarily due to investments through the capital programme including:

- Redevelopment of the Royal Edinburgh Hospital
- Re-provision of Wester Hailes Health Centre
- Tranent Health Centre Extension
- Re-provision of Department of Clinical Neurosciences at the Western General
- Redevelopment of East Lothian Hospitals (Roodlands and Herdmanflat)

3.14 Further investment in the estate infrastructure is a key component of the Capital Plan, and will further reduce the backlog maintenance requirement for clinical areas by an estimated £25.8 million over a period of three years. This will be achieved through improvement and upgrade in a number of clinical areas: HEI; decontamination; endoscopy upgrade.
3.15 Whilst not yet quantified, it is also anticipated that further reductions in the backlog maintenance exposure will be achieved through a rationalisation of non clinical accommodation, through the Lothian Asset Management Strategy Project (LAMS) – to release clinical accommodation and allow further centralisation of corporate services.

3.16 The table below summarises the key actions already underway in the Property Asset Management Strategy which will significantly address backlog maintenance over the next five years. This leaves a residual balance of £42.9m for which plans now need to be developed, although there will also be some investment required in properties prior to disposal or redevelopment.

<table>
<thead>
<tr>
<th>Backlog Maintenance Reduction Programme</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total investment required per PAMS 2012</td>
<td>141.9</td>
</tr>
<tr>
<td>Planned disposals</td>
<td>(30.0)</td>
</tr>
<tr>
<td>Reprovision projects</td>
<td>(43.2)</td>
</tr>
<tr>
<td>Other planned investments</td>
<td>(25.8)</td>
</tr>
<tr>
<td>Rationalisation of non clinical accommodation</td>
<td>TBC</td>
</tr>
<tr>
<td><strong>Balance to be addressed as at October 2012</strong></td>
<td><strong>42.9</strong></td>
</tr>
</tbody>
</table>

Proposed Backlog Maintenance Investment Programme 2012/13

3.17 The risk mitigation set out in sections 3.8 to 3.16 will inevitably take place over a period of years and in the meantime, services continue on the sites mentioned. This continuing risk, coupled with the constraints on capital funding across NHS Scotland (the current NHS Lothian Capital Investment Plan for 2012/13 has only £4 million available from the formula allocation to assist with addressing those items prioritised as high risk in relation to backlog maintenance), mean that it is necessary, therefore, for a robust prioritisation and allocation process to be put in place.

3.18 Over the coming weeks, a number of site visits will be undertaken by key members of the Finance, Capital and Facilities teams to consider options available to address high risks in the immediate term. It is already clear, however, that a significant programme of work needs to be planned over the next 5 years.

3.19 It is also important to note that a number of essential infrastructure works has already commenced, and due to the nature of this work, some aspects can be supported from revenue resources rather than capital funding alone. All existing sources of funding, whether capital or revenue need to be taken into consideration in this programme of work. As already reported to the Corporate Management Team, the Quarter 1 review of the capital expenditure position shows that there is scope for additional capital funding to be made available (c. £4 million). In addition, any scope for revenue funding will be identified through the Mid Year Financial review.
3.20 As the programme is developed there are a number of key considerations which will be taken into account:

- Robust programme and project management support
- Procurement process, including the use of local framework contracts
- Priorities for a site based approach
- Priorities for a ‘works package’ approach
- Accounting treatment (revenue or capital spend)
- Timescales for completion of works

3.21 Data has been extracted from the Estate & Asset Management System (EAMS); and an analysis of the current risk profile over a number of our main sites and land holdings is attached as Appendix 1; this accounts for £77.4m (excluding VAT and fees) of the total backlog maintenance requirements. This highlights the key areas of investment proposed across a number of sites, to address the high risk areas.

3.22 An initial assessment of priorities which can be delivered over the next 18 months to 2 years is included as Appendix 2. Detailed packages of works will require to be assessed, tendered and project managed and it is proposed that this process is overseen by a Programme Board, chaired by the Director of Finance. Proposed membership will be presented to the Board.

4 Key Risks

4.1 The key risks associated with backlog maintenance are highlighted below:

- Failure to comply with statutory legislation, for example Control of asbestos, legionella and fire precautions;
- Reliance on operational policy to maintain safe environment rather than automated engineered solutions, e.g. fire precautions, building management systems and poor fabric (roofs etc);
- Business Continuity e.g. failure of critical service such as electrical distribution, heating plant and bed & passenger lifts;
- Availability of both capital and revenue funding to support investment in the infrastructure of the estate and raise the quality of accommodation to the ‘B standard’;
- Failure to maintain current standards and positive feedback received from HEI visits

5 Risk Register

5.1 There is nothing to further add to the Risk Register at this stage; however this will be considered further in parallel with the programme of works.
6 Impact on Inequality, Including Health Inequalities

6.1 An equality and impact assessment has not yet been undertaken. As assessment will, however, be undertaken for the programme of works once more fully developed.

7 Involving People

7.1 It is proposed that a multi discipline working group be established to oversee the programme of work during the remainder of the year. This may well include a more structure approach to the prioritisation of backlog maintenance and statutory compliance works over the coming years. Senior staff from across Facilities & Estates, Capital Planning, eHealth, and Finance will be involved.

8 Resource Implications

8.1 The resource implications of the investment in backlog maintenance are set out in the body of the report, however further work over the coming weeks will identify the actual level of revenue and capital expenditure expected in the current financial year.

8.2 It is anticipated that dedicated Project Management resource may be required although the likely cost is not yet known

Susan Goldsmith
Director of Finance
12 October 2012
Susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Backlog Maintenance Requirements by Works Package (main sites)
Appendix 2: Backlog Maintenance Initial Priorities
<table>
<thead>
<tr>
<th>Year</th>
<th>Site</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Other</th>
<th>Net Cost</th>
<th>VAT</th>
<th>Fees</th>
<th>Total Gross Cost</th>
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<td>Western General</td>
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<td>Edinburgh Royal</td>
<td>Roodlands AAH</td>
<td>Liberton PAEP</td>
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<td>RHSC</td>
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<td>VAT</td>
<td>Fees @15%</td>
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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).

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 report and action plan following an unannounced visit to the Royal Infirmary (27th – 29th August) and support the implementation of the action plan.

2.2 Reconfirm support the required actions to implement the overarching Vulnerable Peoples improvement plan and support proposed action to accelerate improvement in key areas of practice.

2.3 Consider wider implications of the report in terms of the delivery of patient care.

3 Discussion of Key Issues

3.1 Previous Board meetings have been informed of the pilot inspection at Liberton Hospital in December 2011, the formal visit in April to the WGH and the local mock inspections conducted across all sites examining care for Older People in Acute Hospitals (OPAH).

3.2 The visit on the 27th – 29th August to the Royal Infirmary (RIE) was the first of the unannounced visits to all Health Boards from HIS and the 2nd formal visit to NHS Lothian.

3.3 The Inspection team visited 7 wards, the Combined Assessment Area, the Discharge Lounge and also paid a brief visit to Emergency Department over the 3
days. They examined 37 health care records, spoke to 27 patients and conducted a telephone interview with one carer. They also distributed questionnaires to patients, carers and relatives with a return of 37.

3.4 The focus of the visit was 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 team also observed patients and staff paying particular attention to nutrition and hydration.

3.5 Feedback was given immediately within the areas visited and high level post inspection feedback was given to senior staff both verbally and in writing. The final report differed from the verbal and written post inspection feedback in that only 4 areas of strength were noted (compared to 12 in the post inspection feedback).

3.5.1 The formal report was published on 8th October (Appendix 1) and notes 4 areas of strength and 23 areas which require improvement.

3.5.2 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.

3.5.3 The report indicated the following areas of strength:
- Good practice in relation to guardianship
- Use of Psychiatric Liaison Service
- Tissue Viability Service and use of pressure relieving equipment
- Availability of meals and snacks out with meal times

There were however a significant number of areas identified for improvement as detailed in the report but summarised in themes of
- Compassion, Dignity & Respect
- Dementia & Cognitive Impairment
- Nutritional Care & hydration
- Pressure Ulcer Prevention

3.6 Following each visit a site action plan is required for submission to HIS. The plan following the inspection of the Royal Infirmary is attached (Appendix 2).

3.7 The action plan requires significant work across all sites and all groups of staff to improve the care of Older People. This work needs to be undertaken within the context of current pressures of waiting times, unscheduled care, financial restraint and organisational change.

3.8 In June 2012 the Board agreed to the development of an overarching improvement plan for the care of Vulnerable People (adult) and this plan (available on request) is now complete but will remain a dynamic and evolving document. The Plan encompasses the requirements and recommendations of the OPAH inspections, the National Older Peoples’ Standards and in addition includes the actions required to meet the National Dementia standards. This Improvement Plan acknowledges that the requirements of vulnerable patients are many but highlights
the similarities across the spectrum of core requirements. The key findings of the Older Peoples inspections to date are within the focus of improvement work streams.

3.9 This improvement work is also 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. The rollout plan for these and regular management reporting is now in place and most of the audit findings are those already being addressed in the improvement plan.

3.10 Work is on going to establish an improvement hub to take forward a number of initiatives aligned to the Delivering Better Care agenda a large proportion of which relates to reduction/avoidance of harm and includes many of the issues covered in the vulnerable peoples action plan e.g. Nutrition, frailty, cognitive impairment, falls, pressure damage. This approach will bring together numerous work strands to maximise impact and reduce duplication. This is a one year project supported by additional monies for “Leading Better Care” from Scottish Government. To accelerate the delivery of both the RIE OPAH Action plan and the overarching Vulnerable Peoples Improvement Plan the implementation of the Delivering better Care work needs to be accelerated in terms of scope and timescale.

3.11 HIS, in progressing their work, are developing a specific Improvement programme around the national Person Centred Care agenda As part of this NHS Lothian is a HIS test site for the Care Rounding project in terms of wide scale spread plans. HIS also conducted a Scottish Patient Safety Programme Site visit (10/11 October) and gave very positive feedback about our work on Care Rounding, Pharmacy, Cognitive Impairment Staff training and induction among other things.

3.12 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. (Appendix 3).

3.13 These national findings mirror the issues noted at the RIE. An internal review of all published reports confirmed these common national themes as :-
- Compassion, Dignity & Respect
  - Use of inappropriate language
  - Inaccurate and inconsistent completion of DNACPR
  - Lack of privacy and confidentiality
  - Lack of stimulation and activity for patients who are past their acute care phase pending longer term placement
- Dementia & Cognitive Impairment
  - Lack of screening and assessment
  - Lack of individualised care plans
  - Lack of knowledge of consent and capacity issues
  - Inappropriate environment for confused patients
  - Lack of systems to monitor / reduce boarding of frail confused patients
- Nutritional Care & Hydration
  - Inadequate screening
  - Lack of individualised care plan
• Lack of appropriate equipment
• Lack of adequate recording of food and fluid intake

**Pressure Ulcers**
• Risk assessments not timeously undertaken
• Risk assessment findings not accurately recorded
• Care plans not reflecting care required
• Evaluation of care not in place

3.14 The report raises wider organisational issues for NHS Lothian about our attitude to the Care of Older People. These issues relate to the changing context within hospitals caring for predominantly Older People with complex morbidity and multiple care needs, without a corresponding change in models of care, environment or staffing.

3.15 Issues for the Service relate to
• Models of Care
• Patient Flows (Unscheduled and Elective Care)
• Staffing Levels
• Patient Feedback
• Assurance to the Board on matters of essential patient care
• Working with national organisations to ensure maximum benefit from inspection and improvement requirements

3.16 Issues for all Staff relate to
• Staff Support
• Attitude and Communication skills
• Complexity of improvement work streams in place locally and nationally

3.17 Particular issues relating to Nursing care re:-
• The Role of the Charge Nurse and Clinical Nurse Manager
• Staffing Levels
• Registered Nurse to Unregistered staffing ratios

Work is ongoing to review these key issues and so accelerate the improvements required as described in the action plans noted above.

4 **Key Risks**

Vulnerable patients do not receive the care they require.

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. An unannounced follow up inspection is inevitable and demonstrable change is required in a short time scale.

5 **Risk Register**

5.1 The risk of harm to patients is already noted in the Risk Register. Work set out here and in related programmes (such as the Scottish Patient Safety Programme)
aim to mitigate that risk. Additional work described here, especially in terms of accelerating current improvement programmes will provide further reassurance or indicate the need for further action. 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 vulnerable people and improve care.

6.2 There is no impact assessment required for this report.

6.3 The overarching Vulnerable People’s improvement plan will be impact assessed and a date has been set to conduct this.

7 Involving People

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

8 Resource Implications

Current work within the Delivering Better Care programme and Vulnerable Persons Action Plan is funded by non recurring monies from Scottish Government. To embed and sustain this work recurring funding for facilitation posts is required. To accelerate the improvement work non recurring monies to increase facilitation and support to ward staff is required. Work is in progress with the Finance Director to quantify and source this funding.

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12th October 2012

Appendix 1: HIS Report on Unannounced Inspection to Royal Edinburgh Infirmary
Appendix 2: NHSL Action Plan in response to HIS Report on Unannounced Inspection to Royal Edinburgh Infirmary
Appendix 3: HIS Care for Older People in Acute Hospitals Six Monthly Report (February – July 2012)
Appendix 4: Comparison by Health Board of Inspection Outcomes
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1 About this report

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

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

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

This report sets out the findings from our unannounced inspection to the Royal Infirmary of Edinburgh, NHS Lothian from Monday 27 August to Wednesday 29 August 2012.

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

The inspection team was made up of four inspectors and two public partners, with support from a project officer. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. A key part of the role of the public partners is to talk to patients and listen to what is important to them. Membership of the inspection team visiting the Royal Infirmary of Edinburgh can be found in Appendix 2.

The report highlights areas of strength, areas for improvement and areas for continuing improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 20. Wherever possible, the areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. A list of relevant national standards, guidance and best practice can be found in Appendix 3.

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

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

We carried out an unannounced inspection to the Royal Infirmary of Edinburgh from Monday 27 August to Wednesday 29 August 2012.

We inspected the following areas:

- combined assessment area
- ward 101 (medicine for the elderly – stroke ward)
- ward 106 (general/vascular surgery)
- ward 109 (orthopaedic trauma)
- ward 201 (medicine for the elderly)
- ward 202 (medicine for the elderly)
- ward 203 (medicine for the elderly), and
- ward 204 (respiratory ward).

We also visited the accident and emergency department and the discharge lounge.

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

On the inspection, we spoke with staff and used additional tools to gather more information. In seven wards, we used a formal observation tool. We carried out 13 periods of observation during the inspection. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.

We also carried out patient interviews and used patient questionnaires. We spoke with 27 patients during the inspection. We also had a telephone interview with one carer. We received completed questionnaires from 37 patients.

As part of the inspection, we reviewed 37 patient health records to check the care planned and delivered was as described in the care plans. For this inspection, we reviewed 35 of these patient health records for dementia and cognitive impairment. We also reviewed 32 of them for preventing and managing pressure ulcers, and 26 of them for nutritional care and hydration.

We saw that NHS Lothian has developed a vulnerable adults quality improvement plan. This involves a group of multidisciplinary staff who are involved in making improvements to the care of vulnerable adults. Areas that have been identified for improvement include:

- screening and assessment
• safe, effective and person-centred assessment and care planning, and
• practice development, leadership and quality improvement.

We will look at the impact of this improvement plan at future inspections to NHS Lothian.

Areas of strength
We saw evidence on one ward that staff were confirming with the Office of the Public Guardian about proxy powers held by patients’ appointed welfare power of attorney. This is someone who is appointed to make decisions on someone else’s behalf when they are unable to do so themselves.

Patients can access a hot meal if they are off the ward at mealtimes. Staff are able to offer alternative options to patients if they are unhappy with the meal they received. Snacks for patients are available out of hours.

A tissue viability service is available to provide advice and support to staff on wound care and pressure ulcer prevention and management. Education is provided to staff on induction and through an annual staff training day.

Areas for improvement
We found that further improvement is required when providing care to older people in acute hospitals.

We are concerned about how staff are making sure patients’ dignity and comfort are maintained at all times in the combined assessment area. This is a mixed sex area and patients can be there for a number of days before being discharged or transferred to a ward.

We had to intervene on three occasions whilst inspecting this area of the hospital. Due to the busy nature of the ward, we saw instances where nursing staff would start to care for a patient and then be called away before they were able to complete their tasks. Patients were interrupted on several occasions while treatment and care was given.

Some mealtimes seemed poorly organised. Patients who needed help with their meals waited for a long time before that help was provided. We had significant concerns about the provision of meals across several wards and how some patients were assisted to eat their meals. On a number of occasions, we had to intervene and ask staff to provide help for patients at mealtimes.

There is no routine screening for cognitive impairment taking place when patients are admitted to hospital. Staff in the accident and emergency department confirmed that they do not routinely carry out cognitive screening on all patients over 65 years of age.

We also found that risk assessments for nutritional care and hydration, and to determine whether patients were at risk of developing a pressure ulcer, were not being carried out within the correct timeframes.

We found no information in the care plans outlining the individual needs of older people. This means that there is no information for staff on how they can provide care to meet those individual needs.

Across the hospital, the ward environments inspected were not helpful for people with dementia and cognitive impairment.

This inspection resulted in four areas of strength and 23 areas for improvement. A full list of the areas for improvement can be found in Appendix 1 on page 20.
We expect NHS Lothian to address all the areas for improvement. Those areas where improvement is required to meet a recognised standard must be prioritised.

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

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

Treating older people with compassion, dignity and respect

All seven wards inspected were mixed sex wards, with patients accommodated in either single sex bays or single rooms. Designated male and female toilets and shower facilities were available in the wards. The majority of patients in the wards and departments inspected were out of bed and were dressed in their own clothes.

However, we found that patients were in mixed sex bay areas in the combined assessment area. We had to intervene on three occasions to ask staff to help preserve patients’ dignity. This included a female patient with a learning disability who was uncovered and exposed to other patients, staff and visitors in one of the bay areas.

Medical patients are assessed in this area and have initial clinical tests and treatment. As a result of this assessment, patients may either be discharged home or admitted to the hospital. The patient information leaflet for this area states that patients do not routinely stay for more than 48 hours. However, we were aware of patients who had spent 2–3 days in this area. We noted the busy and noisy nature of the combined assessment area. We were concerned about some poor caring interactions with patients in this area. We saw instances where nursing staff would start to care for a patient and then be called away before they completed their tasks. This meant patients were frequently interrupted while receiving care. One patient’s carer told us that they were finding it difficult to find out what was happening to their relative after an emergency admission to the combined assessment area. They stated that their experience was not pleasant and they felt they were being given conflicting information from staff.

All the wards inspected had a nurse call system in use. We saw that the nurse call handsets were not always placed near to patients to make them accessible. For example, we saw some handsets still attached to the wall next to patients’ beds. Patients told us that the initial response to calls was usually quick. Some patients felt that it could take time to get the actual assistance requested, particularly at night. In the combined assessment area, we had to intervene and find a member of staff for a patient who had no handset available. There were no staff visible in the bay area at this time.

Curtains around the beds were used to maintain the dignity of patients and to provide treatment in privacy. On some wards we noted that the bed curtains were too short and did not always allow privacy for the patient. Some curtains were also starting to fall down off the rails. We drew this to the attention of the senior change nurses on the wards affected. On one ward, we noted that appropriate curtains were in place by the following day.

Personal care information displayed above the beds was kept to a minimum. Personal items, such as glasses, dentures, walking aids and patients’ water jugs were not always easily accessible for patients in all of the wards inspected.

Patient comments

Through our patient surveys and patient interviews, patients had the opportunity to give us their opinion of the care they received. Overall, patients were positive about the care and help they received. Of the 37 patients who completed our questionnaire, 86% stated that they had been given clear information about their condition and treatment. 97% said the quality of care they received was good.
‘Staff on the wards… have been more than caring - well above the call of duty, both day and night, and even when very busy have found time to assist when all you need was a shoulder to cry on.’

‘Ward staff are very helpful. A lot of care in [ward] was put into a wandering soul with dementia. Staff were excellent… and made sure dignity was maintained.’

‘Care has been first class.’

‘I have been coming here for the last 3 years and the care and attention I was given was excellent from doctors, nurses and all was spot on. 10 out of 10.’

‘I was anxious about my stay in hospital but the staff have been amazing and made me feel better.’

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

‘I feel that this is such a busy ward and there are not enough staff at times to cover all aspects of the needs involved.’

‘I have vascular dementia and am not very good at communicating at times and also find it hard to hear and understand when being advised of my condition so I prefer if this is done with my family and more so to the member of my family who is my full-time carer and holds power of attorney on my behalf. It would be most helpful if my family carer could be present when a doctor or nurse have something of importance to tell me as I will not remember what has been said.’

Some patients told us that they found it confusing when they had a number of different doctors visiting them. This left them unsure as to who was the doctor responsible for their care and treatment.

**Patient and staff interactions**

We used a formal observation tool in seven of the wards inspected to observe interactions between staff and patients. For the most part, we saw warm, caring and friendly interactions with patients across all staff disciplines including nurses, medical staff, physiotherapists and occupational therapists. We found that staff were encouraging, supportive and compassionate, and talked to patients in a quiet, gentle and respectful manner. The following examples of what we saw are how we would expect to see staff and patients interacting.

- Staff had taken advice from the Alzheimer Scotland nurse consultant about a patient who likes to walk. Staff were seen spending a lot of time walking with this patient. Staff spoke to the patient in a positive and respectful manner and made sure his dignity was protected and his safety considered. We also saw evidence of involvement from the patient’s family in their care. On another ward, we saw another example of a nurse spending time with a patient who likes to walk.

- A nurse answered questions from a patient who appeared to have issues with their short-term memory. While we observed, the patient asked the same questions on three separate occasions within a short space of time. The nurse answered the patient’s questions in a kind and patient manner using the same tone of voice and giving the same information each time.

However, on one ward, we noted little interaction between some staff members and patients, other than what was needed to complete care tasks. For example, meal trays were put down in front of patients with little or no interaction. We saw one patient ask for help to find their glasses. The staff member looked on the bed table and in the patient’s dressing gown pocket, but then left the patient stating that they could not find them. The patient was left to eat their meal without their glasses on to help them see. This same staff member was observed knocking over a patient’s glass of water while putting down their meal tray. There
was no apology given to the patient or any conversation with the patient while the staff member wiped up the spilt water.

We heard staff use the following inappropriate language when talking about older people in hospital.

- Two members of staff referred to repositioning patients in bed as ‘doing all the turns’ and ‘I just need to turn a little lady.’
- Staff referred to patients as bed or room numbers, such as ‘Bed one needs the toilet’, ‘Put room five back on his bed’ and ‘Have you turned bed five?’
- Staff used terms such as ‘feeding’ and ‘feeders’ when referring to patients eating.
- When a patient asked for help, a staff member replied ‘I need two people, I can’t do you myself.’

We saw that some staff did not always consider patient confidentiality when talking about patients and their conditions or treatment. For example, we heard staff having conversations about confidential patient information in public areas or outside wards. This was particularly notable among the junior medical staff.

**Do not attempt cardiopulmonary resuscitation documentation**

Do not attempt cardiopulmonary resuscitation (DNACPR) relates to the emergency treatment given when a patient’s heart stops or they stop breathing. Sometimes medical staff will make a decision that they will not attempt to resuscitate a patient. This is because they are as sure as they can be that resuscitation will not benefit the patient. For example, this could be when a patient has an underlying disease or condition and death is expected. When this decision is made, opportunities should be taken to have honest and open communication to make sure patients and their families are made aware of the patient’s condition. However, in some cases, clinical staff may decide not to share this information as they feel it may cause too much distress for the patient and their family.

From the patient health records reviewed, we saw a number of DNACPR forms in place. We noted that not all of these DNACPR forms were kept at the front of the patient’s health record. This means that staff would not be immediately aware of the decision made whether or not to resuscitate the patient. We saw one DNACPR form that had been signed by a junior doctor and had not been countersigned by the senior clinician responsible for the patient’s care at the time of our inspection. There was no documented evidence that there had been discussions with patients and their families regarding any DNACPR decisions. If staff take the decision not to speak to a patient and their family about a DNACPR decision, then the reason for not doing so should be documented in the patient’s health record.
Areas for improvement

1. NHS Lothian should ensure that patients’ dignity, privacy and comfort are maintained at all times in the combined assessment area.

2. NHS Lothian should ensure that staff interact with patients to make sure that their experience of attending hospital is as positive as it can be, and that patients are treated with dignity and respect at all times.

3. NHS Lothian should ensure nurse call handsets are available and accessible to patients at all times.

4. NHS Lothian should ensure staff are aware of their interactions with each other when on the wards to ensure patient confidentiality is respected at all times. Staff must always use appropriate language when talking about older people in hospital.

5. NHS Lothian should ensure that if medical staff take the decision not to speak to a patient and their family about a DNACPR decision then the reason for not doing so is documented in the patient’s health record.

Dementia and cognitive impairment

Elderly care assessment team

NHS Lothian’s self-assessment states that elderly care assessment teams are in place on some hospital sites. In the Royal Infirmary of Edinburgh, the elderly care assessment team is available 7 days a week from 7.30am – 6.30pm. The team consists of three nurses and a medicine for the elderly consultant with input from occupational therapists and physiotherapists. Within 24 hours of admission, the team aims to screen all acute medical patients over 65 years of age in the combined assessment area who meet specific referral criteria. NHS Lothian’s self-assessment states that patients are screened using a variety of tools to assess functional (physical) ability, continence and cognition.

Screening and assessment of people with dementia and cognitive impairment

NHS Lothian’s self-assessment states that older people are screened for cognitive impairment on admission. It states that medical staff use a locally developed screening tool for identifying patients with delirium and cognitive impairment, and this has been implemented in several of the medicine for the elderly wards. There are plans to roll this out for use across the hospital.

From the patient health records reviewed, we found that there was no routine screening for cognitive impairment taking place when patients are admitted to hospital. Staff in the accident and emergency department told us that they have carried out audits of cognitive screening. They are aware that this is not routinely being carried out on all patients over 65 years of age. They have plans to introduce a new patient health record and intentional care rounding. This is when staff check on individual patients at defined regular intervals to pre-empt any care needs they may have. The intentional care rounding documentation will include a prompt for cognitive screening for staff to make sure that this is carried out.

Of the 35 patient health records reviewed for dementia and cognitive impairment, 15 had been screened and assessed for cognitive impairment within 24 hours of admission. We noted instances where patients admitted to the combined assessment area, and noted to be confused, were not being screened for cognitive impairment. Reasons for delays in carrying out the assessment were not always documented in the patient’s health record.
We noted one patient who had no formal cognitive assessment. The patient had been discharged from hospital a few days earlier. He had been readmitted to the combined assessment area because he could not manage at home. The patient health record gave conflicting information as to whether the patient accepted the offer of a care package at home. There was also information about the patient being agitated through the night. Staff in the accident and emergency department had requested that a formal cognitive impairment assessment be carried out. There was no evidence of any formal cognitive screening or assessment. We noted that this patient was transferred to a ward in the early hours of the morning after spending 3 days in the combined assessment area.

Record-keeping and care planning for people with dementia and cognitive impairment

NHS Lothian uses the ‘This is Me’ document to request and record key personal information about patients. This document allows patients and their carers to highlight personal information to staff such as habits, background, likes and dislikes and things that are important to them. It also allows carers to identify how involved they wish to be during the patient’s stay in hospital. However, we saw inconsistent use of the document in the wards and departments inspected.

There appeared to be a lack of understanding by some staff on how the document should be used. Staff told us that they sometimes gave the document to families to complete, but not many were returned. Staff are not always taking this opportunity to engage with the families and carers of patients with dementia. In one case, we saw that a patient’s family had completed the document, and given lots of useful information about their relative. However, we found that none of this information was used to develop a personalised care plan for this patient. Staff also told us about the difficulties they can have using a document with an Alzheimer Society logo as this can be insensitive where a diagnosis of dementia has not been made. NHS Lothian told us it is liaising with Alzheimer’s Society to discuss the best way forward to use this document.

In general, we saw a lack of personalised care plans for patients with a cognitive impairment or a known diagnosis of dementia. This meant there was little information to guide staff on how to meet the individual needs of each patient consistently.

Adults with Incapacity (Scotland) Act 2000

We found inconsistent practice and a lack of understanding among some staff of the Adults with Incapacity (Scotland) Act 2000 and managing patients who lack capacity. The Act includes a form that provides the authority to treat patients who are unable to consent themselves.

We saw some good examples of the appropriate certificate of incapacity forms with corresponding treatment plans in place. There was also good evidence of discussion with patients and their families. We noted one patient where staff had confirmed with the Office of the Public Guardian the proxy powers held by the patient’s appointed welfare power of attorney.

We saw examples where capacity assessments had not been carried out. This was despite patients being noted as confused or concerns being raised about their ability to understand the need for, or consequences of, their treatment.

In some cases, we found that certificate of incapacity forms were in place, but these only made reference to a specific intervention, usually a surgical procedure. The patient’s capacity to consent to other treatment or interventions, which may be part of their care, had not been documented.
We were told that there are plans to include training on Adults with Incapacity and assessment of capacity for new junior medical staff coming into the hospital.

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

People with dementia or a cognitive impairment can benefit from environments that are adapted to limit potential confusion and distress. In the wards inspected, we saw that few changes had been made to improve the environment and, as a result, the wards are not helpful to people with dementia. We saw some signs on toilet and shower doors, and day/night picture clocks on some wards. However, we found that the toilet doors were cluttered with too many signs which can be confusing for patients. We also noted that the clocks were positioned too high on the walls. Research\(^1\) states that older people are less likely to see something that is above 1.2 metres. Some of the clocks were also not set correctly and were displaying a night image during the day. One patient told us of waking up and being confused about what time it was.

We saw no evidence that best practice in relation to the use of colour contrast was in use. This is helpful to people with dementia to identify specific areas, such as handrails or toilets.

We noted that many wards were cluttered with healthcare equipment around the bed spaces, in the bay areas and ward corridors. This could restrict patients who like to walk in the ward and it could also increase the risk of patients falling. Lighting on some wards was also poor. On one medicine for the elderly ward, staff told us that one strip light had been removed from each of the light units in the ward corridors. Staff commented that the lighting was poor and did not help older people to see well. Research states that older people need additional light to be able to see well\(^2\).

Throughout the inspection, we noted a lack of stimulation and activity for patients. There were patients who were medically well and awaiting care packages, transfer to a care home or discharge home after a long stay in hospital. Patients told us there was nothing to do. Staff told us that there is no further input provided to patients by allied health professional staff, such as occupational therapists and physiotherapists, when patients reach their rehabilitation potential for that episode of care.

**Psychiatric liaison services for older people**

There is specialist psychiatric liaison input for older people. This is provided one and a half days each week by a specialist doctor. There is currently no nursing or allied health professional input into the psychiatric liaison service. We saw evidence of advice and involvement from the psychiatric liaison service in patient health records. Training on mental health issues that can affect older people is also provided to ward staff.

We are aware that NHS Lothian is also planning to introduce a mental health bridging team. The team will consist of specialist staff who will support general nursing staff in the care and treatment of patients with dementia.

**Patient movement**

People with dementia or a cognitive impairment should not be moved or ‘boarded’ unless this is part of their medical treatment or part of their care pathway. Moving patients can increase their level of confusion and lengthen their stay in hospital. Boarding is when patients are moved from one ward to another to meet the needs of the service not because

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\(^1\) Design features to assist patients with dementia in general hospitals and emergency departments, University of Stirling Dementia Services Development Centre, 2012.

\(^2\) Light and lighting design for people with dementia, University of Stirling Dementia Services Development Centre, 2nd edition 2010.
of the patient’s clinical needs. For example, medical patients being boarded outwith the appropriate specialty to surgical wards.

We found evidence that patients were moved around wards, and between wards. This included patients with dementia or a cognitive impairment.

There is no system in place to track the number of bed or ward moves for patients with dementia or cognitive impairment.

**Areas of strength**

- On one ward, staff told us they are confirming with the Office of the Public Guardian the proxy powers held by patients’ appointed welfare power of attorneys. We saw an example of this.
- NHS Lothian has a psychiatric liaison service for older people, which provides advice and information to staff when required.

**Areas for improvement**

6. NHS Lothian must ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment.

7. NHS Lothian must ensure that patients identified as having a cognitive impairment have a personalised care plan in place. This care plan should identify the specific needs of the patient and how staff will meet these needs.

8. NHS Lothian must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information should be used to inform a plan of care and be shared with all staff in direct contact with the patient.

9. NHS Lothian must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. All staff who have a professional role to implement the legislation must receive training appropriate to their role. When legislation is used, this must be fully documented in the patient health record, including any discussion with the patient or family.

10. NHS Lothian must carry out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment.

11. NHS Lothian must ensure that patients who are medically well and awaiting care packages have access to a range of activities and stimuli to help keep them active and maintain their current level of functioning.

12. NHS Lothian must have a system in place that monitors the number of bed or ward moves patients with dementia are subject to when in hospital.
Nutritional care and hydration

The majority of patients we spoke with were complimentary of the quality of the food and the choices on offer.

- ‘It’s like dining at The Ritz every day, your cooking staff could give Gordon Ramsay a run for his money.’
- ‘No complaints about meals, always dished up nicely and always hot and a good selection.’

Nutritional assessment and personalised care plans

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

Of the 26 patient health records reviewed for nutritional care and hydration, five had a nutritional risk assessment carried out within 24 hours of admission. We noted that if patients were not weighed on admission for clinical reasons, the reason was not always documented in the patient health record.

From the patient health records reviewed, we found that patients admitted to the combined assessment area did not have nutritional risk assessments carried out. These assessments were often carried out once a patient was transferred to a ward.

Where nutritional risk assessments had been carried out, these were not always completed accurately or continuing risk factors were not reflected in the ongoing risk assessments.

- A patient had been weighed by the dietitian during their hospital stay and was noted to have lost approximately 6kg in weight since their admission to hospital. However, the ongoing nutritional assessments continued to note the patient’s weight when they were first admitted to hospital and did not reflect the weight loss.
- A patient had no nutritional risk assessment carried out on admission. The patient was being weighed daily. When reviewing the patient health record, we had to calculate the total weight loss and bring to ward staff’s attention that the patient had lost 10kg in weight over a week. Staff were unaware of this and were not reviewing or calculating the total weight loss.

We found limited information in care plans about patients’ nutritional needs, likes and dislikes, special dietary requirements, food allergies or any assistance needed with eating and drinking. We found that staff were sometimes aware of this, but the information was not always recorded in the care plans or assessment documentation. For example, we looked at the records of a patient who was significantly underweight and had continued to lose weight in hospital. We saw that the patient’s family had provided detailed information for staff about their relative’s dietary requirements and preferences, and what would encourage them to eat. When we looked at the patient health record, we found that none of this information was included in the section about the patient’s nutritional needs. We spoke with staff and asked what information they had about this patient’s likes and preferences. They were unaware of the information provided by the family.
Food and fluid balance charts

Food and fluid balance charts are used to record how much patients are eating and drinking where there are concerns about their intake. Where we saw food and fluid balance charts in place, these were not always completed accurately or consistently. We saw many instances where there was no review or evaluation of patients’ food and fluid intake to make sure that patients were eating and drinking enough. For example, we saw a nurse helping a patient eat their meal. Later in the day, a different nurse then filled in the patient’s food chart. When we asked the original nurse who had helped the patient how much the patient had eaten, this was less than had been recorded in the food chart.

We noted a number of food trays were returned with a lot of food uneaten at times. On one ward, we noted that a large amount of food had been taken back to the trolley after lunch. Only one patient on this ward had a food chart in place. We were told it could be three different staff members who cleared away breakfast, lunch and dinner trays. As a result, there is no overview of how much patients are eating throughout the day. This means that staff cannot be sure that patients are getting the nutritional intake they need.

- We found one patient on a 2 litre fluid restriction. The patient’s fluid balance charts had not been completed, the totals calculated and the results evaluated. We observed two clinical support workers with the tea trolley on this ward. They discussed whether to wake the patient for a cup of tea, and then decided not to due to the patient’s fluid restriction. One of the fluid balance charts recorded that the patient had only received 250mls of fluid over a 24-hour period. There was no record that any action had been taken to report this or any plan put in place to ensure the patient received the correct amount of fluid.

- A dietitian had advised that a patient was started on a 3-day food chart to monitor the patient’s food intake. The food chart commenced the following day. No evening meals were recorded for 2 days. There was no review or evaluation of the food chart. The patient’s weight was recorded twice, and dietary supplements were prescribed on the same day as the food chart started. These were recorded as given to the patient for a week. The dietitian saw the patient again and recorded that the patient should be given milkshakes twice a day and snacks. The patient’s care plan did not reflect how this was to be achieved or how staff would monitor and record this. There was no further recording of the patient being given dietary supplements. We were told that the patient had ‘refused’ to take the supplements after the first week. We were told that this was likely because most patients do not like the taste. There was no evidence that the dietitian had been asked to review the patient’s dietary supplements.

Provision and assistance of nutrition and hydration

Protected mealtimes have been introduced across the hospital. This reduces non-essential interruptions during mealtimes to make sure that eating and drinking are the focus for patients without unnecessary distractions. However, we saw that mealtimes were not always protected. For example, we saw medical staff visiting patients, routine bloods being taken and ensuite toilets in single rooms being cleaned while patients ate their meals.

We found that patients’ needs and abilities were not always taken into account when staff were serving meals. Mealtimes seemed poorly organised on some wards, resulting in patients who needed help with their meals waiting for a long time before that help was provided. We had significant concerns about the provision of meals across several wards and how some patients were assisted to eat their meals. On a number of occasions, we had to intervene and ask staff to provide help for patients at mealtimes.
A patient whose left arm was in a plaster cast had their bowl of soup set down on their left side. The patient was unable to reach the soup with their right hand. After a 20-minute delay, we intervened and were told ‘someone will feed [the patient] soon’. We asked the senior charge nurse to come out of a meeting to make sure this patient got the appropriate help to eat their meal.

A patient who was known to be significantly underweight sat for over 10 minutes with their meal on the table in front of them. The patient was unable to eat without help. The patient fell asleep and had to be woken by staff when they arrived to help.

On two separate occasions, patients with visual impairments (one patient was partially sighted, one patient was blind), were not assisted to find their cutlery or it was placed out of reach. We saw the partially sighted patient eating her meal with their fingers as their cutlery was out of sight under their plate. We had to ask staff to help this patient. The patient who was blind was not handed their cutlery when the meal tray was delivered. We intervened to help this patient find their cutlery.

We observed a patient attempting to drink from their water jug as their glass was out of reach. We intervened to give this patient their glass. This same patient was then observed attempting to eat their meal. They were moving food from the plate to the tray and seemed unable to eat their meal by themselves. We had to ask staff to help this patient. When we looked at this patient’s health record, we noted the patient had been newly admitted to the ward. There was no indication that any assessment of their ability to eat independently had been carried out.

A patient was in a bed very close to the trolley where staff were serving meals. This patient had their meal placed in front of them. It took over 10 minutes for a member of staff to notice the patient was not eating independently and help them. When we looked at the patient health record, we noted that the patient had been admitted from a nursing home and was on dietary supplements. The patient had been seen by a dietitian and staff had been asked to make sure the patient had an adequate intake of food.

In the combined assessment area, patients were served soup in uncovered open bowls which was being taken through the unit on a trolley. As the soup was uncovered and would become cold quickly, staff could not assist patients while they were handing out the soup. Other staff in this area made no attempt to help a patient who kept falling asleep after each spoonful of soup. The patient’s health record noted the patient had a poor appetite. There was no nutritional risk assessment and the patient had not been weighed on this admission to hospital.

We also saw two patients with dry mouths who had not received mouth care. Their mouths were dry and crusted and, as a result, they found it difficult to speak with us. Mouth care is important for patients’ health and wellbeing. It helps patients communicate better, eat more easily and helps them maintain their dignity.

We also noted that patients were not offered opportunities to wash their hands before mealtimes.

Menus and provision of snacks

When patients were off the wards during mealtimes for procedures, we saw that staff were able to access hot meals for them when they returned to the wards. We also noted instances when staff offered an alternative option to patients if they were unhappy with the meal they received.

Snacks, such as sandwiches and yoghurts, are available out of hours for patients who have missed a meal or who wish to have a snack outwith mealtimes. Patients can also have hot
drinks in the evening. This reduces the time between patients receiving their evening meal and breakfast the following morning.

We noted that the hospital does not use picture menus to help patients with a cognitive impairment to make meal choices.

Use of adaptive cutlery and equipment
We noted that adaptive cutlery and equipment such as plate guards were not being used on the wards. Using this equipment can help patients maintain independence, preserve dignity and increase confidence. Staff told us that this type of equipment was not kept on the ward.

Area of strength
- Patients can access a hot meal if they are off the ward at mealtimes. Staff are able to offer alternative options to patients if they are unhappy with the meal they received. Snacks for patients are available out of hours.

Areas for improvement
13. NHS Lothian must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital.
14. NHS Lothian must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients.
15. NHS Lothian must review the way mealtimes are managed on the wards and make sure that all non-essential activity (clinical and non-clinical) is stopped during patient mealtimes.
16. NHS Lothian must ensure that patients enjoy a positive experience at mealtimes, especially those patients who require support and help to eat and drink to ensure they have sufficient nutritional intake and hydration. They should also ensure that patients are assisted in a way that preserves their dignity.
17. NHS Lothian must ensure that patients are provided with equipment and utensils for eating that meet their individual needs.
18. NHS Lothian must ensure that patients’ intake of food and fluid is accurately recorded, monitored and that necessary action is taken if a patient’s intake is inadequate.

Preventing and managing pressure ulcers

Tissue viability service
NHS Lothian has a tissue viability service which consists of four tissue viability nurse specialists. One nurse provides advice and support to ward staff in the Royal Infirmary of Edinburgh on wound care and pressure ulcer prevention and management. The tissue viability nurse specialists assist staff to treat any known complex wounds. They also provide education to staff. This includes training at staff induction on bed adjustment, using specialist mattresses and how to identify pressure ulcers. There is also an annual training day for staff on pressure ulcer prevention and pressure area care.
Ward staff were aware of how and when to access the tissue viability service. They told us that the tissue viability nurse specialist responds quickly to requests for advice and information. Staff also told us that any patients referred to the tissue viability service are seen within 48 hours of referral.

**Pressure area and ulcer assessment and care planning**

NHS Lothian uses a recognised pressure ulcer risk assessment to assess a patient's risk of developing a pressure ulcer. National guidance states that this assessment should be done within 6 hours of admission. In the majority of cases, we noted that these assessments were not carried out within the correct timeframe. Of the 32 patient health records reviewed for pressure ulcer management and prevention, six had a pressure ulcer risk assessment carried out within 6 hours of admission. From the health records reviewed, patients admitted to the combined assessment area were not being assessed for the risk of developing pressure ulcers. Some of these assessments were carried out once a patient was admitted to a ward. Where pressure ulcer risk assessments had been carried out, these were not always completed accurately.

- A patient had been assessed as at a low risk of developing pressure ulcers, with a score of seven. As the patient's age and gender alone would have given them a score of seven, it was not clear that other risk factors, such as weight, skin condition or continence, had been taken into consideration. When we reviewed this patient’s health record, it was clear that these risk factors were present.

From the patient health records reviewed, we also found that it was not always clear what preventative measures or specialist equipment had been put in place to reduce the risk of pressure ulcers developing. There was a variety of different documentation used to record assessments carried out and care given. We found instances where documentation, such as care plans, patient repositioning charts or wound assessment charts were not in place or were not being completed. We noted that care plans also did not often reflect or document the care that staff told us was being given.

- A patient, assessed as at very high risk of developing pressure ulcers, had a repositioning chart completed for one day. No further charts were completed for the next 3 days.
- Another patient assessed as very high risk and with added medical complications had no documented care plan in place.
- There was no wound management chart for a patient with diabetes and foot ulcers. The care plan states that staff should start a wound management chart if a patient has broken skin or a wound.

A skin care bundle, SSKIN (skin, surface, keep moving, incontinence, nutrition), has been implemented in some areas. This tool aims to help staff check patients' skin more regularly and reduce variation in care practice. However, we found that staff did not always complete the documentation correctly, so it was not clear what care was being provided. Some staff told us that they had not been given training in how to use the assessment tool and were unsure how to complete the documentation.

**Specialist pressure relieving equipment**

Specialist pressure relieving equipment, such as therapeutic air mattresses to prevent pressure ulcers, is available for patients. We were told that the mattresses on the hospital beds in the Royal Infirmary of Edinburgh provide relief for patients with a pressure ulcer up to grade 2 severity. Staff told us that they can order specialist pressure relieving mattresses for patients with ulcers assessed as grade 2 severity and above. Staff told us that there are
no issues getting specialist equipment during the week, with equipment delivered to the ward within 2 hours of being ordered.

During weekends and out of hours, staff told us that they can still access specialist equipment, although this may take slightly longer to arrive. We were told that specialist mattresses are readily available in certain departments at the weekends, such as the intensive therapy unit.

Staff told us that specialist pressure relieving cushions can also be ordered. Patients identified as at risk should use these when they choose to sit in a chair at the bedside. We saw some patients identified as at risk of developing a pressure ulcer were sitting in chairs with no pressure relieving cushions in use.

Following pressure ulcer risk assessments, we found that staff were not always taking preventative measures to address any identified risks.

- A patient’s assessment identified that their risk of developing a pressure ulcer had gone up from medium to high. Over the next few days, the patient health record showed that the patient became more confused and staff had found it difficult to provide skin care. Staff had noted concerns that the patient's skin was reddening in areas that were most at risk of pressure damage. However, pressure relieving equipment was not ordered for 5 days.
- Staff had noted a break in the skin of a patient assessed as high risk. The skin care bundle noted that care should be provided at 4-hourly intervals. This was not recorded in the care plan. The patient health record did not show that specialist equipment had been considered or ordered. Staff told us that the patient had a specialist mattress and a pressure relieving cushion on their chair. We found that this equipment was not in place when we saw the patient.

**Area of strength**

- NHS Lothian has a tissue viability service which provides advice and support to staff on wound care and pressure ulcer prevention and management. Education is provided to staff on induction and through an annual staff training day.

**Areas for improvement**

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

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

21. NHS Lothian must ensure that patients assessed as being at risk of developing pressure ulcers are cared for using appropriate specialist pressure relieving equipment, including cushions.

22. NHS Lothian must ensure that wound assessment charts and any related documentation are in place and appropriately and consistently completed.

23. NHS Lothian should ensure all staff involved in the assessment of risk and recording of care in relation to pressure ulcer prevention and management are trained in the procedures and documentation used by the NHS board.
Appendix 1 – Areas for improvement

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

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

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<tr>
<th>NHS Lothian:</th>
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<tr>
<td>1</td>
<td>should ensure that patients’ dignity, privacy and comfort are maintained at all times in the combined assessment area (see page 11).</td>
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<tr>
<td>2</td>
<td>should ensure that staff interact with patients to make sure that their experience of attending hospital is as positive as it can be, and that patients are treated with dignity and respect at all times (see page 11).</td>
</tr>
<tr>
<td>3</td>
<td>should ensure nurse call handsets are available and accessible to patients at all times (see page 11).</td>
</tr>
<tr>
<td>4</td>
<td>should ensure staff are aware of their interactions with each other when on the wards to ensure patient confidentiality is respected at all times. Staff must always use appropriate language when talking about older people in hospital (see page 11).</td>
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<tr>
<td>5</td>
<td>should ensure that if medical staff take the decision not to speak to a patient and their family about a DNACPR decision then the reason for not doing so is documented in the patient’s health record (see page 11).</td>
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### Dementia and cognitive impairment

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<th>NHS Lothian:</th>
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| 6 | must ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment (see page 14).  
This is to comply with Clinical Standards for Older People in Acute Care, Standard 2. |
| 7 | must ensure that patients identified as having a cognitive impairment have a personalised care plan in place. This care plan should identify the specific needs of the patient and how staff will meet these needs (see page 14).  
This is to comply with Standards of Care for Dementia in Scotland, page 15. |
| 8 | must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information |
should be used to inform a plan of care and be shared with all staff in direct contact with the patient (see page 14).

This is to comply with Standards of Care for Dementia in Scotland, page 26.

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| 9 | must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. All staff who have a professional role to implement the legislation must receive training appropriate to their role. When legislation is used, this must be fully documented in the patient health record, including any discussion with the patient or family (see page 14).

This is to comply with Adults with Incapacity (Scotland) Act 2000 Part 5 - Medical treatment and research. |

| 10 | must carry out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment (see page 14).

This is to comply with Standards of Care for Dementia in Scotland, page 26. |

| 11 | must ensure that patients who are medically well and awaiting care packages have access to a range of activities and stimuli to help keep them active and maintain their current level of functioning (see page 14).

This is to comply with Standards of Care for Dementia in Scotland, page 26. |

| 12 | must have a system in place that monitors the number of bed or ward moves patients with dementia are subject to when in hospital (see page 14).

This is to comply with Standards of Care for Dementia in Scotland, page 26. |

| Nutritional care and hydration |

| NHS Lothian: |

| 13 | must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital (see page 18).

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

| 14 | must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients (see page 18).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Standard 2. |
### Nutritional care and hydration (continued)

**NHS Lothian:**

15. must review the way mealtimes are managed on the wards and make sure that all non-essential activity (clinical and non-clinical) is stopped during patient mealtime (see page 18).

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.7.

16. must ensure that patients enjoy a positive experience at mealtimes, especially those patients who require support and help to eat and drink to ensure they have sufficient nutritional intake and hydration. They should also ensure that patients are assisted in a way that preserves their dignity (see page 18).

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

17. must ensure that patients are provided with equipment and utensils for eating that meet their individual needs (see page 18).

   This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 4.6.

18. must ensure that patients’ intake of food and fluid is accurately recorded, monitored and that necessary action is taken if a patient’s intake is inadequate (see page 18).

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

### Preventing and managing pressure ulcers

**NHS Lothian:**

19. must ensure that all patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks (see page 20).

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

20. must ensure that care plans are in place and followed for patients identified as at risk of developing pressure ulcers. The care plan should clearly document the interventions required to reduce pressure ulcers (see page 20).

   This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers, section 4.
## Preventing and managing pressure ulcers (continued)

### NHS Lothian:

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<tr>
<td><strong>21</strong></td>
<td>must ensure that patients assessed as being at risk of developing pressure ulcers are cared for using appropriate specialist pressure relieving equipment, including cushions (see page 20).&lt;br&gt;This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers, section 4.</td>
</tr>
<tr>
<td><strong>22</strong></td>
<td>must ensure that wound assessment charts and any related documentation are in place and appropriately and consistently completed (see page 20).&lt;br&gt;This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers, section 4</td>
</tr>
<tr>
<td><strong>23</strong></td>
<td>should ensure all staff involved in the assessment of risk and recording of care in relation to pressure ulcer prevention and management are trained in the procedures and documentation used by the NHS board (see page 20).</td>
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Areas for continuing improvement are improvements that the NHS board has already identified and started to address. We acknowledge the work carried out by the NHS board at the time of inspection and encourage progress in these areas.

### Areas for continuing improvement

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Appendix 2 – Details of inspection

The inspection to the Royal Infirmary of Edinburgh, NHS Lothian was conducted from Monday 27 August to Wednesday 29 August 2012.

The inspection team consisted of the following members:

Gareth Marr
Lead Associate Inspector

Julie Tulloch
Associate Inspector

Jane Walker
Associate Inspector

Katie Wood
Associate Inspector

Ken Barker
Public partner

Penny Leggat
Public partner

Supported by:

Jan Nicolson
Project Officer

Observed by:

Anne Hanley
Scrutiny and Assurance Manager
Appendix 3 – List of national guidance

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

- **Adults with Incapacity (Scotland) Act 2000** Part 5 – Medical treatment and research
- **Best Practice Statement for Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)
- **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals** (NHS Quality Improvement Scotland, September 2003)
- **Clinical Standards for Older People in Acute Care** (Clinical Standards Board for Scotland, October 2002)
- **Dementia: decisions for dignity** (Mental Welfare Commission, March 2011)
- **National Standards for Clinical Governance and Risk Management** (NHS Quality Improvement Scotland, October 2005)
- **Scottish Intercollegiate Guideline Network (SIGN) Guideline 86 – Management of Patients with Dementia** (SIGN, February 2006)
- **SIGN Guideline 111 – Management of Hip Fracture in Older People** (SIGN, June 2009)
- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)
Appendix 4 – Inspection process flow chart

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

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

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

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BMI</td>
<td>body mass index</td>
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<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
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<tr>
<td>DNACPR</td>
<td>do not attempt cardiopulmonary resuscitation</td>
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<tr>
<td>HDL</td>
<td>Health Department Letter</td>
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<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guideline Network</td>
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</table>
How to contact us

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

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

Edinburgh Office | Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB
Telephone 0131 623 4300
Email hcis.chiefinspector@nhs.net

www.healthcareimprovementscotland.org

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

**NHS Lothian**

**Royal Infirmary of Edinburgh**

**Care For Older People In Acute Hospitals Inspection**

**Inspection Date: 27th – 29th August 2012**

<table>
<thead>
<tr>
<th>Ref:</th>
<th>Action Planned</th>
<th>Timescale to meet action</th>
<th>Responsibility for taking action</th>
<th>Progress</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| 1    | **NHS Lothian should ensure that patients’ dignity, privacy and comfort is maintained at all times in the Combined Assessment Area.**
ACTION: Reinforce the standards for patients’ privacy and dignity to all staff members through existing communication channels paying specific attention to patients with cognitive impairment/challenging behaviour. Give particular consideration to those areas of mixed sex (nationally agreed exceptions). | Immediate and ongoing | Chief Nurses
ALL Charge nurses | This message is continually communicated through ward safety briefs, ward meetings, Intranet page and during patient experience audits/ward walk rounds and our own internal inspection of Patient Quality Indicators (PQI). | Ongoing |
| 2    | **NHS Lothian should ensure that staff interact with patients to make sure that their experience of attending hospital is as positive as it can be, and that patients are treated with dignity and respect at all times.**
ACTION: Short curtains to be removed and replaced with curtains with appropriate length. | Immediate and ongoing | Divisional Medical & Nurse Director
Service Manager, Facilities | All identified short curtains have been replaced and continual review of suitability is now part of general ward | Ongoing | 3 September |
<table>
<thead>
<tr>
<th>Roll out the “peg system” This system uses pegs with information attached e.g. no entry care being delivered to prevent interruptions of care behind curtains.</th>
<th>Divisional Nurse Director</th>
<th>audits. Now in place on Western General Hospital. Roll out across Royal Infirmary planned for November 2012</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure through education, support and training that staff do not use inappropriate language, terms of endearment, nor label patients, e.g. feeder, boarder.</td>
<td>Head of Education and Development</td>
<td>Now included in Professional induction HCSW Induction Dementia awareness training HCSW Delivering Better Care CPD Day Interns development programme SVQ 2 and 3 training Also progressing with HEI and FE partners in preparation for practice</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Action Number</th>
<th>Description</th>
<th>Required Timeframe</th>
<th>Responsible Person</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>NHS Lothian should ensure nurse call handsets are available and accessible to patients at all times and that calls are responded to promptly. ACTION: Implementation of Care Rounding across all ward areas. Care Rounding is a structured, proactive approach to meet the needs of patients and document the care given.</td>
<td>Immediate</td>
<td>Divisional Nurse Director</td>
<td>Tested and now implemented in Royal Victoria Building (Medicine for Elderly) Roll out in progress at Royal Infirmary in Medicine of Elderly, Surgery and Medicine wards. Completion date March 2013. Testing in other specialty areas in progress. All underpinned by educational programme for ward staff. Part of HIS Older Peoples work as test site for spread plans.</td>
</tr>
<tr>
<td>4</td>
<td>NHS Lothian should ensure staff are aware of their interactions with each other when on the wards to ensure patient confidentiality is respected at all times. Staff must always use appropriate language when talking about older people in hospital. ACTION: Reinforce the need for patient confidentiality, in particular discussing patients within earshot of those not privy to the information, specifically in corridors (junior</td>
<td>Immediate</td>
<td>Divisional Medical &amp; Nurse Director</td>
<td>Part of ongoing work on Compassionate Care. Re-emphasised via line management and professional meetings and education provision.</td>
</tr>
</tbody>
</table>
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<tbody>
<tr>
<td><strong>5</strong></td>
<td><strong>NHS Lothian should ensure that if medical staff take the decision not to speak to a patient and their family about a DNACPR decision then the reason for not doing so is documented in the patient’s health record.</strong></td>
<td><strong>Immediate</strong></td>
<td><strong>Divisional Medical Director</strong></td>
</tr>
<tr>
<td></td>
<td><strong>ACTION:</strong> Remind staff through professional and managerial lines. Continue roll out of Liverpool Care of the Dying Pathway (LCP) and SPSP (Scottish Patient Safety Programme) work on Care of the Deteriorating Patient.</td>
<td></td>
<td>Re-emphasised via line management and professional meetings. SPSP Care of the Deteriorating Patient in place at St Johns. Roll out at Royal Infirmary planned for January 2013. LCP roll out will complete by December 2012 across 78 wards (70 wards to date).</td>
</tr>
<tr>
<td><strong>DEMENTIA AND COGNITIVE IMPAIRMENT</strong></td>
<td></td>
<td></td>
<td>Complete</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td><strong>NHS Lothian must ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment.</strong></td>
<td><strong>April 2013</strong></td>
<td><strong>Divisional Medical Director /Divisional Nurse Director</strong></td>
</tr>
<tr>
<td></td>
<td><strong>ACTION:</strong> Implementation of Vulnerable Peoples Action Plan (as shared with inspectors).</td>
<td></td>
<td>Introduced in some ward areas and ongoing roll out. Time scale for completion April 2013</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td><strong>NHS Lothian must ensure that patients identified as having a cognitive impairment have a personalised care plan in place. This care plan should identify the specific needs of medical staff).</strong></td>
<td><strong>June 2013</strong></td>
<td><strong>Divisional Nurse Director</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Work on going with Dementia Champions to develop multidisciplinary</td>
</tr>
</tbody>
</table>
## Improvement Action Plan

**NHS Lothian**

**Royal Infirmary of Edinburgh**

**Care For Older People In Acute Hospitals Inspection**

**Inspection Date: 27th – 29th August 2012**

<table>
<thead>
<tr>
<th><strong>Action</strong></th>
<th><strong>Date</strong></th>
<th><strong>Responsible Director</strong></th>
<th><strong>Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>the patient and how staff will meet these needs. ACTION: Implementation of Vulnerable Peoples Action Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8</strong> NHS Lothian must ensure that staff use existing systems to request and record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing the documentation. This information should be used to inform a plan of care and be shared with all staff in direct contact with the patient. ACTION: Implementation of Vulnerable Peoples Action Plan</td>
<td>April 2013</td>
<td>Divisional Medical Director /Divisional Nurse Director</td>
<td>Re-emphasised via line management and professional meetings. “This is me” documentation in use in some areas. For further roll out with cognitive screening tool.</td>
</tr>
<tr>
<td><strong>9</strong> NHS Lothian must ensure that current legislation which protects the rights of patients who lack capacity, is fully and appropriately implemented. All staff who have a professional role to implement the legislation must receive training appropriate to their role. When legislation is used this must be fully documented in the patient health record, including any discussion with the patient or family. ACTION: Implementation of Vulnerable Peoples Action Plan</td>
<td>March 2013</td>
<td>Nurse Director</td>
<td>Reinforced availability of eLearning module for staff caring for people with cognitive impairment. Clinical areas identifying key staff to undertake this module. Establishing a series of raising awareness sessions for clinicians on</td>
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<tr>
<td><strong>10</strong></td>
<td>NHS Lothian must carry out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment. <strong>ACTION:</strong> Implementation of Vulnerable Peoples Action Plan</td>
<td>March 2013</td>
<td>Divisional Nurse Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Expediting implementation of dementia toolkits to enhance early recognition of contributory factors associated with delirium/dementia/confusion.</td>
</tr>
</tbody>
</table>
Continue the dementia awareness roll out and use of “This is me” document to all clinical areas and monitor through health records audit. Provide additional support to staff in the use of the “This is me”/similar patient specific documents. Reinforce the need during refurbishment to consider the needs of cognitively impaired patients i.e. door colouring, signage etc. All Charge Nurses to implement immediate action to ensure improved environment for patients in place where currently possible i.e. clocks /use of previously identified core signage.
<table>
<thead>
<tr>
<th>Improvement Action Plan</th>
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<tbody>
<tr>
<td><strong>NHS Lothian</strong></td>
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<tr>
<td>Royal Infirmary of Edinburgh</td>
</tr>
<tr>
<td>Care For Older People In Acute Hospitals Inspection</td>
</tr>
<tr>
<td><strong>Inspection Date: 27th – 29th August 2012</strong></td>
</tr>
</tbody>
</table>

| **NHS Lothian must ensure that patients who are medically well and awaiting care packages have access to a range of activities and stimuli to help keep them active and maintain their current level of functioning.** |
| ACTION: Improve patient flow to enable patients who are medically fit to be discharged or move to a non acute facility as part of Unscheduled Care Improvement Programme. Review the current activities of volunteers and volunteer programmes across NHS Lothian and identifying areas of opportunity and good practice that could be shared in other areas, with a view to volunteers assisting with/contributing to the provision of activities for patients with cognitive impairment and for those elderly rehabilitation patients awaiting community placement. |
| September 2013 |
| Nurse Director |
| Part of Unscheduled Care Improvement work. |
| December 2012 |
| AHP Director Chief Nurse Quality and Standards |
| Review to commence November 2012 |

<p>| <strong>NHS Lothian must have a system in place that monitors the number of bed or ward moves patients with dementia are subject to.</strong> |
| ACTION: Implementation of Unscheduled Care Improvement Plan which aims to eliminate Boarding of all patients |
| December 2012 |
| Nurse Director |
| Site and Capacity Team now using Boarding list from TRAK and real time SBARs to limit moves of vulnerable patients. Initial plan developed to use TRAK and SBARs to enable electronic monitoring. |</p>
<table>
<thead>
<tr>
<th>NUTRITIONAL CARE</th>
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</thead>
<tbody>
<tr>
<td>13 <strong>NHS Lothian must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of under nutrition, within 24 hours of admission to hospital (inpatient bed).</strong> ACTION: Nutritional Action Plan (2012/13) being implemented.</td>
</tr>
<tr>
<td>October 2012</td>
</tr>
<tr>
<td>14 <strong>NHS Lothian must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients.</strong> ACTION: Nutritional Action Plan being implemented.</td>
</tr>
<tr>
<td>March 2013</td>
</tr>
<tr>
<td>15 <strong>NHS Lothian must review the way mealtimes are managed on the wards and make sure that all non-essential activity</strong></td>
</tr>
<tr>
<td>October 2013</td>
</tr>
<tr>
<td>Action Number</td>
</tr>
<tr>
<td>---------------</td>
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<tr>
<td>16</td>
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<td>18</td>
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</tbody>
</table>
### ASSESSMENT AND CARE PLANNING

<table>
<thead>
<tr>
<th>Step</th>
<th>Proposal Description</th>
<th>Enactment</th>
<th>Responsible</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 19   | NHS Lothian must ensure that all patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks. (Best Practice Statement for Prevention and Management of Pressure Ulcers, section 2).  
**ACTION:** Ongoing implementation of “From One a day to none a day” Project. (Commenced August 2012) This project covers all aspects of Tissue viability with the improvement target re: **Pressure ulcers** – to achieve zero avoidable hospital acquired pressure ulcers, grade 2 and above by March 2014. | Immediate / ongoing | Divisional Nurse Director | Current policy and practice standards have been reiterated to staff including a reminder of the user friendly resources on intranet. Care Rounding acts as prompt re skin assessments  
Education plan in progress  
HCSW started August.  
RGNs started September. All pressure ulcers grade 2 and above logged on DATIX.  
Annual audit of pressure ulcer incidence and prevalence already in place. Also reported to Board in Quality Report. |
| 20   | NHS Lothian must ensure that care plans are in place and followed for patients identified as at risk of developing pressure ulcers. The care plan should clearly document the interventions required to reduce pressure ulcers. (Best | Immediate / ongoing | Divisional Nurse Director | Current policy and practice standards have been reiterated to staff  
Care rounding acts as |

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**File Name:** FINAL OPAH ACTION PLAN 1830  
**Version:** 2  
**Date:** 3 October 2012  
**Produced by:** CC Directorate of Nursing NHSL  
**Page:** Page 11 of 13  
**Review Date:** W/C 5th November  
**Circulation type (internal/external):**
**Practice Statement for Prevention and Management of Pressure Ulcers, section 4).**

**ACTION:** From One a day to none a day Project

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<tbody>
<tr>
<td><strong>21</strong></td>
<td>NHS Lothian must ensure that patients assessed as being at risk of developing pressure ulcers are cared for using appropriate specialist pressure relieving equipment, including cushions. (Best Practice Statement for Prevention and Management of Pressure Ulcers, section 4).</td>
<td>Immediate / ongoing</td>
</tr>
<tr>
<td><strong>22</strong></td>
<td>NHS Lothian must ensure that wound assessment charts and any related documentation are in place and appropriately and consistently completed. (Best Practice Statement for Prevention and Management of Pressure Ulcers, section 4).</td>
<td>Immediate / ongoing</td>
</tr>
<tr>
<td><strong>23</strong></td>
<td>NHS Lothian should ensure all staff involved in the assessment of risk and recording of care in relation to pressure ulcer prevention and management are trained in the procedures and documentation used by the NHS</td>
<td>Immediate / ongoing</td>
</tr>
</tbody>
</table>
**Improvement Action Plan**

**NHS Lothian**

**Royal Infirmary of Edinburgh**

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<table>
<thead>
<tr>
<th>ACTION</th>
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<tbody>
<tr>
<td><strong>board.</strong></td>
<td>monitoring. Quality Improvement data (QiDs)/Scorecard already in place to assist on-going monitoring.</td>
</tr>
<tr>
<td>ACTION: From One a day to none a day Project See above</td>
<td></td>
</tr>
</tbody>
</table>
Care for Older People in Acute Hospitals

Six-monthly report (February–July 2012)

October 2012
Strategic oversight

On Monday 6 June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. We were asked to carry out these inspections because of our experience of inspecting acute hospitals throughout NHSScotland.

The aim of these inspections is to provide assurance that the care of older people in acute hospitals is of a high standard and to encourage improvement where it is needed.

A regional inspector leads a team of three associate inspectors who carry out each inspection. A project officer and an administrative officer provide project management support.

In the first instance, the inspections include some, or all, of the following key areas:

- treating older people with compassion, dignity and respect
- dementia and cognitive impairment
- falls prevention and management
- nutritional care and hydration, and
- preventing and managing pressure ulcers.

The inspection process

Following the announcement by the Cabinet Secretary for Health, Wellbeing and Cities Strategy, we began developing a methodology for the inspection of the care of older people in acute hospitals. To do this, we consulted with a number of stakeholders including:

- Healthcare Improvement Scotland colleagues
- NHS staff
- members of the public
- professional and voluntary organisations, and
- Scottish Government.

We tried and tested our methodology through a series of pilot inspections in NHS boards that had volunteered to be involved. After each pilot inspection, we reviewed and refined our methodology and inspection tools to be more relevant and appropriate for our inspections. Through this, we were also able to learn what the key issues were for the care of older people in acute hospitals. This led to our focus on the five key areas listed above.

When we were ready to use our methodology, we prioritised hospitals against a range of indicators and created a schedule of inspections. We then asked NHS boards to complete a self-assessment. This enabled them to establish their own performance against the key issues and to start proactive improvement work. The information in the self-assessment submitted to us also informs inspections and allows us to identify the key areas to focus on during inspections.

We then undertake a 3-day inspection to confirm statements in the self-assessment. We check that the policies and procedures are being translated into practice at the
point of care and gather evidence on performance and risk. As the inspections are short and only cover a sample of wards, they provide a limited snapshot of what is happening in the hospital. We observe the care provided to older people to make sure that patients are treated with compassion, dignity and respect. We also review patient health records to make sure that assessments are being completed and care plans are being developed. During the first 6 months of inspection, we reviewed 308 patient health records. Of these:

- 237 were reviewed for dementia and cognitive impairment
- 27 for falls prevention and management
- 142 for nutritional care and hydration, and
- 119 for preventing and managing pressure ulcers.

We carry out surveys and interviews with patients and their visitors and carers. These provide patients with the opportunity to tell us anonymously about the care they have received. In total, we carried out 184 interviews and received 455 patient questionnaires and 125 questionnaires from family members, carers or friends. In general, patients and their visitors were positive about the care older people received.

- ‘My mother has been given superb care. Staff could not have been more helpful, either in their care or in their attention to her relative’s concerns. Doctors and nurses have been available to provide information and answer questions. My mother has always been very conscious of her dignity and everyone concerned with her care has been exemplary in maintaining this.’
- ‘Doctors and nursing staff treated me with respect and were exceptional in every respect, nothing is too much trouble and they go above and beyond the call of duty in everything they do.’
- ‘Care and attention has been first class. Nothing has been any bother. Food variable but in the main good. Staff seem caring, although very busy environment.’

However, some patients and visitors had concerns.

- ‘Communication and information is the most difficult aspect for the relatives of an elderly person – I do not have confidence that staff know what my mother’s needs are.’
- ‘Though I am elderly I have no problems with personal hygiene. So it would be helpful [for] other patients like me [if] there was a walk in shower facility.’
- ‘Nursing staff are obviously understaffed at various times and this affects the care they are able to give.’

We carry out both announced and unannounced inspections. We give NHS boards, 4 weeks’ notice of announced inspection, while no notice is given for an unannounced inspection. Unannounced inspections allow us to see things as they are and lessen the stresses and anxiety felt by staff in preparing for an inspection. Announced inspections allow us to meet with senior members of staff to find out what should be happening within the hospital.

Following inspections, we publish reports based on inspection findings. These reports make sure that learning and best practice is shared across hospitals and NHS boards. NHS boards then develop an improvement action plan to address the areas we identified for improvement and we monitor progress against this.
Key findings

Areas of strength

Inspectors may gather strong evidence that an NHS board is doing well in some practices, ways of working or outcomes for patients. We report these as an area of strength.

In the majority of observations we made, staff treated older people with compassion, dignity and respect. Patient and relative feedback through interviews and questionnaires also showed they were highly satisfied with the care patients received.

We noted that many hospitals had started to make improvements to the ward and hospital environments to make them more suitable for patients with dementia and cognitive impairment. This included improved signage for patients and visitors, particularly for toilets and showers.

We also found that some NHS boards have worked towards setting up specialised services for patients with cognitive impairment. Some NHS boards have set up older people’s psychiatric liaison teams. These teams liaise with other services that may need to care for patients with cognitive impairment to allow a quicker discharge and better care planning. We also saw funding from Alzheimer’s Scotland help appoint specialist nurse consultants to develop dementia care in NHS boards.

NHS boards have also adopted the Dementia Champions’ Programme. The programme helps to make sure that staff have the training they need to improve the experience, care, treatment and outcomes for people with dementia.

When asked about food in hospitals, the majority of patients told us that they were happy with the quality of food and the choices available. In one NHS board, we found there was a particularly good working relationship between ward staff and the kitchen. Ward staff are able to tell the kitchen about new patients arriving on the ward after orders for food have been taken and are able to request meals up to 7.30pm. As a result, patients have better access to food and are more likely to receive the food they want.

Areas for improvement

Areas for improvement mean that an NHS board is not meeting recognised standards or following best practice, and we are concerned about the impact this is having on the patients using the hospital. Areas for continuing improvement are improvements that the NHS board has already identified and started to act on.

During our first 6 months of inspecting, we found that the care delivered to patients was not always person-centred. This was evident in relation to treating patients with compassion, dignity and respect. Medical staff did not always comply with do not attempt cardiopulmonary resuscitation (DNACPR) national guidance on treatment and care for patients. Staff did not always consider the patient’s privacy and dignity when discussing personal issues and what was wrong with them at the patient’s bedside. We heard some staff using inappropriate language when talking about older people in hospitals.

We also found that assessment and care planning were not always person-centred or effective. In relation to assessment, we found that:
• older people treated in accident and emergency or admitted to hospital were not always assessed for cognitive impairment (6 out of 8 hospitals)

• patients, identified as having a potential cognitive impairment, did not always have their capacity to consent to treatment assessed (4 out of 8 hospitals), and

• patients did not always have nutritional screening carried out on admission or on an ongoing basis (4 out of 4 hospitals).

As a result of this, we found that care plans were not always person-centred or effective.

• Patients, identified as having a cognitive impairment, did not always have a care plan in place to identify their specific needs and how staff will meet these (7 out of 8 hospitals).

• Patients did not always have a nutritional care plan developed, implemented or evaluated (4 out of 4 hospitals).

• Patients, identified as ‘at risk’ of developing pressure ulcers, did not always have care plans in place to identify their specific needs and how staff will meet these (4 out of 4 hospitals).

This meant that the treatment patients received was not always effective and they did not always have access to the most appropriate treatments, interventions, support and services.

• Patients with dementia did not always have access to a range of activities and stimuli to keep them active and maintain their current level of functioning (4 out of 8 hospitals).

• There were no systems in place to monitor the number of bed or ward moves for patients with dementia (6 out of 8 hospitals).

• Patients were not always provided with adapted equipment and utensils to help with eating and drinking when they needed them (3 out of 4 hospitals).

• Staff did not always care for patients, identified as at risk of developing pressure ulcers, with the appropriate pressure relieving equipment (4 out of 4 hospitals).

Some of these areas of improvement reflect what is happening at a strategic level and how on the care delivered on the ward is impacted. We also found some isolated instances within specific NHS boards that were seen as reflective of the NHS board as a whole. As these were isolated instances, they are not reported here.

NHS boards in Scotland should:

• ensure the legal and ethical practice of staff acts to safeguard the best interests of patients with dementia and cognitive impairment, their families and carers.

• ensure staff understand and consistently apply the Adults with Incapacity legislation.

• draw on good practice to ensure hospital wards and departments are dementia friendly, and use adapted equipment, activities and stimuli for people with dementia and cognitive impairment.

• review their care planning and record-keeping to ensure patient records are complete, accurately reflect the details of care planned and provided to allow continuity of care between staff and promote high standards of care.
• ensure that medical staff at all grades have access to and complete training on DNACPR national policy on an annual basis.

**Continuing improvement**

The action plans developed by NHS boards following our inspections should help inform and promote improvement in the care of older people in acute hospitals. Sixteen weeks after an inspection, we ask NHS boards to submit an updated action plan to show what improvements they have made. If it is appropriate, we will carry out a follow-up inspection to that hospital to check on improvements. As we continue to carry out more inspections, we will revisit the hospitals we have already inspected to make sure that we inspect all topics in all NHS boards.

As the inspection programme is still relatively new, we are yet to see marked changes in the care for older people in acute hospitals. However, we have been able to see how some improvements are being made through NHS boards sharing learning from inspection, whether through discussions at a national level or through reading other inspection reports. This has led to an increased awareness of some of the issues facing the care of older people in acute hospitals. However, we are still finding that some of the issues that appear on the surface to be the easiest to resolve are most commonly overlooked and solutions harder to find.

We have also found that there is greater awareness of the care of older people in acute hospitals as a distinct area of focus. This has led to staff being more aware of the need for a different approach when caring for older people. It has also led to the development of closer working relationships between ourselves, other colleagues in Healthcare Improvement Scotland, Scottish Government and NHS boards to promote improvement. Improvement programmes are being set up to allow NHS boards to use the learning they take from inspections to make real improvements in the care of older people in acute hospitals.

A key area of focus, as we move forward, are the values and behaviours that determine how older people are cared for in acute hospitals. During our inspections, we have found a number of instances that compromised or did not consider patient dignity. This was most clear in the language sometimes used when discussing the care of older people. We found examples of patients referred to as ‘feeders’ and ‘wanderers’. Patients were also described as needing ‘fed’ or ‘toileted’. We also found that some patients were addressed in a child-like manner and words commonly associated with childhood, such as ‘cot sides’, were used to describe their care. To address this issue, we will follow up on this in our future inspections and our improvement work.

**Next steps**

As we continue our inspection programme, we are aware we need to review and assess the programme’s impact and effectiveness on an ongoing basis. Over the coming months, we will take the learning we have from our first 6 months of inspection and use this to refine our methodology. We will also work to create a stronger working relationship between ourselves and NHS boards to make inspection a meaningful part of informing improvements in the care of older people in acute hospitals.

We will produce another report in 6 months' time.
### Appendix 1 – The hospitals we inspected

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Dates</th>
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<tbody>
<tr>
<td>Western Infirmary</td>
<td>Tuesday 21 – Thursday 23 February 2012</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td></td>
</tr>
<tr>
<td>Hairmyres General Hospital</td>
<td>Monday 5 – Tuesday 6 March 2012</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td></td>
</tr>
<tr>
<td>Royal Alexandra Hospital</td>
<td>Wednesday 14 – Thursday 15 March 2012</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td></td>
</tr>
<tr>
<td>Western General Hospital</td>
<td>Wednesday 11 – Friday 13 April 2012</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td></td>
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<tr>
<td>Glasgow Royal Infirmary</td>
<td>Wednesday 2 – Friday 4 May 2012</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td></td>
</tr>
<tr>
<td>Wishaw General Hospital</td>
<td>Monday 28 – Wednesday 30 May 2012</td>
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<tr>
<td>NHS Lanarkshire</td>
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<tr>
<td>Monklands District General Hospital</td>
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<tr>
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<tr>
<td>Borders General Hospital</td>
<td>Tuesday 17 – Thursday 19 July 2012</td>
</tr>
<tr>
<td>NHS Borders</td>
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</tbody>
</table>
How to contact us

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

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

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

Telephone 0131 623 4300

Email hcis.chiefinspector@nhs.net

www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network (SIGN) are key components of our organisation.
### Appendix 4 Review of Older People In Acute Hospitals – HIS Inspections

<table>
<thead>
<tr>
<th>Inspection Areas – published reports</th>
<th>Announced</th>
<th>Un-announced</th>
<th>Areas of strength</th>
<th>Areas for improvement</th>
<th>Areas for continued improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Borders Borders General Beds 218/Areas Visited x 8</td>
<td>Yes</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway Beds 392/Areas Visited x 8</td>
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<td>2</td>
<td>5</td>
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<tr>
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<td>3</td>
<td>3</td>
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<tr>
<td>NHS GGC Glasgow Royal (follow-up to announced visit) Beds 978/Areas Visited x 13</td>
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<tr>
<td>NHS GGC *Royal Alexandra Beds 666/Areas Visited x 7</td>
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<tr>
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<td>Yes</td>
<td>1</td>
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<tr>
<td>NHS Lanarkshire Wishaw General Hospital</td>
<td>Yes</td>
<td>5</td>
<td>2</td>
<td>2</td>
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</tr>
</tbody>
</table>

**Areas for improvement:**
- Compassion, Dignity & Respect
- Dementia & Cognitive Impairment
- Nutritional care & hydration
- Falls
- Pressure Ulcer

**Announced:**
- 3
- 2
- 7
- 4
- 5
- 5
- 1
- 1
- 5
- 4
- 3
- 2

**Un-announced:**
- 2
- 7
- 4
- 5
- 7
- 1
- 2
- 2
- 2
- 8
- 2
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<tr>
<th>Inspection Areas – published reports</th>
<th>Announced</th>
<th>Un-announced</th>
<th>Areas of strength</th>
<th>Areas for improvement</th>
<th>Areas for continued improvement</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tr>
<tr>
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<td>Yes</td>
<td>4</td>
<td>4</td>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>NHS Lanarkshire *Monklands District General Hospital</td>
<td>Yes</td>
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<td>1</td>
<td>4</td>
</tr>
<tr>
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<td>6</td>
<td>4</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>NHS Lothian *RIE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
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<tr>
<td>Beds 1158/Areas Visited x 8</td>
<td></td>
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</tr>
</tbody>
</table>

*Where an Emergency Department / Receiving Unit were part of the inspection*
COMMITTEE MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree to appoint members of Board Committees.

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

2 Recommendations

2.1 It is recommended that the Board agrees to confirm the appointment of Donald Grant and Ricky Henderson to the Audit & Risk Committee.

3 Key Risk

3.1 If members are not appointed the Audit & Risk Committee Committees may have difficulty in achieving a quorum.

4 Risk Register

4.1 There are no implications for NHS Lothian’s Risk Register

5 Impact on Inequality, Including Health Inequalities

5.1 Not required as this is an administrative matter.

6 Involving People

6.1 The Board Chairman has discussed these proposals with the members concerned.

7 Resource Implications

7.1 There are no resource implications.

Peter Reith
Secretariat Manager
28 September 2012
peter.reith@nhslothian.scot.nhs.uk
COMMITTEE TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the amended Terms of Reference of the Audit & Risk Committee.

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

2 Recommendations

The Board is recommended to agree the amended Terms of Reference of the Audit & Risk Committee.

3 Risk Register

3.1 There are no implications for NHS Lothian’s Risk Register.

4 Impact on Inequalities

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

5 Involving People

5.1 The amended Terms of Reference have been agreed by the Audit & Risk Committee.

6 Resource Implications

6.1 There are no resource implications arising from these recommendations.

Peter Reith
Secretariat Manager
11 October 2012
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Amended Terms of Reference for the Audit & Risk Committee
AUDIT & RISK COMMITTEE

Introduction
These terms of reference have been prepared to ensure that the Committee complies with the Scottish Government Audit Committee Handbook (July 2008). Where applicable, the provisions of the UK Code of Corporate Governance (Financial Reporting Council, June 2010) and the associated “Guidance on Audit Committees” of December 2010, has also been considered.

Remit and Delegated Authority:

- The main objective of the Audit & Risk Committee (the Committee) is to support the Accountable Officer and Lothian NHS Board in meeting their assurance needs. This includes:
  1. Helping the Accountable Officer and Lothian NHS Board formulate their assurance needs with regard to risk management, governance and internal control.
  2. Reviewing and constructively challenging the assurances that have been provided, as to whether their scope meets the needs of the Accountable Officer and Lothian NHS Board.
  3. Reviewing the reliability and integrity of those assurances, i.e. considering whether they are founded on reliable evidence, and that the conclusions are reasonable in the context of that evidence.
  4. Drawing attention to weaknesses in systems of risk management, governance, and internal control, and making suggestions as to how those weaknesses can be addressed.
  5. Commissioning further assurance work for areas that are not being subjected to sufficient review.
  6. Seeking assurance that previously identified areas of weakness are being remedied.

- The Committee has no executive authority, and is not charged to make or endorse any decisions. The only exception to this principle is the approval of the Board’s accounting policies and audit plans. The Committee exists to advise the Board or Accountable Officer who in turn make the decisions.

- The Board authorises the Committee to investigate any activity within its terms of reference, to request any Board member or employee to attend a Committee meeting, and request a written report or seek any information it requires. The Board directs all employees to co-operate with any Committee request.

- The Board authorises the Committee to obtain outside legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
• The Board authorise the Committee to co-opt members for a period up to 1 year, with the approval of the Board and Accountable Officer, to provide specialist skills, knowledge and experience which the Committee needs at a particular time. N.B. A co-opted member is an individual who is not a member of Lothian NHS Board, and is not to be counted as part of the Committee’s quorum.

Membership:

Lothian NHS Board shall appoint all members of the Committee. All members shall be non-executive members of the Lothian NHS Board, with the exception of any co-opted members. The Board shall appoint at least three, and up to six non-executive board members to the Committee.

The Committee members must also be independent and objective. The Board shall give due regard to whether a proposed non-executive member for appointment to the Committee is sufficiently independent from other Board Committees.

The Board shall give all members a fixed term of appointment that does not exceed 3 years. Members can only be re-appointed by the Board on two further occasions, so long as they continue to be independent.

The Board shall ensure that the Committee’s membership has an adequate range of skills and experience that will allow it to effectively discharge its responsibilities. With regard to the Committee’s responsibilities for financial reporting, the Board shall ensure that at least one member can engage competently with financial management and reporting in the organisation, and associated assurances.

The Chairman of Lothian NHS Board cannot be a member of the Committee. All Board members, through the Chair of the Committee may request to attend any meeting. All Board members shall receive the minutes of the Committee (at the Board meeting), and shall have the right to have access to the Committee papers.

At the Committee the role of executive Board members and officers is to provide information, and to participate in discussions, either for the whole duration of the meeting or for particular agenda items. The following people will normally be routinely invited to attend Committee meetings:

• Chief Executive
• Director of Finance
• Chief Internal Auditor or representative
• Clinical Governance & Risk Manager or representative
• Statutory External Auditor or representative

However, only the Committee members are entitled to be present at meetings, and it is for those members to decide if non-members should attend for a particular meeting or agenda items. The Committee members will usually
meet in a closed session at the commencement and conclusion of each meeting.

The Committee can request any member of the Board or employee to attend a meeting with respect to specific items being considered. Committee members are entitled to discuss matters directly with the Chair of the Audit & Risk Committee and Chair of Lothian NHS Board. Furthermore members also have a right of access to the Accountable Officer where they feel that this is necessary.

The Chair of the Committee may
- Call a meeting at any time, or when required to do so by the Board
- May exclude all parties other than Members of the Committee from the deliberations of the Audit Committee

**Quorum:**
No business shall be transacted at a meeting of the Committee, unless at least three non-executive Board members are present.

There may be occasions when due to the unavailability of the above non-executive members, the Board Chairman will ask other non-executive members of Lothian NHS Board to act as members of the Committee so that quorum is achieved. Such occasions will be drawn to the attention of Lothian NHS Board, when subsequently adopting the Committee minutes, and the Board will be asked to approve the membership of the Committee meeting as having been appropriate and in quorum.

**Core Functions of the Audit & Risk Committee:**

**Overall Assurance on Corporate Governance, Internal Control and Risk Management**

- To support the Board and the Accountable Officer in comprehensively defining their assurance needs.
- To assess whether there are sources of assurance in place that provide coverage for all of the identified assurance needs.
- To test and determine the reliability of the sources of assurance which are available.
- To form an opinion on the exposure to risk relevant to the Board’s Risk Appetite, and the adequacy and effectiveness of the systems of internal control for individual areas/subjects.
- Drawing from the consideration of individual assurances, to form an overall view on the state of risk management, corporate governance and internal control. This will inform the content of the Accountable Officer’s Governance Statement.
Corporate Governance

- Assess the Board’s arrangements to be assured on its compliance with all relevant laws, regulations and Government directions that are pertinent to the Board’s functions and responsibilities.

- Review the Board’s arrangements to promote and uphold the Lothian NHS Board Code of Conduct for Board members, and the required standards of business conduct for all employees.

- Seek assurance that the Board has in place arrangements whereby employees may, in confidence, raise concerns about possible improprieties in matters of administration, financial reporting, fraud, breaches of standards of conduct or any other concerns of an ethical nature. The Committee will require assurance that there are arrangements for proportionate and independent investigation of such matters, and for appropriate follow-up action.

- Ensure that the Standing Orders package are periodically reviewed, including the Standing Financial Instructions and the Scheme of Delegation, and to advise the Board when any changes are required.

- Ensure that the circumstances associated with each occasion when Standing Orders are waived and suspended, are appropriately examined.

- Periodically review the Board’s Risk Management Policy, and advise the Board of the Committee’s views as to its adequacy.

- Review the Board’s arrangements for the prevention and detection of fraud and other irregularities.

- Receive and review schedules of losses and compensations where the amounts exceed the delegated authority of the Board, before they are referred to the Scottish Government for approval.

- Evaluate the assurances that are provided to support the Accountable Officer’s Governance Statement.

- Advise the Scottish Government Health & Wellbeing Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

- To present to the Board an Audit & Risk Committee Annual Statement of Assurance.

- The Committee will annually review these terms of reference and its own effectiveness, and recommend any necessary changes to the Board.
Internal Control

➢ Receive and review all reports from internal and external audit.

➢ Review audit reports from auditors of national, regional or shared systems upon which NHS Lothian relies, e.g. audit reports from NSS.

➢ Review of other material pertinent to improving systems of corporate governance and internal control, e.g. Best Value material, studies from other organisations, national performance audit reports from Audit Scotland.

➢ Receive and review stewardship reports from senior staff in areas that are key to corporate governance, e.g. finance, HR, ICT.

➢ Receive and review a summary of issues raised by line managers in the annual managerial statements of internal control, which inform the drafting of the Governance Statement.

➢ Receive and review assurance reports from other Board Committees, so as to inform the review of the Governance Statement.

➢ Receive assurance that the Board has adequate and effective systems for internal financial control (identify, assess, manage and monitor financial risks) and to produce the annual accounts.

➢ Review of fraud and theft reports as reported to it from the NHS Lothian Fraud Liaison Officer.

➢ Reviewing quarterly payment verification reports in relation to primary care contracting and reports relating to the Quality Outcomes Framework.

Systems of Risk Management

The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk.

However the Committee shall seek assurance that:

➢ There is a comprehensive risk management system in place to identify, assess, manage and monitor risk at all levels of the organisation.

➢ There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management.

➢ The Board has clearly defined its risk appetite (i.e. the amount of risk that the Board is prepared to accept, tolerate, or be exposed to at any
time), and that the executive’s approach to risk management is consistent with that appetite.

In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- At each meeting, receive and review a report summarising any significant changes to the Board’s corporate risk register, and what plans are in place to manage them. The Committee may also elect to occasionally receive information on significant risks held on other risk registers held in the organisation.

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board.

- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required.

- Reflect on the assurances that have been received to date, and identify whether entries on the Board’s risk management system requires to be updated.

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk.

Whilst the Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions, the Board’s Healthcare Governance Committee shall provide particular oversight to clinical risks and all matters relating to the Board’s legal duty to monitor and improve the quality of health care which it provides (Reference: S12H of National Health Service (Scotland) Act 1978).

The Healthcare Governance Committee shall also provide oversight to the Board’s responsibilities for information governance, through the Information Governance Assurance Board.

The Staff Governance Committee shall have particular oversight of risks relating to the Board’s legal duty in relation to the governance of staff. (Reference: S12I of National Health Service (Scotland) Act 1978)

Financial Reporting
The Committee shall consider the following:

- The accounting policies, any changes to them, and any significant estimates and judgements. The Committee is authorised to approve accounting policies of the Board.
- The significant financial reporting issues and judgements made in connection with the preparation of the annual accounts.

- Any significant or unusual transactions that have been flagged by management, where the accounting treatment is open to different approaches.

- The appropriateness of all the above in light of any comments from the Board’s external auditors.

- The clarity and completeness of disclosures in the financial statements, and whether the disclosures made are set properly in context.

- Any related information presented in the financial statements, e.g. Governance Statement, Operating and Financial Review.

The Committee shall perform the above for the Board’s annual accounts, and the Board’s patients’ private funds annual accounts.

If the Committee is not satisfied with any aspect of financial reporting, it will report its views to the Board.

Internal Audit

- Review the Internal Audit Strategy and plan for the forthcoming year, which are prepared by the Chief Internal Auditor, and assess its appropriateness to give reasonable assurance on the whole of risk, control and governance. The Committee is authorised to approve the Internal Audit Strategy and plans.

- Receive internal audit reports and review the progress of the delivery of the internal audit plan.

- Review the adequacy of internal audit staffing and other resources.

- Review the adequacy of the formal remit that has been granted to the internal audit function to discharge its function.

- Monitor and assess the role and effectiveness of the internal audit service in the context of the Board’s system of risk management.

- Review and monitor management’s responsiveness to internal audit’s findings and recommendations.

- Meet the Chief Internal Auditor once a year without the presence of management.

- Ensure that the Chief Internal Auditor has direct access to the Board Chairman and the Chair of the Audit & Risk Committee.
The Chief Internal Auditor will be selected and appointed by a panel chaired by a non-executive Board member, preferably the Chair of the Audit & Risk Committee. The Chair of the Audit & Risk Committee shall approve the composition of the panel.

External Audit

- Approve the remuneration of the External Auditors within the range set by Audit Scotland
- Examine any reason for the resignation or dismissal of the External Auditors
- Review and confirm the External Auditor’s strategy and plans
- Receive and review the outputs from the work of the Board’s external auditor.
- Ensure that the External Auditor has direct access to the Board Chairman and the Chair of the Audit Committee. Meet the External Auditor once a year without the presence of management
- Annually appraise the performance of the External Auditors and report results to Audit Scotland.
- Receive assurance that the external auditor has arrangements in place to maintain their independence and objectivity. This should include consideration as to whether any of the audit staff have any business interest with Lothian Health Board, or personal relationships with any of the Board employees, which could compromise independence and objectivity.
- To develop and recommend to the Board a policy on the provision of non-audit services by the external auditor. The Committee should also set out in its annual report whether such services have been provided during the year.

Communication with the Board and Accountable Officer

The Board secretariat shall prepare minutes of every Committee meeting, and these will be presented at the next Board meeting.

The Secretary and Chair of the Committee will ensure that matters arising from the Committee are communicated appropriately to relevant parties for action and information as appropriate, and in particular ensure that this is circulated to other Board members

If required, the Chair of the Audit & Risk Committee may meet individually with the Chief Internal Auditor, the External Auditor, and the Accountable Officer.
Administrative Arrangements

Support to the Committee

The Director of Finance is responsible for providing the necessary support to facilitate the effective functioning of the Committee.

The Corporate Governance Manager shall be the Secretary to the Committee, supported by the Board’s secretariat function. The Secretary shall ensure that all necessary administration shall be undertaken to ensure the effective conduct of Committee business, as set out in the Scottish Government Audit Committee Handbook.

Frequency of Meetings:

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. A meeting is normally scheduled to occur in February, April, June, October and December each calendar year. In any event meetings shall be held no less than four times per year.
1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with the external auditors’ report on NHS Lothian for 2011/12, completed by Audit Scotland.

2 Recommendation

2.1 The Board is requested to:

Note the report, the business risks identified within the document and the response and action deadlines contained within Appendix 1 to the report.

3 Key Issues

3.1 The work of the external auditors is primarily concerned with arriving at an opinion on the annual financial statements, however Audit Scotland’s responsibilities and remit also extends to providing a view on overall organisational performance, regularity and use of resources. This is done with the aim of supporting improvement in performance and accountability.

3.2 The Audit Committee received the report at its meeting of 9 October 2012.

3.3 The key messages from the report are:

- The external auditors have provided an unqualified audit opinion on the 2011/12 accounts.
- The Board met its financial targets. The report summarises the key issues that have been, and require to be managed, in order to maintain this. The report also sets out the continuing and increasingly challenging financial climate that all of the public sector must respond to in terms of prioritisation of resources for delivery of key targets and achieving a recurrent financial balanced position.
- The Board’s high level corporate governance and control systems operated satisfactorily during the year. However the auditors have commented on the culture issues preventing the reporting of the underlying waiting times to the Board, and the reputational damage arising.
- The report from the auditors highlights the Board’s commitment to and arrangements for securing Best Value in its use of resources.
- The key issues identified for the Board in 2012/13 are rebuilding the organisational credibility, improving the robustness of its performance reporting
and addressing financial prioritisation of resources within increasingly constrained budgets.

- The Board has key risks that need to be managed, and these are summarised in the Action Plan on pages 30-33 of the report. Management’s response to these issues is also summarised in the Action Plan.

4 Key Risks

4.1 The report highlights risks that populate the Board’s corporate and Finance directorate risk register and the management responses in the report addresses how these risks are to be managed.

5 Impact on Health Inequalities, Equality and Diversity

5.1 The report itself has no impact on inequalities, although the activities of the Board do. The report acknowledges that the Board’s corporate objectives include addressing health inequalities, as well as the progress made in achieving these targets, e.g. smoking cessation, alcohol interventions.

6 Involving People

6.1 The report has already been circulated in draft form within the Finance directorate and the final report was reviewed by Audit Committee at its meeting on 9 October 2012.

7 Resource Implications

7.1 The report summarises key issues of financial governance for the Board as at July 2012 that are replicated on the Corporate Risk Register.

Susan Goldsmith
Director of Finance
11 October 2012

List of Appendices

Appendix 1: External Auditors’ Report on NHS Lothian for 2011/12
NHS Lothian
Annual report on the 2011/12 audit

Prepared for the Board of NHS Lothian and the Auditor General for Scotland
July 2012
Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Government and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.
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Key messages

2011/12

The Scottish public sector faces significant challenges in balancing budgets while also delivering on its commitments. In 2011/12 we assessed the key strategic and financial risks being faced by NHS Lothian. We audited the financial statements and we also reviewed the use of resources and aspects of performance management and governance. This report sets out our key findings.

Financial statements

We have given an unqualified audit report on the financial statements of NHS Lothian for 2011/12. We also concluded that in all material respects, the expenditure and income shown in the financial statements were incurred or applied in accordance with applicable enactments and relevant guidance issued by Scottish Ministers.

Financial position and use of resources

The Board achieved all of its financial targets in 2011/12 and returned a saving against its total Revenue Resource Limit of £0.922 million as at 31 March 2012.

In 2011/12 the Board achieved savings of £50.1 million, of which £47.6 million was derived from efficiency savings with the balance being offsets from strategic reserves and other under spends. However, over £10.5 million of the efficiency savings were achieved on a non-recurring basis, meaning that the Board has an underlying recurring deficit which will require to be addressed in future years.

The Board's five year financial plan involves cost savings of around £28 million per year to be generated from recurring sources, which will be extremely challenging. The plan assumes 1% future funding uplifts and initially an additional £12.3 million of resource re-alignment (NRAC) funding each year, and any variation to this will make the delivery of cost savings even more important. These issues, combined with growing cost pressures in the current economic climate mean that difficult decisions will have to be made to determine priorities.

The Board's financial planning arrangements include regular monitoring, reporting and updating of information to allow potential risks to be addressed promptly.

Governance and accountability

In 2011/12, the Board had sound overall governance structures in place which included a number of standing committees overseeing key aspects of governance. The Board also maintained an effective internal audit function and anti-fraud arrangements were in place. We examined the key financial systems underpinning the organisation’s control environment and concluded they operated sufficiently well to enable us to place reliance on them.
However, an independent investigation into management culture at the Board highlighted significant issues to be addressed to change leadership style, develop a values culture and re-establish trust and confidence in the Board. The widely publicised issues on the identification and reporting of waiting times were a major area of service and reporting failure. Reports into waiting times recording and the reporting of this information to the Board have been published and resulted in considerable reputational damage for the organisation. The Board has amended its recording practices and is taking steps to expedite the treatment of those recorded as breaching, or about to breach waiting times guarantees.

Performance and best value

The Board's performance management arrangements did not identify the reporting failures in relation to waiting times. The Board is taking steps to confirm the robustness of their performance reporting and re-establish confidence in the system. Reported performance in 2011/12 demonstrated good performance against a number of challenging HEAT targets, but some critical targets were not achieved.

The Board is committed to the principles of best value and produces an annual best value assurance report. The Lean in Lothian programme is now in its sixth year in delivering process redesign and increasing productivity, underpinning ongoing action to deliver increasingly challenging savings targets.

The Board has arrangements in place to consider national performance reports issued by Audit Scotland, with local action plans in place to address recommendations for improvement.

Outlook

2011/12 was a difficult year for the Board, with significant damage to its reputation. It will be a challenge to rebuild that reputation and the Board must ensure that it fully implements the recommendations arising from the independent reports on waiting times and management culture.

The financial position going forward is becoming even more challenging than previous years with limited increases in funding, increasing cost pressures and challenging savings targets. To achieve continuing financial balance the Board will require to deliver £37.4m of recurring cost savings. Expenditure during the year will require to be closely monitored to identify and address any emerging budget pressures or projected overspends at an early stage.

Progress on the development of the re-provision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences facilities at Little France has been delayed, due to the inability of its PFI partner (Consort Healthcare) to obtain agreement from all of its funding participants to facilitating changes in its PFI contract with the Board. Completion of construction is not now expected until 2017.
The significant financial challenges in 2012/13 and beyond will require the Board to prioritise further its use of resources. This will make maintaining or improving on the performance targets set by the Scottish Government even more challenging, including the key area of waiting times.
Introduction

1. This report is the summary of our findings arising from the 2011/12 audit of NHS Lothian. The purpose of the annual audit report is to set out concisely the scope, nature and extent of the audit, and to summarise the auditor’s opinions (i.e. on the financial statements) and conclusions and any significant issues arising. The report is divided into sections which reflect the extent of our public sector audit model.

2. A number of reports have been issued in the course of the year in which we make recommendations for improvements (Appendix A). We do not repeat all of the findings in this report, but instead we focus on the financial statements and any significant findings from our wider review of NHS Lothian.

3. Appendix B is an action plan setting out the high level risks we have identified from the audit. Officers have considered the issues and agreed to take the specific steps in the column headed "planned management action". We do not expect all risks to be eliminated or even minimised. What we expect is that NHS Lothian understands its risks and has arrangements in place to manage these risks. The Board and Accountable Officer should ensure that they are satisfied with the proposed management action and have a mechanism in place to assess progress.

4. This report is addressed to the Board and the Auditor General for Scotland and should form a key part of discussions with the Audit Committee, as soon as possible after the formal completion of the audit of the financial statements. Reports should be made available to stakeholders and the public, as appropriate. Audit is an essential element of accountability and the process of public reporting.

5. This report will be published on our website after consideration by the Board. The information in this report may be used for the Auditor General's annual overview of the NHS in Scotland's financial performance later this year. The overview report is published and presented to the Public Audit Committee of the Scottish Parliament.

6. The management of the Board is responsible for preparing financial statements that show a true and fair view and for implementing appropriate internal control systems. Weaknesses or risks identified by auditors are only those which have come to our attention during our normal audit work, and may not be all that exist. Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.
Financial statements

7. Audited bodies’ financial statements are an essential part of accounting for their stewardship of the resources made available to them and their performance in the use of those resources.

8. Auditors are required to audit financial statements in accordance with the timescales set by Audit Scotland, which may be shorter than statutory requirements, and give an opinion on:
   - whether they give a true and fair view of the financial position of audited bodies and their expenditure and income
   - whether they have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements
   - the regularity of the expenditure and income.

9. Auditors review and report on, as appropriate, other information published with the financial statements, including the director's report, governance statement and the remuneration report. This section summarises the results of our audit of the financial statements.

Audit opinion

10. We have given an unqualified opinion in that the financial statements of NHS Lothian for 2011/12 give a true and fair view of the state of the body's affairs and of its net operating cost for the year.

11. NHS Lothian is required to follow the 2011/12 Government Financial Reporting Manual (the FReM) and we confirm that financial statements have been properly prepared in accordance with the FReM.

12. We have also reviewed the Board’s governance statement and concluded that it complies with Scottish Government guidance.

Regularity

13. The Public Finance and Accountability (Scotland) Act 2000 imposes a responsibility on auditors that requires us to certify that, in all material respects, the expenditure and income shown in the accounts were incurred or applied in accordance with applicable enactments and guidance issued by Scottish Ministers. We have been able to address the requirements of the regularity assertion through a range of procedures, including written assurances from the Accountable Officer as to his view on adherence to enactments and guidance. No significant issues were identified for disclosure.
Accounting issues

Accounts submission

14. A full set of accounts was due to be presented for audit on 2 May 2012. The draft accounts together with the draft template accounts were presented on 8 May 2012. However a number of the accompanying disclosure notes were still being worked on at that date, and were not finalised until 12 June 2012. The audit process in partnership with NHS Lothian finance staff was sufficiently flexible to deal with these variations from the target date in delivering a completed audit on time.

15. Working papers provided for audit were generally of a satisfactory standard. Difficulties were encountered in obtaining directors' assurance statements timeously in the lead up to the conclusion of the audit. However we were able to conclude our audit within the agreed timetable and provided our proposed opinion to the Audit Committee on 26 June 2012 as outlined in our Annual Audit Plan.

16. Several unadjusted differences were identified during the audit, where if adjustments were made these would have had a net effect of decreasing operating costs/excess of expenditure over income for the year shown in the Statement of Comprehensive Net Expenditure by £334,000. The net impact on the balance sheet would be that net assets would decrease by £334,000. These differences, whilst not negligible, are not material to the accounts as a whole. Officers in finance proposed not to adjust the accounts for these unadjusted differences and we concurred with this.

Post balance sheet event

17. On 27 April 2012 the Board's Chief Executive, Professor James J Barbour, retired from the Board. In addition to Professor Barbour's reported remuneration, recorded within the Remuneration report, the Board in accordance with the Chief Executive's contract elected to make a payment to him in lieu of 6 month's notice and outstanding contractual holiday entitlements in 2012/13. The Board have indicated that they did not request Professor Barbour to work his period of notice due to their urgent need to review their management structure. Mr Tim Davison was appointed as Interim Chief Executive pending a formal recruitment process.

Prior year adjustments - donated asset reserve and transfer of prisoner healthcare

18. The 2011/12 FReM required Boards to change the accounting treatment for donated assets which led to the removal of the donated asset reserve from their accounts. This requirement was a change in accounting policy which was reflected in the financial statements of NHS Lothian with appropriate amendments made to prior year statements.

19. In addition, responsibility for the healthcare of prisoners transferred from the Scottish Prison Service to health Boards on 1 November 2011. The transfer was a machinery of government change, which the FReM requires to be accounted for using merger accounting and entailed prior year comparatives being restated and adjusted to achieve uniformity of accounting
policies. The appropriate adjustments to prior year comparatives have been reflected in the financial statements.

Equal pay claims

20. The National Health Service in Scotland has received in excess of 10,000 claims for equal pay and by the end of March 2012 there remained 1643 grievances registered against NHS Lothian. These have been referred for the attention of the NHS Scotland Central Legal Office (CLO) to co-ordinate the legal response to this issue.

21. Discussions have been held between Audit Scotland, their partner firms, the Scottish Government, the CLO and Board representatives to ascertain the appropriate accounting treatment of equal pay claims in 2011/12. Due to lack of movement in any cases, there is no additional information which would enable NHS Scotland to estimate the probability and the value of the liability associated with these claims. Consequently these claims continue to be disclosed as an unquantifiable contingent liability in the notes to the accounts of NHS Lothian.

22. We continue to strongly encourage NHS Lothian, working with Scottish Government Health and Social Care Directorates, the CLO and other NHS Boards to form a view of the potential liabilities as soon as possible taking into account the progress of cases in Scotland and England. As with other Boards, NHS Lothian has not been able to quantify the extent of its liability for Equal Pay claims. There is a risk that these liabilities could have an impact on the Board’s financial position.

Risk Area 1

Heritage assets

23. A heritage asset is a tangible asset with historical, artistic, scientific, technological, geophysical or environmental qualities that is held and maintained principally for its contribution to knowledge and culture. From 2011/12 Boards were required to separately disclose any heritage assets. During 2011/12 the Board conducted a review of non-current assets which identified that no such assets were held by the Board. We understand that all heritage assets (mainly works of art) are held at hospital sites within NHS Lothian, with the exception of one work on recorded public loan to a public gallery, and are owned and controlled by the Edinburgh & Lothians Health Foundation. Management provided assurance in their letter of representation that NHS Lothian does not own or control any heritage assets.

HD Partners

24. Two payments authorised by the Director of Finance were made to HD Partners based on two separate contractual arrangements for 'Waiting Times' capacity solutions for 2011/12 and 2012/13. These contractual arrangements arose from urgent work authorised by the previous Chief Executive and current Director of Finance. The payments amounted to £75,600 including VAT, with expenses recently agreed.

25. A lack of a fully documented and clear audit trail for the procurement of one piece of work for the 'Waiting Times' capacity solution for 2011/12 made it difficult to conclude that the payment
fully complied with NHS Lothian's Standing Financial Instructions. Management provided assurance in their letter of representation that the payment for 'Waiting Times' capacity solutions 2011/12 properly falls within the delegated powers of the Director of Finance. However, we would recommend that urgent contract procurements should be formally evidenced.

**Risk Area 2**

**Register of interests**

26. The regular updating of the Register of Interests is a binding requirement on Board members, the contents of which help inform the Related Party Transactions note in the financial statements. The Register of Interests was last updated in October 2011. Our review of the note in the financial statements highlighted an omission in the Register and we also noted registered interests that had not been properly considered for the Related Party Transactions note. Management provided assurance in their letter of representation that the 'Register of Interests' is now fully up to date with all interests registered.

**Pay and conditions accrual**

27. There have been a number of significant movements in the accrual in 2011/12 and the overall impact was a net reduction of £2.1m, with the overall accrual reducing from £12.5million at the end of 2010/11 to £10.4million at the end of 2011/12. During 2011/12 an additional £2.96million was accrued in respect of backdated pay owed to staff placed on transitional pay points following the introduction of Agenda for Change, and staff who were not paid entitlements due to them during periods of annual leave or sickness absence. This was a new element of the overall accrual and the figure was reached through the use of modelling techniques. In addition to our own review which concluded that the accrual appeared reasonable, management have provided assurance in their letter of representation that the figure as at 31 March 2012 is complete and represents a valid obligation to NHS Lothian.

**Outlook**

**Endowments**

28. As a result of an agreed derogation from the FReM NHS Scotland Boards were not required to consolidate endowment funds within their 2011/12 financial statements, in terms of IAS 27, Consolidated and Separate Financial Statements. The Treasury and Scottish Government have delayed the consolidation of NHS Endowment Funds until financial year 2013/14. The Board will require to have endowment fund figures available for inclusion in their financial statements.
Financial Position

29. Audited bodies are responsible for conducting their affairs and for putting in place proper arrangements to ensure that their financial position is soundly based.

30. Auditors consider whether audited bodies have established adequate arrangements and examine:
   - financial performance in the period under audit
   - compliance with any statutory financial requirements and financial targets
   - ability to meet known or contingent, statutory and other financial obligations
   - responses to developments which may have an impact on the financial position
   - financial plans for future periods.

31. These are key areas in the current economic circumstances. This section summarises the financial position and outlook for the organisation.

The Board’s financial position as at 31 March 2012

32. All Health Boards are required to work within the resource limits and cash requirement set by the Scottish Government Health and Social Care Directorates (SGHSCD). In 2011/12, the SGHSCD required NHS Boards to differentiate between core and non-core expenditure for both revenue and capital.

33. Lothian Health Board achieved all its financial targets in 2011/12 as outlined in Table 1 below:

<table>
<thead>
<tr>
<th>Financial Target</th>
<th>Target</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue Resource</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core</td>
<td>1,143,227</td>
<td>1,142,306</td>
<td>921</td>
</tr>
<tr>
<td>Non Core</td>
<td>102,307</td>
<td>102,306</td>
<td>1</td>
</tr>
<tr>
<td><strong>Capital resource</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core</td>
<td>53,742</td>
<td>53,742</td>
<td>-</td>
</tr>
<tr>
<td>Non Core</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Cash position</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash requirement</td>
<td>1,339,000</td>
<td>1,338,188</td>
<td>812</td>
</tr>
</tbody>
</table>

34. The Board has achieved a cumulative surplus of £0.922 million. The Board had budgeted to breakeven against its Revenue Resource Limit in 2011/12. Historically, Boards have relied upon a measure of non-recurring funding to achieve financial targets. However, due to the
one-off nature of this type of funding, the tighter financial settlement compared to the past and reduced flexibility within expenditure budgets, there is less scope for reliance on non-recurring income to achieve financial balance as NHS Boards seek to rationalise their cost base.

35. In 2011/12 the Board recorded an underlying recurring deficit of £10.5 million which was met by a non-recurring surplus. The challenge for 2012/13 will be to ensure that recurring expenditure is met through recurring funding as projected within the financial plan.

36. A total of £47.6 million of efficiency savings were achieved in 2011/12 against a target of £50.1 million with the balance being offset from strategic reserves and other under spends. However, of the total efficiency savings achieved, £10.5 million represented non-recurrent savings and this has been re-provided in the 2012/13 financial plan.

Capital resource limit

37. The Board broke even against its total Capital Resource Limit (CRL) in 2011/12 with total capital expenditure of £53.742 million (all core capital allocation). This expenditure reflects progress with the re-provision programme and ongoing investment in statutory standards, eHealth and replacement medical equipment. Major areas of expenditure during the year included the re-provision of the Royal Victoria Hospital (£23.5 million) and £11.3 million on the new Primary Care centre in Musselburgh.

38. Progress was also made on the new Royal Hospital for Sick Children (RHSC) and relocation of the Department of Clinical Neurosciences project (DCN) with £6.9 million of expenditure on development costs including enabling works and design costs. However, the re-provision of the RHSC and DCN facilities at Little France has been delayed and completion is not now expected until 2017. This delay results from Consort Healthcare's inability to secure all the 11 funders' approval to undertake the facilitating works. The anticipated date for the next stage of the project is the issuing of the OJEU in September 2012 but any failure to secure the funders approval or failure to agree all terms in connection with enabling works will further delay the process. One consequence would be that RHSC and DCN will have to continue on their current sites potentially impacting on NHS Lothian's ability to provide world class care.

Risk Area 3

Workforce reduction

39. Around 70% of the Board's expenditure relates to staff costs. NHS Lothian's workforce reduction plans started to take effect in 2010/11 with a 762 Whole Time Equivalent (WTE) reduction. During 2011/12 the Board continued to develop workforce plans with a reduction in the workforce by a further 681.9 average WTE. The annual target of 734 was not reached in 2011/12 with the most significant variance being in nursing as a consequence of the activity pressures including the resolution of the waiting times problems in surgery. The 2011/12 financial statements included £2.024 million of costs in relation to the Board's voluntary severance arrangements and other non-compulsory early retirement arrangements. During 2011/12 there were 42 exit packages approved. The Board has recently finalised its workforce redesign plans for 2012/13 and beyond, with further reductions in the workforce planned. It is
anticipated that these manpower savings will be achieved through natural turnover and redeployment.

Financial planning to support priority setting and cost reductions

40. Uplifts in financial settlements have been reducing in recent years. In 2010/11 there was a general uplift of 2.55%, in 2011/12 the corresponding figure was 2.1%. This pattern has continued into 2012/13, with the Board's baseline revenue funding uplift being confirmed as 1%, although the Board has received a total 'notional' funding uplift of 2.7%. This is mainly as a result of an allocation of additional National Resource Allocation Committee (NRAC) parity funding (£12.3million) and an increase in the change fund allocation (£1.4million). In May 2012 the Board approved a 5 year financial plan 2012/13 - 2016/17. Given the current economic conditions and the impact of national spending priorities, there is a risk that funding uplifts will be even lower in future years. These pressures will have a significant impact on long term financial planning and the control of pay and non-pay costs.

41. The cost challenges facing the Board are significant and in some cases there is an element of uncertainty about further potential increases in costs. The Board plans to break even in 2012/13. In 2011/12 the Board's cost savings plan was key to the Board achieving financial balance. The plan set a savings target of £50.1million, of which £47.6million was achieved as efficiency savings and the balance being offset from strategic reserves and other under spends, £37.1 million of this balance being achieved on a recurrent basis and the remaining £10.5million being achieved on a non-recurrent basis.

42. The Board's ability to achieve financial balance is again largely dependent on it successfully implementing a comprehensive recurring cost savings plan. There is currently a funding shortfall of £37.4million (including the 2011/12 carry forward) which will require to be met through the achievement of efficiency savings. This represents a major challenge to NHS Lothian. Expenditure during the year will require to be closely monitored to identify and address any emerging budget pressures or projected overspends at an early stage.

43. The Board continues to face significant cost pressures relating to the rate of growth in prescribing costs, anticipated increases in workforce costs and supplies during 2012/13, and the impact of changes in the demographics of the NHS Lothian population. There are provisions in the 2012/13 Financial Plan to cover some of these issues, however, risks remain that need to be managed, including the delivery of recurring savings, the availability of SGHSCD funding for previously separately funded programmes, the revenue impact of the capital investment programme, new or changed policy initiatives emerging during the year and investment required to deliver the waiting times targets.

44. All additional expenditure will require to be met from the Board's existing resource and as a result any significant fluctuations in these costs will present a significant challenge to NHS Lothian achieving financial balance for the coming year. The cost savings require to be achieved through a number of means, including service redesign, strict vacancy management, more efficient procurement practices and a continued focus on primary care and hospital prescribing costs.
45. The delivery of the cost savings plan in 2012/13 will be more challenging than it has been in recent years. The level of flexibility within expenditure budgets is considerably reduced by the release of cost savings in previous years. Failure to achieve planned cost savings will impact on the Board’s ability to achieve a break even position.

46. The Board’s Local Delivery Plan (LDP) for 2012/13 aligns the Board’s strategic priorities with its financial plans, workforce plans and asset plans. The Board’s financial planning arrangements include regular monitoring, reporting and updating of information to allow potential risks to be addressed properly. It is therefore important that the Board continues to closely monitor costs in order to take any required remedial action through supplementary cost saving schemes.

Risk Area 4

Outlook

Significant financial risks beyond 2012/13

47. The Board’s 2012/13 - 2016/17 financial plan provides indicative figures for the level of cost savings required for the 5 year period in order to achieve financial balance. The plan highlights that the level of savings required per annum, beyond 2012/13 will be in the region of £28 million. The majority of the cost savings in each year are expected to be generated from recurring sources. These levels of savings will be extremely challenging as the majority of readily achievable savings initiatives will have already been identified in recent years.

48. The Board’s financial plan assumes that future funding uplifts will be in the region of 1%. This, combined with growing cost pressures and any uncertainties around the Board's assumption that the SGHSCD will initially provide an additional £12.3 million from NRAC funding over each of the years, will make the delivery of cost savings even more important.

Risk Area 4

Pension costs

49. Following the advice of the Scottish Government, Note 24: Pension Costs reflects a net liability of £370 million for the NHS Superannuation Scheme arising from the most recent actuarial valuation. Note 1 of the accounts, Accounting Policies, states that the most recent actuarial valuation was for the year 31 March 2004. Given that the Scheme ought to be subject to a full actuarial valuation every four years, a more up to date valuation would have been expected to have been reflected in the 2011/12 accounts.

50. While there was a more recent actuarial valuation carried out at 31 March 2008, the publication of this valuation has been placed on hold by HM Treasury pending the outcome of public sector pension reforms. Given that periodic actuarial valuations are key to determining the adequacy of employer and employee contributions to the Scheme, publication of the latest actuarial valuation will bring clarity as to the adequacy of current contributions to meet the future commitments of the Scheme. The position was reported by the Board’s Head of Corporate Reporting to the Board Audit Committee in April 2012.
Governance and accountability

51. The three fundamental principles of corporate governance – openness, integrity and accountability – apply to all audited bodies, whether their members are elected or appointed, or whether they comprise groups of people or an individual accountable officer.

52. Through its chief executive or accountable officer, each body is responsible for establishing arrangements for ensuring the proper conduct of its affairs including the legality of activities and transactions, and for monitoring the adequacy and effectiveness of these arrangements. Audited bodies usually involve those charged with governance (including audit committees or similar groups) in monitoring these arrangements.

53. Consistent with the wider scope of public audit, auditors have a responsibility to review and report on audited bodies’ corporate governance arrangements as they relate to:
   - corporate governance and systems of internal control
   - the prevention and detection of fraud and irregularity
   - standards of conduct and arrangements for the prevention and detection of corruption.

54. In this part of the report we comment on key areas of governance.

Corporate governance

Processes, committees and management culture

55. The corporate governance framework within NHS Lothian is centred on the Board which is supported by a number of standing committees that are accountable to it. These standing committees include:
   - Audit
   - Healthcare Governance and Risk Management (HGRM)
   - Finance and Performance Review (FPR)
   - Ethics
   - Remuneration
   - Staff Governance
   - Service Redesign
   - Mutuality and Equality Governance
   - Joint Board of Governance

56. Our overall conclusion is that the overarching governance structures within NHS Lothian at Board and committee level are broadly satisfactory and have operated throughout 2011/12. We have however noted that Heat Target reporting arrangements in respect to waiting times
was an area of service and reporting failure. Reports into waiting times recording and the reporting of this information to the Board and FPR committee have been published and presented to the Board. As a result the Board has amended its recording practices and is taking steps to expedite treatment of those recorded as breaching, or about to breach, waiting times guarantees. The Board need to be satisfied with the robustness of Heat Target reporting.

**Risk Area 5**

57. More detailed information on the waiting times issue is outlined in the next section of this report. An independent investigation was also undertaken into the underlying management culture which prevented full disclosure and reporting of waiting times problems. This review highlighted significant issues to be addressed to change leadership style, develop a values culture and re-establish trust and confidence in the Board. The recommendations from this report should be implemented in full to lessen the risk of similar issues happening again.

**Risk Area 6**

**NHS Lothian management of waiting times**

58. The Board in October 2011 became aware of issues of concern in connection with the recording and measurement of inpatient and outpatient waiting times against quality targets, specifically regarding unavailability codes in the management of NHS waiting times. The Board, after an initial in house review commissioned a detailed investigation by PricewaterhouseCoopers. Commissioning of this investigation was assumed by the SGHSCD and the final report was published on 21 March 2012.

59. The report highlighted administrative practices that were unacceptable in that these practices did not comply with the waiting times recording and measurement guidance. As a result, the Board has amended its recording practices and taken steps to expedite treatment of those recorded as breaching, or about to breach waiting times guarantees. Additionally, the Board have initiated proceedings to investigate potential serious misconduct on the part of certain staff members in connection with the inappropriate administrative practices. The investigation and any subsequent disciplinary process is expected to be completed during the financial year 2012/13.

60. The Chairman of the Board in consultation with the Scottish Government Cabinet Secretary for Health and Wellbeing and Cities Strategy instigated a review of the scope of information received at its meetings to ensure best governance practices and to examine the root causes of senior management cultural issues which prevented full disclosure of waiting times issues from progressing through the governance framework of the Board. The review reported its findings to the Cabinet Secretary on 30 April 2012. It is crucial that the Board implements fully the recommendations from both the 'Waiting Times' report and the 'Review of Scope of Information' report. The issues identified in NHS Lothian have resulted in two national level studies - one co-ordinated review by Board internal audit teams and a review by Audit Scotland of the broader use of unavailability codes in the management of Waiting Times.
Patient safety and clinical governance

61. Patient safety is at the heart of clinical governance and risk management and a number of national arrangements and initiatives are in place to assist Boards in this area. NHS Healthcare Improvement Scotland (NHS HIS) has lead responsibility for reviewing Boards' performance in relation to patient safety, and for working with Boards to improve patient safety. The remit of the Healthcare Environment Inspectorate (part of HIS) is to reduce the risk of Health Acquired Infections (HAI) in acute hospitals through assessment, inspection and reporting of Boards' performance against HAI standards.

62. Following an unannounced inspection by NHS HIS at St Johns Hospital on 24 January 2012 a report was published on 5 March 2012 and an action plan with four requirements identified, of which two are now complete. NHS Lothian manages and reduces Healthcare Associated Infection (HAI) through maintaining enhanced weekly surveillance of MRSA and MSSA to target resources for a sustained reduction. NHS Lothian's Infection Prevention and Control Team will continue to perform investigations into HAI to give the Board assurance that high standards of practice are being monitored, maintained and improved.

63. NHS Lothian is on course to meet 2013 HEAT targets set for MRSA and MSSA, however the targets are challenging to achieve on a continuous basis e.g. Staphylococcus aureus Bacteraemia (SAB) Cases - set target of 0.26 or less cases per 1000 Acute Occupied Bed Days by March 2013. The challenge going forward is to reduce even further.

Partnership working

64. Partnership working in the NHS covers a number of areas, including partnerships with staff groups, local authorities, the voluntary sector, private healthcare providers and regional planning with other NHS Boards. The Board has an established Community Health Care Partnership (with West Lothian Council) and Community Health Partnerships with Edinburgh, East Lothian and Midlothian Councils. These partnerships provide care and public health services in a local setting to meet the needs of the local population.

65. NHS Lothian is committed to the delivery of shared outcomes with its community planning partners. Public Partnership Forums are established in each CH(C)P area with relevant committees meeting during the year. These ensure that service users are involved in service developments, and links are established with other local governance structures, for example, community planning committees, to co-ordinate services which meet the needs of local areas. This is very much a developing area at a national level, and the Scottish Government's plans for integrating health and social care are further discussed in the Outlook paragraphs of this section of our report.

66. The Cabinet Secretary for Health, Wellbeing and Cities Strategies recently announced new national standards for delayed discharges. These will form part of the Board's HEAT targets for 2012/13 and beyond. The census in March 2012 reported 84 delays, which was an increase on the number of patients delayed in February. Whilst improvements were made in reducing the number of patients delayed over 6 weeks, the national target was not met. Improvements in the overall numbers delayed and a lowering of the average length of stay
have been made since the year end, however, the area of delayed discharges continues to be a challenge for the Board. The new target introduced for health Boards is to have no delays over 4 weeks by 2013 and no delays over 2 weeks by 2015. This further highlights the need to work effectively with other public sector bodies and consider fully the impact of closures and capacity issues in the private care sector which can also impact on targets.

67. NHS Lothian continues to be a key partner in the South East and Tayside (SEAT) regional planning group which works to implement services across NHS Board boundaries. NHS Lothian promotes this partnership to the benefit of patients across Scotland. Agreement has been reached to develop 5 workstreams where a shared service approach across the region is expected to bring quality and efficiency/productivity benefits.

**Internal control**

68. While auditors concentrate on significant systems and key controls in support of the opinion on the financial statements, their wider responsibilities require them to consider the financial systems and controls of audited bodies as a whole. However, the extent of this work should also be informed by their assessment of risk and the activities of internal audit. Key controls within systems should operate effectively and efficiently to accurately record financial transactions and prevent and detect fraud or error. This supports a robust internal control environment and the effective production of financial statements.

69. In their annual report for 2011/12 NHS Lothian Internal Audit provided their opinion that, based on the internal audit work undertaken during the year, that generally adequate and effective internal controls have been operating throughout the year. During the year no reports were issued with a 'fully satisfactory' or 'unsatisfactory' rating, although 8 audit reports (38%) were concluded as requiring improvement.

70. As part of our audit we reviewed the high level controls in a number of NHS Lothian systems that impact on the financial statements. This audit work covered a number of areas including cash and cash equivalents, trade payables, trade receivables, family health services, payroll, capital accounting and inventories. We also reviewed employee severance schemes, the acceptance of gifts and hospitality, the register of interests, the use of credit cards and expenses. Our overall conclusion was that NHS Lothian had adequate systems of internal control which operated effectively during 2011/12. We identified some areas where controls could be strengthened and agreed an action plan of improvements with management. This will be followed-up at a future date to confirm that improvements have been made.

**Internal audit**

71. A key element of our work on internal controls is the extent of reliance that we can place on the work of internal audit in terms of International Standard on Auditing 610 (Considering the Work of Internal Audit). We carried out a review of internal audit in December 2011 and concluded that the internal audit service operates in accordance with Government Internal Audit Standards and has sound documentation standards and reporting procedures in place.
We placed reliance on internal audit work in relation to the General Ledger. This not only avoided duplication of effort but also enabled us to focus on other significant risks.

**Governance statement**

72. The governance statement, provided by the Board’s Accountable Officer, reflects the main findings from both internal and external audit work, and highlights the process by which the accountable officer obtains assurances over the adequacy and effectiveness of the system of internal control. This is a new format of disclosure for 2011/12 as specified by the SGHSCD. The new format includes the requirement for an overt assurance that arrangements have been made to ensure Best value. Overall it was concluded by the Interim Chief Executive and Accountable Officer that no significant control weaknesses or issues have arisen, with the exception of waiting times management and related issues of management culture. Otherwise the statement reports that no significant failures have arisen in the expected standards for good governance, risk management and control, and that appropriate arrangements for Best Value are in place. Our audit has confirmed that we concur with this assessment.

**ICT Service review**

73. As part of our 2011/12 audit we carried out an ICT service review within NHS Lothian. The audit involved a high-level risk based assessment of ICT services in five key areas; governance and delivery, strategy, access controls and compliance, asset protection and business continuity. The report was issued to the Director of eHealth on 31 May 2012.

74. Our overall conclusion is that the eHealth Directorate is a well run service providing access to integrated information for practitioners and is continuing to expand the skills and technology available to benefit the Board. The review also identified a small number of areas where improvements can be made and an action plan has been agreed with officers to ensure that arrangements are put in place to address the risk areas identified from the review.

**Use of Government procurement cards and other credit cards**

75. Across the public sector government procurement cards have been used to reduce the costs relating to the purchase of small items and some internet based purchases where a credit card is the most effective way of making payment. A recent significant fraud, in another public body, which in part resulted from misuse of the government procurement card, highlighted that bodies need to ensure that their processes for the use of these cards are fit for purpose.

76. As part of our audit, we carried out a high level review of the use of such cards within the Board and the controls applied to them. Our review identified that draft staff guidance on the usage and processes for credit cards has not been finalised and issued to staff. In general, however, we concluded that the controls within the system were operating effectively.

**Prevention and detection of fraud and irregularities**

77. Audited bodies are responsible for establishing arrangements to prevent and detect fraud and other irregularity. Auditors review and report on these arrangements.
78. NHS Lothian has in place a number of measures to prevent and detect fraud, including Standing Financial Instructions, Standing Orders and supporting policies and procedures. The Board has also entered into a formal partnership agreement with NHS Scotland Counter Fraud Services (CFS).

79. The Board has a formal programme of internal audit work which, although not designed to detect fraud, does provide assurance on the operation of the control systems which are designed to prevent fraud. The Board also a formal protocol covering a programme of regular payment verification checks with the Practitioner Services Division of NHS National Services Scotland. In 2011/12 these checks included verification against patient records, requesting patients to confirm treatment, visits to practices and examination of patients.

80. We concluded that the Board's arrangements were adequate in relation to the prevention and detection of fraud and irregularities, although it should be noted that no system can eliminate the risk of fraud entirely.

NFI in Scotland

81. NHS Lothian participates in the National Fraud Initiative (NFI). This is a counter-fraud exercise that uses computerised techniques to compare information about individuals held by different public bodies, and on different financial systems, to identify circumstances (matches) that might suggest the existence of fraud or error. Where matches are identified, public bodies are required to investigate these matches and, if fraud or error has taken place, to stop payments and attempt to recover the amounts involved.

82. The most recent data matching exercise collected data from participants in October 2010 and the national findings were published by Audit Scotland in May 2012. Specific arrangements are monitored at a local level as part of the ongoing audit. Based on the 2010/11 exercise it was recognised that NHS Lothian had made a strong commitment to the NFI process with a number of errors identified and potential recoveries in excess of £36,000.

83. Participants should now be preparing for the 2012/13 exercise where data will be requested by October 2012. The national report published in May 2012 includes a self-appraisal checklist that all participants were recommended to use prior to NFI 2012/13.

Standards of conduct and arrangements for the prevention and detection of corruption

84. Audited bodies are responsible for ensuring that their affairs are managed in accordance with proper standards of conduct and have proper arrangements in place for implementing and monitoring compliance with standards and codes of conduct, standing orders and financial instructions. Auditors consider whether bodies have adequate arrangements in place. With the exception of issues surrounding management culture highlighted at paragraph 57, we have concluded that the arrangements in NHS Lothian are satisfactory and we are not aware of any further specific issues that we need to identify in this report.
Outlook

Partnership working

85. This is very much a developing area at a national level. In December 2011 the Cabinet Secretary for Health and Wellbeing and Cities Strategy announced the Scottish Government’s plans to integrate adult health and social care across local government and the NHS. The main proposals are as follows:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships (HSCPs). The partnership will be the joint responsibility of the NHS and local authorities, and will work with the third and independent sectors.
- HSCPs will be accountable to Ministers, leaders of local authorities and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people’s care.
- NHS Boards and local authorities will be required to produce integrated budgets for older people’s services.
- The role of clinicians and social care professionals in the planning of services for older people will be strengthened.

86. A smaller proportion of resources, money and staff, will be directed towards institutional care and more resources will be invested in community provision. The Scottish Government launched a consultation on the integration of adult health and social care on 8 May 2012. The consultation sets out proposals to inform and change the way that the NHS and Local Authorities work together and in partnership with the third and independent sectors. The Board recognise that the agreement of joint business and service priorities is essential to implementing these changes. The chief executives of the four local authorities and NHS Lothian continue to discuss the implications of these proposals and have reached an agreement that a joint role will be created at a senior level to support the CHPs in the short to medium term. We will monitor progress in this area.

Equality Act 2010

87. In April 2011, the Equality Act 2010 introduced a new public sector ‘General Duty’ which encourages equality to be mainstreamed into public bodies’ core work so that it is not a marginal activity but part and parcel of how public bodies operate. The Scottish Government consulted on a set of ‘Specific Duties’ which came into force in May 2012. There are nine specific duties listed which aim to support public bodies to better perform against the ‘General Duty,’ including the duty to assess the impact of equalities in all policies and decisions as well as the requirement to publish a set of equality outcomes (and reporting requirements) no later than 30 April 2013. We will consider progress made by the Board in implementing these requirements as part our 2012/13 audit.
Best Value, use of resources and performance

88. Accountable officers have a specific responsibility to ensure that arrangements have been made to secure Best Value.

89. The Auditor General may require that auditors consider whether accountable officers have put in place appropriate arrangements to satisfy their corresponding duty of Best Value. Where no requirements are specified for auditors in a period they may, in conjunction with their audited bodies, agree to undertake local work in this area.

90. As part of their statutory responsibilities, the Auditor General and the Accounts Commission may procure, through Audit Scotland, examinations of the use of resources by audited bodies and publish reports or guidance. Auditors may be requested from time to time to participate in:
   • a performance audit which may result in the publication of a national report
   • an examination of the implications of a particular topic or performance audit for an audited body at local level
   • a review of a body’s response to national recommendations.

91. Auditors may also consider the use of resources in services or functions, where the need for this is identified through local audit risk assessments. Audit Scotland has prepared a series of Best Value toolkits to facilitate its reviews in these areas.

92. During the course of their audit appointment auditors should also consider and report on progress made by audited bodies in implementing the recommendations arising from reviews in earlier years.

93. This section includes a commentary on the Best Value / performance management arrangements within NHS Lothian. We also note any headline performance outcomes / measures used by NHS Lothian and comment on any relevant national reports and the Board’s response to these.

Management arrangements

Best Value

94. In March 2011, the Scottish Government issued new guidance for accountable officers on Best Value in Public Services. The guidance, in essence, required public bodies to take a systematic approach to self-evaluation and continuous improvement.

95. The guidance identifies the themes which an organisation needs to focus on in order to deliver the duty of Best Value, but notes that implementation should be appropriate and proportionate to the priorities, operating environment, scale and nature of the body’s business.
NHS Lothian is committed to the principles of Best Value and continuous improvement, and produces an annual Best Value assurance report. The Lean in Lothian Programme involves and engages front line staff in identifying waste within their current working processes and agreeing and implementing service improvements. The programme is now in its sixth year in delivering process redesign and increasing productivity, most recently in areas such as elderly care and rehabilitation, dementia care, stroke medicine and orthopaedics hip fracture treatment times. These and other initiatives support the Board's ongoing actions to deliver increasingly challenging savings targets.

We will continue to monitor the Board's arrangements for demonstrating its commitment to Best Value and continuous improvement.

Service redesign

NHS bodies need to deliver high quality services in a challenging financial environment which requires them to focus on the design and sustainability of services. A crucial part of this process is the Board's local reinvestment plan (LRP) where significant service redesign is critical to achieving financial balance and future savings.

NHS Lothian continues its commitment to developing a sustainable health service through its Improving Care, Investing in Change (ICIC) programme. There is regular tracking of ICIC projects and reporting of progress to the Service Redesign Committee. The programme includes significant capital investment such as the Royal Hospital for Sick Children and the Department of Clinical Neurosciences.

In line with the rest of Scotland the ageing population will lead to a change in the type of demand for services. Demographic forecasts for the Lothians predict a 53% rise in the elderly population between 2009 and 2028, which will impact on the demand for community based services which are already nearing capacity. ‘Our Health, Our Future NHS Lothian Clinical Strategy 2012-2020' will be fundamental as to how NHS Lothian and its partners continue to deliver services over the next 5 to 10 years with an emphasis on quality and value.

The strategy identifies how NHS Lothian plans to deliver safer, more effective and person-centred health and healthcare for the people of Lothian. This strategic framework will concentrate on the core business functions of the organisation underpinned by the three main drivers; finance, demography and the medical workforce.

The impact of all service developments are to be closely monitored by the Board to ensure that they continue to contribute to improving the patient experience whilst delivering Best Value.

Performance management

Current delivery and performance management arrangements for the NHS are based on Local Delivery Plans (LDPs), which are structured around a hierarchy of four key ministerial objectives: health improvement, efficiency, access, and treatment (HEAT) and a range of supporting measures. NHS Boards are required to produce LDPs which state their planned...
levels of performance against each of the key performance measures. These are agreed with the SGHSCD and form the basis for performance monitoring.

104. The HEAT performance management system is updated on a monthly basis with the latest performance information at both national and Board level. This is available on NHSNet and allows both the SGHSCD and the Boards to monitor performance against the key targets on an ongoing basis. Boards’ performance against these targets is a key component of the Annual Reviews with the Cabinet Secretary for Health and Wellbeing and Cities Strategy.

105. Overall NHS Lothian has the main elements of a sound performance management framework, including:

- A consistent approach to monitoring performance across the organisation.
- Bi-monthly reporting to the Finance and Performance Review Committee.
- Monthly reports to the Board on waiting times and access targets.
- Performance is linked into individual performance appraisal of directors and senior managers.

However, this framework did not operate effectively in 2011/12 in relation to reporting of performance on waiting times. This raises questions and wider concerns about the accurate reporting of performance information. The Board should take steps to confirm the robustness of performance reporting and re-establish confidence in the system.

Risk Area 5

People Management

106. As with other health Boards in Scotland, NHS Lothian faces a challenge in achieving the new 3.5% sickness absence target set for all Scottish Health Boards. The average sickness absence rate over the year to 31 March 2012 was 3.96% (2010/11 4.47%). The absence rate reduction equates to 86 whole time equivalent staff worth approximately £3.4m. The Board has implemented a range of approaches in order to reduce absence levels further.

Risk Area 7

107. It is important for NHS Lothian to have effective workforce planning arrangements in place in order to secure best value and meet challenging performance targets. Workforce efficiency reports are presented to the Finance & Performance Review Committee on a regular basis and the Board continues to develop its planning arrangements, to help ensure workforce plans are properly aligned to service and financial plans. The Board acknowledges this as a risk area and work is ongoing to deliver an affordable workforce plan in line with the financial savings plan and LDP.

The Role of Boards – follow-up audit

108. The Role of Boards – A follow-up audit was carried out by local auditors in 2011/12 to assess the progress that NHS Lothian has made to improve the performance and operation of its
Best Value, use of resources and performance

Board against the recommendations made in Audit Scotland’s national performance report ‘The Role of Boards’ (September 2010).

109. In carrying out the study we used a checklist based on the key issues identified in the national report. Our final report will be issued to the Audit Committee in due course. Our findings indicate that NHS Lothian faces a number of challenges, both as a result of local and national issues. The Board recognise that maintaining an effective governance framework is essential to help face these challenges and to ensure that the best outcomes are delivered for all stakeholders.

Using locum doctors in hospitals – follow-up audit

110. Using Locum Doctors in Hospitals – A follow-up audit was carried out by local auditors in 2011/12 to assess the progress made by NHS Lothian against the recommendations made in Audit Scotland’s national report 'Using Locum Doctors in Hospitals' (June 2010). This follow-up report assesses the extent to which the Board is using locum doctors more efficiently, effectively and safely.

111. In carrying out the study we used a checklist based on the key issues identified in the national report. Our final report will be issued to the Audit Committee in due course. We found that good progress has been made by NHS Lothian in applying the recommendations identified in the report. However, the Board faces a challenge in achieving compliance with its own authorisation procedures and the system developed to collect and record performance information is not yet fully operational.

Overview of performance targets in 2011/12

112. The Finance & Performance Review Committee receives regular performance reports on progress towards achieving the key performance targets set by the Scottish Government (HEAT targets and standards) and local targets. Overall, the Board's reported performance has been mixed. Of the 33 standards and targets that are monitored by NHS Lothian, 15 are being or are met, 4 are currently behind the set milestones with standards yet to be applied, whilst 10 standards have not been achieved or are falling below milestones. 4 targets have yet to have performance milestones set up towards the 2016 targets.

113. The Board demonstrated good performance against a number of challenging HEAT targets by the end of March 2012 including the alcohol brief interventions, cardiovascular health checks targets and wait for cardiac interventions, Healthcare Associated Infection (CDIF) episodes in patients over 65 and dementia. However some important targets, including 18 week referral to treatment, new outpatients, 4-hour emergency, hip surgery, delayed discharges over six weeks were not achieved. In addition, the SGHSCD's new standard that 90% of patients will wait no longer than 18 weeks from referral to treatment was one of the key targets that was missed - NHS Lothian achieved 86.5%.

114. The Board is taking steps to expedite treatment of those recorded as breaching, or about to breach, waiting times guarantees. Capacity has been sourced elsewhere in Scotland, such as NHS Borders. Cases have also been sent to Spire Murrayfield and various other private sector
providers. The forecast of the private sector provision cost for the first quarter of 2012/13 is approximately £9 million.

115. In terms of Healthcare Associated Infection (HAI), the standards require Boards to reduce HAIs so that by March 2013: staphylococcus aureus bacteraemia (SAB) cases are 0.26 or less per 1,000 acute occupied bed days, (no more than an average of 17 episodes per month for the 12 month period); and the rate of Clostridium difficile infections (C diff) in patients 65 and over is 0.39 cases or less per total occupied bed days, (no more that an average of 27 episodes per month for the 12 month period). These episode numbers have fluctuated throughout 2011/12 with March 2012 figures reported as being 22 episodes of SAB and 14 of C diff. These standards continue to be a challenge to achieve.

National performance reports

116. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland. The findings and key messages of these studies are published in national reports.

117. All Audit Scotland reports are considered for their applicability to NHS Lothian by the Corporate Governance team. Those national reports which are considered to be of specific interest to NHS Lothian are considered in detail by officers, with action to be taken discussed at the Board’s Operational Audit Sub-Committee (OASC). Relevant senior managers are invited to attend to outline the impact of the findings and the Board’s response and progress in addressing recommendations locally. In respect of other national reports which have been considered to be non-applicable or more over-arching in nature, a record of decisions taken by officers following review are then presented to the OASC for approval. NHS Lothian has a robust system for reviewing Audit Scotland's national reports and implementing improvement actions, as appropriate.

118. Reports in the last year that may be of relevance to the Board include:

Table 2: A selection of National performance reports 2011/12

<table>
<thead>
<tr>
<th>Report</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport for Health and Social Care</td>
<td>Aug 2011</td>
</tr>
<tr>
<td>Scotland’s Public Finances – Addressing the Challenges</td>
<td>Aug 2011</td>
</tr>
<tr>
<td>A Review of Telehealth in Scotland</td>
<td>Oct 2011</td>
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<tr>
<td>Overview of the NHS in Scotland’s performance 2010/11 (Dec 2011)</td>
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<tr>
<td>Cardiology services (Feb 2012)</td>
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<td>Commissioning social care (Mar 2012)</td>
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Outlook

Performance

119. Over recent years the Board has invested substantial resources in order to achieve challenging performance targets set by the Scottish Government. The significant financial challenges that will be faced in 2012/13 and beyond may require the Board to prioritise its resources further. This will make maintaining or improving performance even more challenging, including achieving waiting times targets.

120. Questions have been raised in 2011/12 on the reliability of the Board's performance management and performance reporting arrangements. A priority in 2012/13 is to confirm the robustness and re-establish trust in the system.
## Appendix A: audit reports

External audit reports and audit opinions issued for 2011/12

<table>
<thead>
<tr>
<th>Title of report or opinion</th>
<th>Date of issue</th>
<th>Date presented to Audit Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Audit Reliance Letter</td>
<td>27 March 2012</td>
<td>5 April 2012</td>
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<tr>
<td>Annual Audit Plan</td>
<td>27 March 2012</td>
<td>5 April 2012</td>
</tr>
<tr>
<td>Internal Controls Management Letter</td>
<td>19 June 2012</td>
<td>26 June 2012</td>
</tr>
<tr>
<td>Computer Services Review</td>
<td>31 May 2012</td>
<td>26 June 2012</td>
</tr>
<tr>
<td>Report to Audit Committee in terms of ISA 260</td>
<td>20 June 2012</td>
<td>26 June 2012</td>
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<tr>
<td>Independent auditor’s report on the financial statements</td>
<td>20 June 2012</td>
<td>26 June 2012</td>
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<tr>
<td>The Role of Boards - Follow-up audit</td>
<td>TBC</td>
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<td>Locum Doctors - Follow-up audit</td>
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<td>Best Value toolkits - Follow up audit</td>
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</table>
## Appendix B: action plan

### Key Risk Areas and Planned Management Action

<table>
<thead>
<tr>
<th>Action Point</th>
<th>Refer Para No</th>
<th>Risk Identified</th>
<th>Planned Management Action</th>
<th>Responsible Officer</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22</td>
<td>NHS Lothian as with other Boards has not been able to quantify the extent of its liability for Equal Pay claims. There is a risk that these liabilities could have a significant impact on the Board’s financial position.</td>
<td>The Board’s HR function continues to work with NSS’ Central Legal Office in managing this risk. Any potential liability, subsequently identifiable, will be initially classified as Annually Managed Expenditure, and any subsequent effect on the Board's Revenue resource limit will be discussed on a national basis with SGHSCD.</td>
<td>Director of HR and OD</td>
<td>Ongoing</td>
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<td>2</td>
<td>25</td>
<td>The lack of a fully documented and clear audit trail for urgent expenditure made it difficult to conclude that one urgent payment fully complied with NHS Lothian’s Standing Financial Instructions (Annex 4, Section 29). There is a risk that urgent expenditure does not comply with SFI’s.</td>
<td>Section 29 of Annex 4 to the Scheme of Delegation within the Board's SFIs provides for specific authority to the Director of Finance for any departure from the requirements of Market testing and Tendering in special urgent circumstances.</td>
<td>Director of Finance</td>
<td>Immediate</td>
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<tr>
<td>Action Point</td>
<td>Refer Para No</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
<td>Target Date</td>
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<td>3</td>
<td>38</td>
<td>Progress on the development of the re-provision of the RHSC and DCN facilities at Little France has been delayed and completion is not now expected until 2017. This is due to Consort Healthcare’s inability to secure all 11 funders' approval to the proposed facilitating works. There is a risk that the project is delayed beyond 2017, with a consequential impact on levels of care.</td>
<td>Progress on the RHSC/DCN re-provision forms a regular part of the agenda of the Board's Finance and Performance Review committee. The Board meets with Consort regularly in order to progress PFI contract related issues. The funding difficulty is entirely the responsibility of Consort to resolve, with our support.</td>
<td>Director of Finance</td>
<td>Sept 2012.</td>
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<tr>
<td>4</td>
<td>46-48</td>
<td>The delivery of the cost savings plan in 2012/13 will be more challenging because of the release of cost savings in previous years and the current severe financial pressures. It is therefore important that the board continues to closely monitor costs in order to take any required remedial action through supplementary cost saving schemes. The longer term financial plan remains at risk of not being affordable due to the wide range of financial challenges and pressures being faced by the board.</td>
<td>The Board's formal quarterly and mid-year financial forecasting review process is the key element of the risk management approach to this challenge. The Board has established an Efficiency and Productivity group which reviews savings proposals and progress with agreed savings schemes and workstreams. Progress and recommended actions are reported regularly to the Corporate Management Team and Director of Finance</td>
<td>Ongoing</td>
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<td>Action Point</td>
<td>Refer Para No</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
<td>Target Date</td>
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<td></td>
<td></td>
<td>or that savings targets may not be achieved.</td>
<td>the Finance and Performance Review committee of the Board.</td>
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<td>5</td>
<td>56/105</td>
<td>HEAT Target reporting arrangements in respect to Waiting Times was unsatisfactory. As a result the board has amended its recording practices. There is a risk that other Heat targets may be incorrectly reported and the Board should take appropriate steps to confirm the robustness of their performance reporting.</td>
<td>Following the Chairman-commissioned report to the Board on its information requirements, arrangements are being made to underpin the reliability of data reported on Waiting Times and other operational performance targets' delivery. This is being monitored through the Steering Group set up by the Board to address issues arising from the mis-reporting of Waiting Times (see also 6. below).</td>
<td>Medical Director</td>
<td>March 2013</td>
</tr>
<tr>
<td>6</td>
<td>57/60</td>
<td>A review was undertaken by the Board of the root causes of senior management cultural issues which prevented full disclosure of waiting times problems from properly progressing through the governance framework of the Board. There is a risk that the problems identified may recur if the Board does not implement fully the recommendations from both the 'Waiting Times' report and the information review in partnership with trades union representatives. A Steering Group, which also includes non-executive Board members, is overseeing progress of implementing the</td>
<td>Under the leadership of the Interim Chief Executive, the Board is taking forward the recommendations from the Waiting Times report and the information review in partnership with trades union representatives.</td>
<td>Interim Chief Executive</td>
<td>March 2013</td>
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<tr>
<td>Action Point</td>
<td>Refer Para No</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
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<td>report and the 'Review of Scope of Information' report.</td>
<td>recommendations and will report to the Board through its Staff Governance committee. Following its first meeting the Board has established a number of priority improvement actions and made some enabling organisational changes at senior management level.</td>
<td></td>
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<tr>
<td>7</td>
<td>106</td>
<td>NHS Lothian faces a challenge in achieving the new 3.5% sickness absence target set for all Scottish Health Boards.</td>
<td>Key workforce metrics (including absence) are reported regularly to Corporate Management Team and Finance and Performance committee meetings of the Board. Specific actions on variance on trajectory towards targets are agreed at such meetings and implemented in partnership with staff representatives.</td>
<td>Director of HR/OD</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
COMMUNICATIONS RECEIVED

1 Purpose of the Report

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Government:

<table>
<thead>
<tr>
<th>No</th>
<th>No reference number</th>
<th>Title</th>
<th>Date</th>
<th>Reference</th>
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<tr>
<td>1</td>
<td>No reference number</td>
<td>Recruitment to Salaried General Dental Practitioners Posts</td>
<td>01/08/2012</td>
<td>DPH</td>
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<tr>
<td>2</td>
<td>CEL 28(2012)</td>
<td>Review of NHSScotland Pin Policies</td>
<td>01/08/2012</td>
<td>D of HR &amp; OD</td>
</tr>
<tr>
<td>3</td>
<td>CEL 29(2012)</td>
<td>Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy</td>
<td>01/08/2012</td>
<td>MD, ND D of SP &amp; PC</td>
</tr>
<tr>
<td>4</td>
<td>SGHD/CMO(2012)8</td>
<td>Guidance on Legal Issues Relevant to Donation Following Cardiac Death</td>
<td>03/08/2012</td>
<td>MD</td>
</tr>
<tr>
<td>5</td>
<td>CEL 31 (2012)</td>
<td>Medical Revalidation: Annual Appraisal Documentation</td>
<td>03/08/2012</td>
<td>03/08/2012</td>
</tr>
<tr>
<td>6</td>
<td>PCA(P)(2012)12</td>
<td>Community Pharmacy Contract: Infrastructure Support – Staff Training</td>
<td>18/07/2012</td>
<td>D of SP and PC, GM PC Contracts</td>
</tr>
<tr>
<td>7</td>
<td>SGHD/CMO(2012)7</td>
<td>Disposal of Pregnancy Losses up to and including 23 Weeks and 6 Days Gestation.</td>
<td>18/07/2012</td>
<td>MD, ND</td>
</tr>
<tr>
<td>8</td>
<td>PCA(O)(2012)4</td>
<td>General Ophthalmic Services 1. Increase in the Continuing Education and Training Allowance. 2. Increase in the Pre-registration Supervisors Grant. 3. Revised Statement</td>
<td>9/08/2012</td>
<td>D of SP &amp; PC, GM PC Contracts</td>
</tr>
<tr>
<td>9</td>
<td>CEL 33 (2012)</td>
<td>Delivering Waiting Times</td>
<td>8/08/2012</td>
<td>MD D of SP &amp; PC</td>
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<tr>
<td></td>
<td>Document ID</td>
<td>Description</td>
<td>Date</td>
<td>Responsible Body</td>
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<td>Community pharmacy services: Drugs tariff remuneration arrangements</td>
<td>29/8/2012</td>
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<td>community migration shadow fees, payment supplement &amp; CMS capitation</td>
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<td>PCA(P)(2012)016</td>
<td>Pharmaceutical services: Community pharmacy practitioner champions</td>
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<td>SGHD(CDO)(2012)001</td>
<td>IR(ME)R</td>
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<td>SGHD(CMD)(2012)009</td>
<td>Temporary programme of pertussis (whooping cough) vaccination of pregnant</td>
<td>02/01/12</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>PCA(M)(2012)011</td>
<td>Primary medical services (Directed enhanced services) (Scotland) (no.2)</td>
<td>02/10/12</td>
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<td>directions 2012</td>
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**Douglas Weir**  
Corporate Services Manager  
12 October 2012

**AFC** Agenda for Change  
**CEL** Chief Executive Letter (the designation for general circulars)  
**CMO** Chief Medical Officer  
**SAN** Safety Action Notice (a standard priority notice where action can be planned rather than immediate)  
**HAZ** Hazard Notice (a high priority notice where immediate action is required)  
**MDA** Medical Devices Agency  
**PCA** Primary Care Administration (circulars relating to Primary Care staff i.e. P - Pharmacy, D - Dentistry)  
**PCS** Pay & Conditions of Service (circulars relating to the pay and conditions of service of staff)  
**SHS** Scottish Health Service  
**SPPA** Scottish Public Pensions Agency  
**SSI** Scottish Statutory Instrument