NHS LOTHIAN

BOARD MEETING

DATE:       WEDNESDAY 26 SEPTEMBER 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
3.5. Staff Governance Committee - Minutes of the Meeting held on 29 August 2012

3.6. West Lothian Community Health & Care Partnership Sub-Committee - Minutes of the Meeting held on 21 June 2012

3.7. West Lothian Community Health & Care Partnership Board - Minutes of the Meeting held on 29 May 2012

4. Chairman’s Report (10.00am - 10.10am)

5. Performance Management (10.10am - 11.00am)

5.1. Financial Position to 31 August 2012

5.2. Performance Management

5.3. Waiting Times Progress and Performance

5.4. Unscheduled Care

6. Policy & Strategy (11.00am - 11.40am)

6.1. Consultation on Integration of Health & Social Care

6.2. Creativity, Arts, Health & Wellbeing in NHS Lothian

7. Governance (11.40am - 12.20pm)

7.1. Quality Report

7.2. Area Clinical Forum Proposed Constitution

7.3. Healthcare Associated Infection Update

7.4. The Second Joint Health Protection Plan

7.5. Report from the Organ Donation Committee 2011/12

7.6. Unannounced Inspection of the Care of Older People in RIE

8. Other Items (12:20pm - 12:30pm)

8.1. Committee Chairs and Membership

8.2. Schedule of Board and Committee Meetings

8.3. South East and Tayside Regional Planning Group Update

8.4. List of Communications Received

9. Date, Time and Venue of Next Meeting: Wednesday 24 October 2012 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

   LUNCH 12:30 p.m.

Dates of Meetings in 2012:

28 November 2012
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 25 July 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Executive Directors: Mr T Davison (Interim Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Dr D Farquharson (Medical Director); Mrs M Hornett (Nurse Director); Dr A K McCallum (Director of Public Health and Health Policy); Mrs C Potter (Associate Director of Finance – Deputing for the Director of Finance) and Professor A McMahon (Director of Strategic Planning and Primary Care).

Non-Executive Directors: Dr C J Winstanley (Chair); Mrs S Allan; Dr M Bryce; Mr E Egan (Vice-Chair); Councillor R Henderson; Councillor C Johnstone; Mrs J McDowell; Professor P Murray; Councillor F Toner; Mr G Walker; Mr I Whyte and Dr R Williams.

In Attendance: Dr D Chandler (Shadowing Dr McCallum); Mr A Jackson (For Item 43); Mr D Small (General Manager, East and Midlothian Community Health Partnership); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications).

Apologies for absence were received from Mr J Forrest, Mrs S Goldsmith, Councillor D Grant, Professor J Iredale, Mr P Johnston and Mr B Peacock.

Declaration of Financial and Non-Financial Interest

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

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

35.1 The Chair welcomed members of the public and press to the meeting. Dr Daniel Chandler, Acting Consultant in Public Health Medicine, who was shadowing Dr A McCallum was also welcomed, as were a number of international students from the School of Nursing and Midwifery and Social Care at Edinburgh Napier University. The Board noted that Mr Andrew Jackson (Associate Director of Strategic Planning) would be attending to assist with the presentation around the waiting times recovery paper.

35.2 The Chair advised there would be a requirement for a brief Private session of the Board to agree a technical paper on the Royal Hospital for Sick Children/Department of Clinical Neurosciences. The requirement arose from the need to discuss items of commercial confidentiality not appropriate at a meeting in public.
36. **Valedictory Remarks – Professor Pat Murray**

36.1 The Chair reported that Professor Murray had indicated that she was stepping down as Chair of the Area Clinical Forum after two terms in office. He advised this would be her last Board meeting, with her successor being advised in due course. The Chair, on behalf of the Board, thanked Professor Murray for her considerable professional and personal input and for the positive work she had taken forward on behalf of the Board through her chairmanship of the Healthcare Governance and Risk Management Committee.

37. **Minutes of the Previous Meeting of Lothian NHS Board held on 27 June 2012**

37.1 The Minutes were approved as a correct record.

38. **Matters Arising**

38.1 **Proposal to Reduce Paediatric Inpatient Activity at St John’s Hospital during July 2012** – Councillor Toner sought an update on the future long-term plans for the paediatric service at St John’s Hospital, as well as the outcome of the recent interview process. Dr Farquharson commented following a successful interview process, a total of six joint consultant posts between the Royal Hospital for Sick Children and St John’s had been appointed with a further possibility of a locum appointment. He advised as a consequence of the temporary inpatient closure between 9 and 23 July 2012, twenty-seven West Lothian patients, who would normally have been admitted to St John’s Hospital had been treated at the Royal Hospital for Sick Children. The Board was advised it was still the intention to open inpatient facilities at St John’s Hospital on 31 July and from August the system would benefit from an additional three trainees being allocated to St John’s.

38.1.2 The Board noted the update report.

38.2 **Royal Hospital for Sick Children/ Department of Clinical Neurosciences Reprovision – Little France** – Mrs Potter advised following ongoing discussions with Consort and the eleven lenders, she was pleased to advise that the final bank had agreed to remove the remaining hurdle to achieving consent for Supplemental Agreement 6, with this position only having been confirmed the previous evening. It was anticipated final sign-off would be achieved by 10 August 2012. She advised further detail around commercial aspects of the Agreement would be discussed at the Private meeting to be held immediately following the conclusion of the formal Board meeting in public.

38.2.1 The Board noted the procurement process for the preferred bidder could commence and the planned completion date for the project remained 2017. The Vice-Chair reminded the Board the provision of soft facilities management and clinical services remained under the control of NHS Lothian.

38.2.2 The Board noted the update report and agreed to consider further detail of a commercial and in confidential nature in Private session later in the day.
39. Committee Minutes

39.1 Finance & Performance Review Committee – Minutes of the meeting held on 6 June 2012 – the Board adopted the Minutes. Mr Walker advised the Committee would now regularly consider whether Business Cases were meeting their trajectory. He commented it had been decided to delay the work on the dashboard performance indicators until the review of the Committee structure had been concluded, in order to avoid a duplication of work streams.

39.1.1 Mr Walker commented following comments made by the Vice-Chair about the Burns Unit temporary transfer, he would arrange for the Finance and Performance Review Committee to revisit this topic at its next meeting.

39.2 Service Redesign Committee – Minutes of the Meeting held on 11 June 2012 – the Board adopted the Minutes.

39.3 East Lothian Community Health Partnership – Minutes of the Meetings held on 23 February and 25 April 2012 – the Board adopted the Minutes.

39.3.1 Dr Williams questioned the position in respect of the signing of the lease for the Musselburgh Primary Care Centre and commented on the need for a standard lease agreement to be produced. Mr Small advised the use of the Hubco funding model in future would, in all likelihood provide standard lease clauses and would mitigate issues experienced previously. Mrs Potter would confirm the Hubco position on standard leases.

40. Chair’s Report to Lothian NHS Board

40.1 The Board noted the Chair’s report focussing on the process for the appointment of a substantive Chief Executive. In addition, progress with the Community Gardens Steering Group was noted.

41. Financial Position to 30 June 2012

41.1 Mrs Potter advised NHS Lothian was reporting an overspend of £1.6m for the first 3 months of the year. This comprised an operational overspend of £1.2m and under-delivery of £0.4m against the efficiency savings target. She advised the outcome of the quarter 1 financial review would be reported to the Board once it had been considered by the Corporate Management Team. She commented from the initial detail of the quarter 1 review that financial break-even would be achieved at the year end. She commented further scrutiny of areas of overspend would determine any underlying issues requiring additional focus.

41.2 Mrs Potter reported ongoing work would identify the core requirement which, in part, would be addressed by additional non-recurrent funding. She advised the main financial risk was the £4.8m residual gap on the savings target and this would be considered in detail by the Efficiency and Productivity Group. It was noted
whilst some non-recurring support would be available, the intention was to deliver the financial position as recurrently as possible.

41.3 The Board was advised that previous issues raised around backlog maintenance were being looked at as part of the quarter 1 financial review process linking with the capital programme. The Interim Chief Executive commented the backlog maintenance requirements went beyond NHS Lothian’s immediate resources and would need to be subject to a risk assessment. He reminded the Board Treasury capital was significantly reduced and there would be real challenges on how to balance the spending of resources. The Interim Chief Executive commented whilst NHS Lothian would continue to receive its fair share of national resources, there was no expectation that there would be additional or new capital made available. He commented because of the tough challenges that lay ahead, it would be important to establish an appropriate prioritisation process.

41.4 The Vice-Chair commented capital and backlog maintenance issues, in particular, were a Scotland and UK-wide problem. He was concerned about the number of beds still open which were meant to be closed and the frustration this was causing clinical staff. He felt a different approach needed to be adopted in respect of communicating the financial position to staff, some of whom were perplexed with the requirement for them to make savings, whilst a substantial amount of money had been identified from within the system to address issues around waiting times.

41.5 The Board noted the financial position to 30 June 2012.

42. Performance Management

42.1 Professor McMahon referred the Board to the revised performance report commenting moving forward it would include a range of other measurables like IVF, scoliosis and the 18 week referral to treatment time by speciality and availability slots, which would allow the Board the opportunity for further scrutiny. He commented this would be aligned to the work underway to develop performance dashboards, which would help to highlight performance on an exception basis.

42.2 Professor McMahon provided the Board with an overview of performance against key targets, guarantees and milestones on an exception basis with a particular focus on accident and emergency attendances and delayed discharges, both of which were recognised as areas requiring further local focus.

42.3 Mr Walker welcomed the establishment of the Unscheduled Care Group and questioned whether consideration would be given to looking at the surgical assessment unit as a means of relieving pressure within the system. Mrs Hornett commented the Group had met twice and the next meeting would start to consider some key plans, which would be shared with the Board. She advised patient safety and experience would be key issues in future with the intention being to look at the total patient pathway, including primary care and community and links with elective work. She advised further details of the efficacy of the surgical observation unit would be reported.
42.4 The Interim Chief Executive reminded the Board the three key challenges facing it were around unscheduled care, elective waiting times and the financial position, all of which were inter-dependent. He commented three cross-populated groups had been established to look at the individual workstreams, as the problem was too large to be resolved by a single group. The Interim Chief Executive commented current hospital and other sites were not adequately connected and the current practice was to manage interfaces rather than the total patient journey. He stressed the key challenge was around unscheduled care, as this was a particularly complex area and would require the bringing together of all the key components of the organisation, as well as increased engagement with General Practitioners, which would follow on from the recent successful workshop session.

42.5 The Interim Chief Executive reported following a recent organisational review, Dr Farquharson would be responsible for waiting times, Mrs Hornett for unscheduled care and Mrs Goldsmith for organisational financial efficiency. He commented the timescale around resolving unscheduled care issues was longer in gestation because this would require fundamental service redesign. He commented a report would be brought back to the Board once thoughts had crystallised.

42.6 The Vice-Chair commented once the substantive Chief Executive had been appointed, it would be necessary for there to be a step change in progress in delayed discharges, as it was not possible to provide services to patients without adequate resources. He felt there was merit in looking at the longest stays on a targetted basis. Professor McMahon advised work was already underway in this regard and long waiting patients, as well as those waiting less than 6 weeks would be shown as a percentage in future iterations of the Board paper. Mrs Hornett commented work was already underway to look at patients with a length of stay greater than 28 days. The Interim Chief Executive reminded the Board new national targets would require improved focus in this important area.

42.7 Mrs McDowell noted the delayed discharge process was distressing for patients and often felt open-ended, particular in hospital or temporary care facilities and there was a need to think about a schedule of reasonable expectations. Professor McMahon advised conversations around these issues should be held with patients as near the point of admission as possible and within the context of the “Moving On” policy, which, he conceded, still needed to be applied consistently. Mrs Hornett advised this issue would also be addressed as part of ongoing work under unscheduled care.

42.8 The Chair commented the Board would be seeking evidence that a system of coherent communications were in place for patients and their families.

42.9 The Board noted and welcomed the format of the new performance report.

43. Waiting Times Progress and Performance

43.1 Dr Farquharson advised Mr Andrew Jackson, Associate Director of Planning would provide, at the appropriate point, a presentation describing how Medinet would assist with the waiting times backlog using the “see and treat” model.
Dr Farquharson reported the circulated paper demonstrated a turn around in the inpatient waiting times position, with patients receiving treatment, albeit not as quickly as would have been desired as a consequence of the summer holiday period. He advised whilst plans were in place to address the inpatient position there was a need for more focus on outpatients. He reminded the Board there would be an 18 week treatment guarantee for patients introduced with effect from 1 October 2012.

The Board noted that the Corporate Management Team and the Waiting Times Group chaired by the Interim Chief Executive were striving to make best use of existing capacity both internal to the NHS and external private resources like Medinet. Dr Farquharson reported all patients would have a treatment date by the end of August.

The Board noted the over-12 week outpatient position continued to worsen with the intention being to utilise Medinet and the “see and treat” model to start to ameliorate this position. Dr Farquharson confirmed proper verification procedures had been put in place prior to Medinet engagement to ensure patient treatment and safety issues were adequately addressed. He further commented Lothian consultant staff would work in parallel with Medinet colleagues and this would ensure appropriate advice was available if required. Dr Farquharson advised General Practitioners would be informed in due course about the “see and treat” model. Dr Williams commented a common theme from the recent GP workshop event had been a desire for as much information to be provided as early as possible on all topics.

The Interim Chief Executive commented the paper before the Board focussed on the waiting times backlog and not new patients. He reminded the Board the focus was to get the inpatient position down to zero, although because of capacity issues the outpatient position continued to worsen. He reported NHS Lothian had been working with the Scottish Government Health Directorates QuEST (Quality and Efficiency Support Group) team to develop capacity plans. The Interim Chief Executive reminded the Board he had previously highlighted the need to invest in additional capacity, although he stressed this would take time, particularly in terms of recruiting scarce medical resources which, in some instances, could take up to 6 months to complete. He advised, therefore, for the foreseeable future, it would be necessary to continue to use Medinet and the private sector, although this would abate once internal capacity increased.

Dr Farquharson reported through the work with QuEST specific capacity issues had been identified, particularly in respect of theatre nurses, anaesthetics and some surgical specialties with a further report on investment proposals being brought to the Board, although, in advance, some upfront investment might be required in particular to support the recruitment process.

Mr Jackson provided the Board with a presentation covering inpatient, day cases and outpatients, as well as a breakdown on the waiting times position by specialty, advising the “see and treat” model, previously referred to was the key to resolving the current position. In response to Dr Williams, he advised discussions had been
held with Medinet about responsibilities and compliance with Lothian pathways, including continuing care.

43.8 Mrs Allan commented it would be important to understand on a speciality-by-specialty basis why backlogs had occurred in the first instance, as well as identifying the capacity needed to address the position in the longer term linking with consideration of the financial consequences. She suggested the current high demand areas would continue into the future and this would need to be addressed in the capacity planning process. The Board was advised whilst the problem was predominantly one of capacity, this was not exclusively the case and the Interim Chief Executive reminded the Board, in some instances, it could take up to 6 months to have senior clinical appointments in post.

43.9 The Interim Chief Executive advised NHS Lothian’s capacity was not sufficient to sustain a standstill position far less to deal with increasing service demand. He commented as a consequence of demographic changes and multiple conditions associated with age, there had been significant increases in demand for plastic surgery, breast surgery and cancer services, amongst others. In order to start to address this position, additional investments had already been made in theatre teams, anaesthetics and nursing posts. He advised it was necessary to triangulate four or five different streams of recruitment to reach a co-ordinated position to create additional capacity and that the availability of extra theatre time was dependent upon all different aspects of the process coming together.

43.10 Mr Walker commented whilst he welcomed the clarity contained in the paper, he would welcome the inclusion of data on capacity and activity plans and evidence of when the first benefits of these would be seen. The Interim Chief Executive advised capacity plans were available and had been discussed earlier in the week although, at the moment, further work was needed to ensure these all linked appropriately as this was currently not the case. He suggested over the course of the next three to four Board meetings the position would begin to crystallise, although the Corporate Management Team would need to be in a position to move quickly in areas where it was obvious only one course of action to improve the position was available. He commented realistically the timescale for getting all necessary medical staff posts in place would be between two and three years and, in the meantime, there would continue to be reliance on using private and external capacity. The Interim Chief Executive advised further discussions around these complex issues would be held at the development session to be held immediately after the Board meeting and which would be attended by the Postgraduate Medical Dean.

43.11 Dr Bryce questioned the extent to which the Board had factored in the impact of the ageing workforce as part of the workforce planning exercise. Mr Boyter undertook to take a paper to the Staff Governance Committee showing what the position was in relation to the age of the workforce along with an analysis of any issues associated with an ageing workforce, together with actions being taken or planned.

43.12 The Board welcomed the update report on the waiting times position and noted the positive progress being made.
44. Mental Health Strategy

44.1 Professor McMahon provided the Board with a verbal progress update on the Mental Health Strategy, which was now in year 2 of delivery. He advised good performance continued to be made against HEAT (Health, Efficiency, Access and Treatment) targets. Professor McMahon provided update reports on progress around the reprovisioning of the Royal Edinburgh Hospital, ongoing work around prison healthcare and advocacy services including prisoners and gypsy travellers.

44.2 Professor McMahon undertook to provide a written further update to the September Board meeting.

44.3 The Vice-Chair questioned what steps were in place to keep people in their own homes through the utilisation of outreach teams and whether a single Lothian solution was being pursued to address current inconsistencies, as well as considering the relationship with other services citing as a good example the relationship with Veteran’s First in respect of ex-service personnel. Professor McMahon confirmed good relations existing with other service providers, particularly in respect of the desire to provide community support, although he acknowledged further ongoing work was necessary in some areas like the need to repatriate some forensic service patients. In particular, Professor McMahon updated the Board on work in progress with Veteran’s First with a view to extending the care support model for families of veterans in liaison with local authorities.

45. Sexual Health Strategy

45.1 Professor McMahon provided the Board with an update on progress with the Sexual Health Strategy, which had been approved by the Board last year. He commented positive progress had been made and the Chalmers facility was now open and functioning well. He advised work was underway to provide in-reach services into communities to provide support in areas of deprivation.

45.2 Professor McMahon reported the Health Improvement Scotland report had identified some areas of further improvement and these were being progressed with outcomes being reported to the September Board meeting. Dr McCallum commented she had also been in discussions with the Scottish Government Health Directorates and had provided re-assurances the system would now be back on track to meet the required increase in provision of long acting contraception.

45.3 The Board agreed to receive an update report in September.

46. Quality Report

46.1 Dr Farquharson presented the Board with a report setting out Lothian’s core quality measures of safe and person-centred care, and effective measures for child and maternal health. He advised the report also included details on the recent Healthcare Improvement Scotland (HIS) review on the management of significant adverse events in NHS Ayrshire and Arran. He reported in the next Board report, it
was intended to incorporate the “hospital scorecard” measures, which were due to be released by the Scottish Government Health Directorates and this would have some overlap with the current Quality report core measures.

46.2 Dr Farquharson commented in respect of the HIS review and the management of significant adverse events in NHS Ayrshire and Arran, his report summarised the key findings from the report and confirmed actions were in place within Lothian to address these. He reminded the Board Lothian’s risk management arrangements had been reviewed the previous year and largely addressed the issues raised in the HIS report.

46.3 Dr Bryce advised she was pleased to note the response around fast feedback on pain as she felt a number of people still had unacceptable pathways, particularly for day cases patients. Mrs Hornett advised an update report would be provided to the Healthcare Governance and Risk Management Committee to provide assurance progress was being made in this area.

46.4 Dr Williams felt some of the performance against HEAT targets was open to challenge, reminding the Board some of these were stretch targets and, whilst often the national target was met, the stretch target was not always achieved and this caused a degree of frustration in the way it was reported. He felt the system was devoting time and resource to meeting stretch targets when this would be better utilised elsewhere. The Chair commented whilst he agreed with Dr Williams, he felt there was a need in some instances to aspire to performance beyond that required to meet HEAT targets. Dr Farquharson agreed commenting the HEAT target was the basic target and advised the channelling of additional resource beyond that level needed to be considered on an individual basis.

46.5 The Interim Chief Executive agreed there were areas where targets could be set to exceed the minimum but felt the key issue should be to ensure all routine issues such as waiting times were being addressed properly in the first instance.

46.6 The Board received and noted the Quality report.

47. **NHS Lothian’s Quality Improvement Strategy 2011-2014**

47.1 The Board received the annual report on the implementation of the NHS Lothian Quality Improvement Strategy.

48. **The Role of the Board in Quality and Safety NHS Lothian Action Plan**

48.1 Mrs Hornett advised the first Boards-on-Boards two day event had been held in January 2011 with over one hundred Executive and Non-Executive Board members attending. A follow-up event had been held in February 2012 to share experiences and to set new development goals. She advised this event, which had been delivered in collaboration with the Scottish Patient Safety Programme (SPSP), NHS Education for Scotland, the Institute for Healthcare Improvement (IHI) and other NHS Scotland partner Board teams had been asked to develop
action plans detailing how they planned to take forward the quality and safety agenda.

48.2 Mrs Hornett advised appendix 1 of the circulated paper populated NHS Lothian’s current position and proposed plans for review, discussion and identification of additional areas for ongoing development.

48.3 The Chair advised he was seeking strong Lothian representation at the next whole country learning session, which would be held in Glasgow on the 8 and 9 November. Mr Weir would canvas Board member availability to attend this event and advise Mrs Hornett accordingly. The Interim Chief Executive suggested six attendees would be a minimum requirement. The Chair commented thereafter there would be a need to develop a mechanism to represent the outcomes of the event within the strategy agenda of the organisation.

48.4 The Interim Chief Executive reported Boards would be asked to provide details of specific actions taken to make improvements since the previous event. He commented in many areas of Lothian, the quality of care provided was excellent although the challenge was that, as always, there was room for improvement in other areas. He advised it was important the work continued to feature on the Board’s agenda.

48.5 The Chair advised the new Chair of the Healthcare Governance and Risk Management Committee, once appointed, would be a key person in drawing together the benefits derived from these national events and linking this with NHS Lothian’s own internal work. The Vice-Chair commented presently there was a complete divorce between patient and other health and safety aspects and this was at times resulting in a loss of opportunities. He felt there would be a need for the new Chair of the Healthcare Governance and Risk Management Committee to have preliminary discussions with the Medical Director, Nurse Director and the Director of Human Resources and Organisational Development in this regard. The Interim Chief Executive commented if there were single opportunities to consider safety issues then these should be utilised.

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

49. Healthcare Associated Infection Update

49.1 Dr McCallum provided the Board with an update on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian advising this was part of her regular report to the Board. The Board noted NHS Lothian remained on trajectory to meet its targets.

49.2 The Board was advised by Dr McCallum that there had been a rise in reported Clostridium difficile infection in June distributed across the organisation. Only one ward had two cases in the month with there currently being no evidence these were linked. Dr McCallum stressed all episodes of Clostridium difficile infection were investigated, although the outcome of the process around the current rise in reported cases was not yet complete. Dr McCallum commented norovirus remained an issue and appropriate staff groups were working to manage the
impact of these outbreaks. Dr McCallum reported hand hygiene compliance generally remained good and there had been an improvement in compliance with antimicrobial management.

49.3 Dr McCallum provided the board with an update in respect of the recent legionella outbreak advising this phase of the outbreak had officially been classified as being over. She advised, from a public health perspective, she was confident the actions undertaken had been effective. The Board noted a range of complicated tasks were ongoing in order to attempt to establish a causal change. Collaboration continued with the Health and Safety Executive and the police looking at other consequences under the duty of collaboration. Dr McCallum advised the final report of the outbreak would be made available to Parliament, the Board and members of the public.

49.4 The Board noted the positive progress being made in meeting the Healthcare Associated Infection targets.

50. Reference Committee Chair

50.1 The Board agreed the recommendation to appoint Mr Peter Johnston as Chair of the Reference Committee with immediate effect.

51. Communications Received

51.1 The Board received the list of communications from the Scottish Government Health Directorates.

52. Date and Time of Next Meeting

52.1 The next meeting of Lothian NHS Board would be held on Wednesday, 26 September 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

53. Suspension of Standing Order 16b

53.1 The Chair sought permission to invoke Standing Order 16b to allow a meeting of Lothian NHS Board to be held in private. The Board agreed to invoke Standing Order 16b. The requirement arose from the need to discuss items of commercial confidentiality that would not be appropriate at a meeting in public.
LOTHIAN 2011-2016 SEXUAL HEALTH AND HIV STRATEGY: FIRST YEAR UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on the first year of implementation of the 2011-2016 Sexual Health and HIV strategy.

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

2 Recommendations

The Board is recommended to:

2.1 Acknowledge the successful developments in 2011/12 to implement the Lothian Sexual Health and HIV Strategy.

2.2 Identify support to help meet the challenges to fully implement the strategy.

3 Discussion of Key Issues

3.1 The NHS Lothian Board launched the Lothian 2011-2016 Sexual Health and HIV Strategy in May 2011 following a robust public consultation. The strategy focuses on partnership working to achieve the following outcomes:

- There is reduced harm from sexual ill health and HIV
- People with HIV live long and healthy lives
- There are fewer unintended pregnancies
- People make confident and competent decisions about sex

3.2 The national policy context for this programme area was refreshed in August 2011 with the publication of the Scottish Government’s Sexual Health and BBV Framework. The objectives in the Lothian strategy are fully aligned with the Scottish Government Framework.

3.3 The implementation of the Lothian Sexual Health and HIV Strategy is overseen by the Sexual Health and HIV Strategic Programme Board with senior representation from all relevant pan-Lothian NHS and third sector organisations. Local Authorities are also encouraged to provide strategic representation but this has not been consistent across the four Lothian Local Authorities. The Programme Board is supported by five sub-groups which are topic (Sexual Health and HIV Clinical groups) or population specific (Young People, People from Sub-Saharan Africa, Men who have sex with men (MSM)). There are also local sexual health groups within each Local Authority area.
3.4 Progress to implement the strategy is monitored through objectives within an action plan for the programme board and indicators are updated annually from national reports. The indicators and action plan will be updated in October 2012 after publication of data by ISD Scotland.

4 Healthcare Improvement Scotland

4.1 NHS Lothian was visited by Healthcare Improvement Scotland (HIS) in May 2011 to assess the Board’s performance against the 2008 NHS QIS Sexual Health Standards. A report published in September 2011 confirmed the key strengths in Lothian were:

- An explicit tiered approach to the sexual health service with robust planning for integration;
- A wide range of targeted services for those with specific needs;
- Good partnership working arrangements, particularly with Edinburgh City; and
- Effective use of information technology for clinical and management needs, for example, EMPOWER, Refhelp and HIV clinical database

4.2 There were three specific recommendations for NHS Lothian to address.

- Increase longer acting and reversible methods of contraceptive provision in primary care and access to intrauterine contraception in specialist services
- Develop a systematic approach to partner notification;
- Implement termination of pregnancy improvements in St Johns hospital

4.3 NHS Lothian’s response to the recommendations was reported to the NHS Lothian Health Care Governance and Risk Management Committee in October 2011. The recommendation to increase longer acting reversible methods of contraception in primary care is the only one of the three recommendations which has not been implemented in NHS Lothian. Additional investment of £150K in the second half of 2012/13 has been agreed to increase the provision of LARC through the Primary Care Local Enhanced Service. This will increase activity in primary care but will be insufficient to meet the standard – an increase of £303K per annum is required to meet the LARC rate considered essential by Healthcare Improvement Scotland.

5 Sexual Health and HIV Strategy: First Year

5.1 Work in the first year of the new strategy has focussed on implementing the strategy action plan and specifically focusing on system redesign to increase access for populations at greatest risk of poor sexual health and unintended pregnancy and to reduce inappropriate demand on centrally located specialist services.

5.2 The priority in 2011 was to establish the new integrated Lothian Sexual and Reproductive Health Service (LSRHS) combining the Genitourinary Medicine and Family Planning Departments into the Chalmers Sexual Health Centre. The focus has been on establishing a single culture in the service with clinical staff dual-trained in both specialities to achieve true integration rather than simply co-location of services.
5.3 Demand for the new service has increased and is difficult to meet. This is due to a combination of factors including the prevalence of sexual ill-health and unintended pregnancy in Edinburgh, the historical use of the Family Planning Service for routine contraception and the accessibility of the service though the provision of both a daily drop-in service and bookable appointments. The service capacity was also limited by difficulties experienced with the National Sexual Health (NaSH) clinical management system. Work to improve access to the service included:

- Review of Sexual Health Peripheral Clinics. This will increase capacity in peripheral clinics, reducing demand on the central service and improving access to the specialist service for populations at higher risk of poor sexual health and unintended pregnancy. Three peripheral clinics are being relocated to communities with greater need.

- Development of Clinical Priorities: The LSRHS has developed the clinical priorities of the new service and identified routine clinical activity which can be delivered in primary care. Clinical leads from the LSRHS have met with General Practitioners at CHP Primary Care meetings to describe the clinical priorities and to seek support for a public information campaign to direct people towards their local GP for most sexual health interventions and contraception (primary care already provide most sexual health advice and treatment in Lothian). There is support from primary care and the campaign content will be developed in partnership with the Lothian GP sub-committee and will be launched later in 2012.

5.4 The structure of the programme board and sub-groups enables clinical issues spanning all services to be addressed to improve effectiveness and efficiency of service provision. Examples of this include the decision in 2011 to stop endocervical swabs and the plan to stop high vaginal swabs later in 2012. This involved agreement between LSRHS, Primary Care and Laboratories. NAAT testing has been introduced into primary care which enables GPs to test for gonorrhoea and chlamydia, reducing the need for patients to attend the specialist service and improving the detection rate of gonorrhoea. The number of cases diagnosed in primary care has already increased, but new referral pathways that reflect our tiered approach to service delivery have ensured that over 90% of positive cases are now managed in Chalmers. In addition to ensuring accurate antibiotic provision, this maximises opportunities for partner notification.

5.5 Another development to improve access to services and reduce harm from sexual ill health and HIV which demonstrates the partnership working in the programme has been the development of the 10a service, a pilot community-based rapid HIV and Syphilis Near Patient Testing service targeted towards Men who have Sex with Men (MSM). The pilot was developed in partnership between the LSRHS, Harm Reduction Team, Laboratories and Gay Men’s Health and uses point of care tests (POCT) to provide rapidly available results, allowing immediate client management and potentially improving outcomes through improved partner notification and reduced onward transmission of infection. The pilot required quality assurance by Laboratories and LSRHS because testing is undertaken by non-clinical staff.

5.6 NHS Greater Glasgow and Clyde and NHS Lothian are working together to build on existing HIV prevention work programmes and to develop and implement enhanced
interventions aimed at reducing HIV incidence in the MSM population. Working in partnership both Boards will now take forward a joint HIV prevention needs assessment of MSM. This is intended to inform longer term planning for refocused HIV prevention interventions.

5.7 The African HIV Sub-group is implementing the Lothian HIV African Strategy and NHS Lothian has funded an African Development Worker employed in Waverley Care to work with African’s living in Lothian to reduce the stigma and barriers to accessing HIV testing and sexual health services.

5.8 A review of Young People’s Sexual Health services in Lothian was completed in February. Work has commenced to enhance existing integrated and accessible sexual health services for young people that meet their needs and are targeted toward young people at highest risk of sexual ill health and unintended pregnancy.

6 Key Risks: Sexual Health and HIV Strategy: Second Year (2012/13)

6.1 The strategy remains a challenge to implement because of the wide-range of social, cultural and economic factors which contribute to poor sexual health, HIV and unintended pregnancy. This requires an integrated approach from statutory and third sector organisations and communities to address. The programme board will continue to improve the effectiveness of activity in the programme through developing service provision targeted at populations at higher risk, ensuring all interventions are evidence-based and refocusing activity in appropriate service tiers which are accessible and cost-effective. The programme board can utilise funding from Scottish Government to target services and support system redesign. There are also opportunities to reduce and reallocate expenditure through a programme budgeting approach.

6.2 Partnership working is crucial to implement the strategy and whilst the partnership working between NHS Lothian and City of Edinburgh Council was commended in the 2011 Healthcare Improvement visit further work is required by all partners to increase effective partnership working with other councils.

6.3 NHS Lothian funds seven third-sector organisations in total over £1M per year to provide services for people who are at higher risk of poor sexual health or blood-borne viruses. In 2012/13 NHS Lothian is reviewing the activity and outcomes achieved by these organisations and will use a competitive procurement process to offer new contracts. This process will be led by NHS Lothian and will involve other stakeholders, including potential service providers, in developing the specifications for the new contracts.

7 Risk Register

7.1 There are no risks for the NHS Lothian Corporate Risk Register.

8 Impact on Inequality, Including Health Inequalities

8.1 An impact assessment was carried out on the final version of the 2011-2016 Sexual Health and HIV Strategy.
9 Resource Implications

9.1 The resource implications are related to the need to increase funding for the provision of LARC in primary care, as outlined above.

Jamie Megaw
Strategic Programme Manager for Sexual Health
31 August 2012
Jamie.megaw@nhslothian.scot.nhs.uk
Minutes of the NHS Lothian Audit Committee Meeting held at 9.00am on Monday, 26 June 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

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

In Attendance: Mr T Davison (Interim Chief Executive); Dr T Gillies (Associate Divisional Medical Director); Mrs S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D McConnell (Audit Scotland); Mr D Woods (Chief Internal Auditor); Dr C J Winstanley (Chairman); Mr A Payne (Corporate Governance & Value-for-Money Manager); Mr A Perston (Audit Scotland) and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr Boyter and Mr Peacock.

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. The Chair declared that his employer had an interest in shared services contracts discussed at the Finance and Performance Review Committee. The Chair declared an interest as an employee of the City of Edinburgh Council in respect of items detailed within the matters arising. Mr Egan declared an interest in relation to his brother’s role in item 15.2.

10. Minutes of the Previous Meeting

10.1 Minutes of the Previous Meeting held on 5 April 2012 – previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 5 April 2012 were approved as a correct record.

11. Matters Arising

11.1 Matters Arising from the Meeting of 5 April 2012 – the Committee noted the previously circulated paper detailing the matters arising from the Audit Committee meeting held on 5 April 2012, together with the action taken and the outcomes.

11.1.1 Mrs Goldsmith explained that the ratio of the highest and lowest earners in NHS Lothian was 14 to 1 based on Consultant and Agenda for Change Band 1 staff. Members anticipated Mr Boyter’s full report in October 2012.
11.1.2 In response to a query on paragraph 8.1.1 of the Audit Committee minutes, Mr Payne clarified that the Committee had previously agreed to receive a summary briefing on the progress of the critical incident review. This was so the Committee was kept informed of any issues relating to governance or internal control generally, and thereby inform the Committee's assessment of what is presented in the draft Governance Statement.

Mr Martin entered the meeting.

11.1.3 Mr Payne confirmed that the initials PM detailed within the action note were in fact Councillor Paul McLellan not Professor Pat Murray.

11.1.4 Mr Payne gave a brief overview of the action note. The Committee agreed that the proposed composite paper on Professional Registration would be considered by the Staff Governance Committee in the first instance. Professor Murray advised the Committee that she had discussed the report on the reconciliation of doctors on payroll to GMC connect with Dr Farquharson and Mrs Hornett.

11.1.5 Mrs Douglas queried whether the issue of lapsed registration was on the risk register or picked up during the application process for disclosure Scotland. Professor Murray agreed to look into this and feedback the outcome to the Committee.

11.1.6 The Committee discussed the review of the Scheme of Delegation, and agreed it was important that the document was tested with colleagues to ensure that it was understood and applied in practice. Mr Payne agreed to take this forward as part of the development process.

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

11.2 Business Continuity Management – Mrs Goldsmith spoke to the previously circulated report providing the Committee with an update on how the actions from the Internal Audit report on Business Continuity have progressed.

11.2.1 The Committee agreed the recommendations detailed within the report subject to the Audit Committee revisiting the matter in a year.

12. Operational Audit Sub-Committee

12.1 Minutes of the Operational Audit Sub-Committee held on 26 March 2012 – the Committee noted the previously circulated minutes of the meeting of the Operational Audit Sub-Committee held on 26 March 2012.

12.1.1 Following Dr Winstanley’s request, the Committee agreed that a report on the future role of the Operational Audit Sub-Committee as a supporting body to the Audit Committee would be brought forward for consideration at the next meeting of the Audit Committee.
12.1.2 The Committee agreed to adopt the minutes of the Operational Audit Sub-Committee meeting held on 26 March 2012.

13. Linkages with Other Board Committees

13.1 Finance & Performance Review Committee - Minutes of the Meetings held on 18 April 2012 - the previously circulated minutes of the Finance & Performance Review Committee meeting held on the 18 April 2012 were received.

13.1.1 Mr Egan made reference to the lack of context with regard to item 2.1 of the minute, specifically decisions made surrounding the relocation of the psychiatry Old Age Ward from the Royal Victoria Hospital to the Royal Edinburgh Hospital. Mrs Goldsmith explained that following a piece of work to scope the move no feasible alternative had been identified; however it was not clear whether the report was disseminated to the relevant Committees.

_Dr Gillies entered the meeting._

13.1.2 Mrs Douglas highlighted the failure to include the relocation of the ward in the Royal Victoria Business Case. Members were assured that lessons learnt from the Royal Victoria Business Case would be applied to the Royal Hospital for Sick Children Business Case.

13.1.3 The Committee noted the Finance and Performance Review Committee minutes of 18 April 2012 and the information therein.

13.2 Healthcare Governance & Risk Management Committee - Minutes of the Meeting held 3 April 2012 - the previously circulated Minutes of the Healthcare Governance & Risk Management Committee meeting held on the 3 April 2012 were received.

13.2.1 The Chair commented on recent discussions on backlog maintenance work at the Healthcare Governance and Risk Management Committee. Mrs Goldsmith advised members of proposed work to identify the required maintenance work by site. The Finance and Performance Review Committee will then review the outcome from this exercise.

13.2.3 In response to Professor Murray’s comments on risks related to the attitudes of staff about reporting maintenance issues, Mrs Goldsmith advised that Mr Curley would take these matters forward as part of the review on the backlog of maintenance.

13.2.4 The Committee noted the Healthcare Governance and Risk Management Committee minutes of 3 April 2012 and the information therein.
14. Internal Audit Reports

14.1 Private and Overseas Patients

14.1.1 Mr Woods gave a detailed introduction to the previously circulated report following the internal audit of Private and Overseas Patients. Mr Woods explained that the audit report had been issued in March and would ordinarily have been presented to the Operational Audit Sub-Committee. While separate topics, Mr Woods explained that processes regarding private and overseas patients are covered by a joint policy and procedures, with both topics involving consultants and front-line staff as well as Finance. Mr Woods highlighted the main issues raised in the report, in particular that consultants have not always been noting within job plans their intention to do private work, private patients are not always being identified, overseas visitors’ liability status is not always being identified, and decisions about waiving costs for charitable cases may not be appropriate. The Chair expressed concerns regarding the issues raised.

14.1.2 Dr Gillies responded by noting that she had only recently taken on her current role, and her predecessor had expressed reservations about some of the audit findings. For example, Dr Gillies explained that at no time was the requirement to hold insurance for private work disseminated to consultants, and work was required to reconcile the terms of consultants’ contracts with NHS Lothian’s new procedures for private patients. However, Mr Woods advised that the previous policy issued 5 years ago had clearly stated a requirement for consultants to hold insurance. Mr Woods added that the draft version of the audit report had resulted in discussions about where risk and liability would lie for patients treated privately on NHS Lothian’s premises. Mr Woods suggested that NHS Lothian would be faced with at least a reputational risk if any incident occurred.

14.1.4 In response to comments by Dr Gillies, Mr Woods explained that difficulties had been experienced in trying to agree the report with service managers. However, the report was factually correct despite service managers still not wanting to accept some of the findings. Mrs Goldsmith agreed that the audit findings could not be faulted, however the Board needed to be clear about NHS Lothian’s stance about treating private patients, with a robust system in place or the facilities removed.

14.1.5 Mr Davison advised that this was not something that he had come across before in his capacity as Chief Executive of NHS Lanarkshire. He proposed that the organisation should consider whether in principle it should be hosting private work. If it was agreed that NHS Lothian should be doing this, there should then be an evaluation of the materiality of the activity, and an agreement as to what the required return on investment needs to be.

14.1.5 The Committee agreed that if it was accepted that NHS Lothian would host private patient activity, then it should be done so through a robust system of management where clinicians are required to have explicit authority to conduct private practice.
14.1.6 Mr Egan stated that a number of these cases presented as routine treatment on high risk patients which develop into complex cases and the treatment that follows was not recharged by the NHS.

14.1.7 It was agreed that Mrs Goldsmith, and Dr Gillies would liaise to identify:

- what happens at present,
- what processes would be required to be in place, and
- the cost of introducing a robust process.

14.1.8 It was agreed that a report on this would be considered by the CMT. Mr Egan requested that the Partnership Forum be involved in the process.  

14.2 Internal Audit – Progress Report June 2012

14.2.1 Mr Woods gave a brief overview of the report and highlighted the completed 2011 plan (except for one report which remains in draft), progress made with starting the 2012 plan and 4 specific pieces of extra work which would impact on the 2012 plan. Mr Woods summarised the 4 pieces of extra work: NHS Waiting Times Arrangements which is covered by a separate agenda item; Review of Information Received by the Board which represents follow-up work requested by the Chair of the Board; payments for waiting list initiatives which follows on from a Critical Incident Review; and questions raised during a recent internal audit regarding a contract for supplementary staffing. The Chair requested that Mr Woods carry out a scoping exercise to determine how many days each additional review would take and report back to the Operational Audit Sub-Committee.

14.2.3 The Committee agreed that the Chair of the Audit Committee should be kept appraised of any issues with regard to staffing levels and calls upon the time of Internal Audit, where it has a bearing on the delivery of the internal audit plan. The Committee agreed it was important to keep the lines of communication open and transparent.

14.2.4 Dr Winstanley advised that the Review of Information Received by the Board had been led by him and supported by an external consultant, rather than commissioned from an external consultant as stated in the Internal Audit Progress Report.

14.2.5 With regards the performance percentages quoted in the Internal Audit Progress Report, Mrs Douglas queried whether the target to issue draft reports within 2 weeks following the end of fieldwork was realistic. Mr Woods explained that the 2-week target had been set by him, and he considers the target to be desirable and realistic. Mr Woods advised that the target helps to focus attention on getting reports issued, as well as identifying aspects of the audit process that could be improved.

14.2.6 The Committee noted the previously circulated Internal Audit Progress Report June 2012 and the assurances therein.
14.3 Internal Audit – Reports with Fully Satisfactory & Satisfactory” Ratings - Mr Woods gave a detailed overview of the previously circulated report and summarised the main findings from the audits of Pool & Leased Cars (Follow-up), Hospital Laundry and Complaints & Litigation. In response to an earlier request, Mr Woods agreed to check that a copy of the final report on Pool & Leased Cars (Follow-up) had been sent to Mr Peacock for his information.

14.3.1 With regards Pool & Leased Cars, the Chair requested that Mrs Goldsmith take the issues surrounding the correlation of excess and insurance premiums offline. Mrs Goldsmith advised the Committee of ongoing national discussions and recent measures taken to request that staff were more careful.

14.3.2 The Committee noted the positive progress since the earlier audit of Pool & Leased Cars and the work done by the Transport and Access Committee.

14.3.3 With regard to Hospital Laundry, the Committee noted that many long-standing issues remain, including overweight laundry bags, rogue items being found within laundry bags, incidents not being reported on DATIX, and health & safety procedures not always being followed. Also, the Committee noted that prices have not been revised for commercial services. The Committee questioned whether the overall rating was really “satisfactory” in the light of these findings. Mr Woods advised that the satisfactory rating reflected many positive aspects with the operation of the laundry.

14.3.4 The Committee agreed to note the outcome of the audit on Hospital Laundry and requested that Internal Audit remain vigilant as laundry services go forward.

14.3.5 With regards Complaints & Litigation, Dr Winstanley noted the importance of a sufficient Complaints Department in relation to the recent waiting times incident. He proposed that it would be timely to request that following the conclusion of waiting times work that the Corporate Management Team look at the broad strategic issues surrounding complaints. Mr Davison advised caution in tasking an already over stretched Corporate Management Team with another large project. He proposed that in the first instance this matter should be taken forward through Clinical Governance and Patient Experience groups.

14.3.6 Mr Egan commented on the challenges the Complaints department have had in trying to secure an appropriate location, with the team currently based in an open plan office environment. He also highlighted the importance of the quality of responses versus the achievement of targets and failure to recognise learning coming out of incidents. Members agreed that the team needed to be properly resourced to ensure that lessons learned from complaints are embedded into service delivery.

14.3.7 The Committee noted the previously circulated Internal Audit - Reports with Fully Satisfactory & Satisfactory Ratings and the assurances therein.
14.4 Property Maintenance – May 2012 – Mr Woods introduced the previously circulated report which had covered the 5 maintenance teams and focused on the use of the Backtrack system. Mr Woods gave an overview of the main issues raised in the report including that Backtraq is not being actively managed for outstanding jobs and completion rates, the coverage and quality of the Planned Preventative Maintenance programme varies across sites and jobs are not always being completed, team structures vary across sites with shift patterns and on-call arrangements varying, and practices vary for dealing with jobs raised following inspections.

14.4.1 The Committee noted reports produced by Estates that a further £140 million was required to bring all sites up to a satisfactory standard. Also, reports to the Executive Management Team and Board had advised that £20 million is needed to address major risks across the main hospital sites. The Chair requested that the Operation Audit Sub-Committee take forward a detailed risk review of the issue of property maintenance, following the consideration of the issue at the Finance & Performance Review Committee.

14.4.2 Mrs Goldsmith urged the Committee to be careful when using the term backlog maintenance, noting that a large section of this maintenance was related to life-cycle issues and recent Healthcare Environment Inspectorate inspections. In response to Mrs Douglas’s query regarding Consort’s approach to life-cycle maintenance, Mrs Goldsmith advised colleagues that she would take all issues related to property maintenance forward with Mr Graham and Mr Curley. The Committee noted that the internal audit did not include maintenance at the Royal Infirmary of Edinburgh.

14.4.3 The Committee noted the previously circulated report on Property Maintenance May 2012 and the assurances therein.

14.5 CFS Referrals & Operations – June 2012 – Following a brief introduction from Mr Woods, the Committee noted the CFS Referrals and Operations Report June 2012. In particular, the Committee noted that 11 referrals and 6 operations were open at the time the report was prepared. From the operations, Mr Woods advised that an ex-employee had pled guilty in March to continuing to work as a registered nurse despite letting her NMC registration lapse, with sentencing deferred until September. Also, a former nurse who pled not guilty to forging prescriptions is due to return to court in June, and 2 ex-employees have been reported to the Procurator Fiscal for working elsewhere while claiming sick-leave from NHS Lothian. Finally, Mr Woods advised that a dentist is being investigated for suspicions about claiming for services not provided and materials not used, and a GP is being investigated for possibly altering records to claim extra payments under the Quality Outcomes Framework.

14.6 Fraud Referrals & Operations for year to end 31 March 2012 – Mr Woods spoke to the previously circulated report that provided the Committee with statistics on fraud referrals and operations raised during the year ending 31 March 2012. Mr Woods gave an overview of the main figures and highlighted the 7 cases which had led to criminal convictions during the year.
14.6.1 In response to a question from Professor Murray, Mr Woods advised that NHS Lothian shares information with other Boards through Counter Fraud Services whilst ensuring that Data Protection and confidentiality policies are observed.

14.6.2 The Committee agreed to accept the report.

14.7 Counter Fraud Services – Quarterly Report – March 2012 - Mr Woods noted the Counter Fraud Services quarterly report underlining Operations BARRA and PLASMA from NHS Lothian.

14.7.1 The Committee agreed to accept the CFS Quarterly Report – March 2012.

14.8 Counter Fraud Services – Intelligence Alerts

14.8.1 The Committee noted the previously circulated paper about Counter Fraud Services bulletins and the information therein. In particular, the Committee noted that the alerts had been distributed to relevant senior managers on the day of receipt.

14.9 Counter Fraud Services – Patient Exemption Checking and Potential

14.9.1 The previously circulated report to provide the Committee with information on the latest analysis of fraudulent and erroneous claims from exemption from patients’ charges was received.

14.9.2 Mrs Goldsmith assured the Committee that fraud had significantly reduced following the removal of prescription charges and the proactive approach to fraud in NHS Lothian.

14.9.3 The Committee agreed to accept the assurances detailed within the report subject to the amendment of item 3.2 in respect of reference to the now dissolved Primary and Community Partnership Committee (PCPC).

14.10 Internal Audit - Annual Report for 2011/12 - Mr Woods presented the annual report and confirmed that Internal Audit’s work indicated that generally adequate and effective internal controls had been operating throughout the year. Mr Woods highlighted that 13 internal audit reports (62%) had received ratings of Satisfactory, while 8 reports (38%) had been issued with ratings of Requires Improvement, in line with the general pattern over recent years. From the audits, Internal Audit had raised 65 issues: one Critical issue, 52 Significant issues and 12 Important issues. Also, Mr Woods commented that 49 issues raised in Internal Audit reports remained outstanding at 31 March 2012, including 35 with management actions outstanding past their target dates for completion. Mr Woods reminded the Committee of the report presented in October 2011 which indicated that 92% of management actions are not completed by agreed target dates. Nevertheless, Mr Woods summarised that Internal Audit could report positively against the requirements of the guidance for supporting the Governance Statement.
14.10.1 In response to concerns about the late completion of management actions, Mr Woods agreed to present a detailed analysis of outstanding issues to a future meeting of the Audit Committee.

14.10.2 In response to the information presented in the report and issues already discussed from recent internal audit reports, the Committee debated whether assurances are sufficient to conclude that controls are adequate and effective. Following consideration of the wider control framework and many positive aspects, Mr Davison concluded that he had sufficient assurances for the purposes of the Governance Statement.

14.10.3 The Committee agreed to accept the report.

14.11 Internal Audit Review of NHS Waiting Times Arrangements – Terms of Reference – the Committee noted the previously circulated letter and attached terms of reference issued by the Scottish Government.

14.11.1 Mr Woods advised the Committee that Internal Audit was currently scoping the size of the audit. In particular, Mr Woods noted that various service teams across NHS Lothian manage different waiting lists, including support from Health Records and medical secretaries. As such, the audit will require meetings with many teams. Also, the results of data queries to be run on waiting lists will greatly influence the amount of work required.

14.11.2 Separately from the audit, Mr Davison explained that a report would be submitted to the Board reflecting the revised arrangements in place for managing waiting times, in particular the team of Martin Egan, Andy Jackson and Harry Purser has been tasked with monitoring recommendations being put in place.

14.11.3 The Committee agreed to accept the terms of reference, but noted that the Scottish Government’s deadline of 17 December would require Internal Audit’s report to be ready for the October Audit Committee. As this is not possible it was agreed a special meeting of the Audit Committee will need to be convened to receive the report.

15. External Audit Reports

15.1 NHS Lothian: 2011/12 Review of Internal Controls - the previously circulated report on NHS Lothian: 2011/12 Review of Internal Controls from Mr McConnell was received.

15.1.1 Mr McConnell presented the report highlighting the key findings in relation to the overall systems of internal control, the completion of the audit plan and the responsibility of the management to decide on the extent of the internal control systems appropriate to NHS Lothian. The report did not include any “high priority” matters.

15.1.2 The Committee agreed to accept the report.
15.2 NHS Lothian: Computer Services Review - Mr McConnell advised that overall e-Health’s performance was satisfactory, however there were 4 areas of improvement: timely removal of access rights for staff who have left, emergency power for servers at the Royal Infirmary of Edinburgh, risks relating to information security as the Board moves forward with hand-held devices and remote access to the internet, and the review of procedures for technical services. Members noted that 3 out of the 4 actions were complete.

15.2.1 The Committee agreed to accept the report.

Professor Murray left the meeting.

16. General Corporate Governance

16.1 2011/12 Healthcare Governance Committee Annual Report to Lothian NHS Board - the previously circulated report to provide the Committee with the annual report of the Healthcare Governance & Risk Management Committee, so as to provide a source of assurance with respect to the Governance Statement was received.

16.1.2 The Committee accepted the report provided as a source of assurance to support the Governance Statement.

16.2 Lothian NHS Board Annual Report of the Chair of the Finance & Performance Review Committee Period Ending 31 March 2012 - the previously circulated report to provide the Committee with the annual report of the Finance & Performance Review Committee, so as to provide a source of assurance with respect to the Governance Statement was received.

16.2.1 The Committee accepted the report provided as a source of assurance to support the Governance Statement.

16.3 2011/12 Annual Report from the Staff Governance Committee - the previously circulated report to provide the Committee with the annual report of the Staff Governance Committee, so as to provide a source of assurance with respect to the Governance Statement was received.

16.3.1 The Committee accepted the report provided as a source of assurance to support the Governance Statement.

16.4 2011/12 Annual Report from the Information Governance Assurance Group - the previously circulated report to provide the Committee with the annual report in respect of the Information Governance Assurance Group, so as to provide a source of assurance with respect to the Governance Statement was received.

16.4.1 The Committee accepted the report provided as a source of assurance to support the Governance Statement.
16.5 **2011/12 Summary Assurance Report on Best Value** – the report to brief the Committee on how NHS Lothian progresses the duty of Best Value was received.

16.5.1 The Committee accepted the report provided as a source of assurance to support the Governance Statement.

16.6 **Lothian NHS Board Annual Report of the Chair of the Operational Audit Sub-Committee Period Ending 31 March 2012** - the previously circulated report to provide the Committee with the annual report of the Operational Audit Sub-Committee was received.

16.6.1 The Committee accepted the report provided as a source of assurance to support the Governance Statement.

16.7 **NSS Service Audit Reports 2011/12** – the previously circulated report to provide the Committee with assurance on the systems of control managed by NSS on the Board’s behalf was received.

16.7.1 The Committee acknowledged the unqualified opinions from the service auditors for each area and accepted these as a source of assurance in respect of the Board’s systems of internal control.

16.8 **Primary Care Payments** – the previously circulated report to provide the Committee with assurance in regard to payments made to family Health Service Practitioners and that this report was a relevant source of assurance to support the 2011/12 governance statement was received.

16.8.1 The Committee agreed to accept the report as a source of assurance to support the 2011/12 governance statement.

16.9 **SFR 18.0 – Summary of Losses and Payments for the Year Ended 31 March 2012** – the previously circulated report to provide the Committee with an opportunity to review the summary of losses and compensations payments incurred throughout 2012 was received.

16.9.1 Mrs Goldsmith highlighted the improvements in respect of overseas patients, decreased debt in respect of turnover of staff, and advised the Committee that her team would continue to press for improvement and progress in relation to the historic debt accumulated by the University of Edinburgh.

16.9.2 The Committee noted the paper.

16.10 **Formal Consideration of Resources Available to the Committee** - the Committee agreed that the resources made available to the Committee (e.g. through audit days and supplementary support) had been adequate for the Committee to discharge its functions. However, the Committee agreed that it needed to monitor the impact of difficulties highlighted by the Chief Internal Auditor about attracting and retaining suitable auditors as salary levels paid by NHS Lothian for auditors are below market rates.
16.10.1 The Committee agreed to accept the report.

16.11 **Update on Action Plan to Improve Awareness of and Compliance with Policies and Procedures** – the previously circulated report to provide the Committee with an update on the action plan that it received on 21 June 2011 that was prepared in response to the Internal Audit report on compliance with Policies and Procedures March 2011 was received.

16.11.1 The Committee agreed to accept the action plan as evidence of progress made.

*Dr Winstanley left the meeting.*

16.12 **Addressing the Governance Issues from the Waiting Times, Board Information and Culture Reviews** – Mrs Goldsmith introduced the previously circulated report on addressing the governance issues from the waiting times and board information and culture review.

16.12.1 The Committee agreed to accept the briefing as a source of assurance that the governance and internal control issues arising from the various reviews would be systematically addressed and the action plan transparently monitored.

16.13. **Governance Statement Assurance** – The Committee received the previously circulated report to meet the Committee’s request to see what was disclosed by direct reports to the Chief Executive through the managerial statements on internal control. This is one of the sources of assurance for the Accountable Officer’s Governance Statement which is incorporated into the 2011/12 annual accounts.

16.13.1 The Committee agreed to note the report.

17. **Annual Accounts**

17.1 **Governance Statement** - a previously circulated paper, together with the draft Governance Statement was received. Mr Martin spoke to the Governance Statement noting in detail the arrangements put in place to support the statement.

17.1.1 Following its review of the Governance Statement, the Committee agreed to support the Statement and recommend the Statement to the Board, subject to minor correction in relation to a form of words being included in respect of proactive follow up, the culture review, and the correction in the title of the Finance and Performance Review Committee.

17.2 **Representation Letter** - the Committee received a previously circulated report, together with a draft Letter of Representation to the External Auditors.
17.2.1 Following discussion, it was agreed that the statement properly represented confirmation to the External Auditors on matters arising during the course of their audit of the accounts for the year ended 31 March 2012, and to recommend to the Board that the letter be adopted subject to the minor amendment to Mr Davison’s title.

17.3 External Audit - Lothian NHS Board – Draft Report to those charged with Governance on the 2011/12 Audit - a previously circulated draft report to those charged with governance on the 2011/12 Audit was received.

17.3.1 Mr McConnell spoke to the report highlighting preparative work, matters arising, outcomes and that the final audit opinion would be formally submitted later today.

17.3.2 The Committee agreed to accept the report subject to the re-working of paper 8.2.

17.4 Annual Accounts for the Year ended 31 March 2012 - the Committee received the annual accounts for 2011/12 and proceeded to scrutinise each page of the accounts in detail.

17.4.1 Following a detailed consideration of the draft annual accounts for 2011/12, a number of minor amendments to the annual accounts were agreed. Subject to these amendments, the Committee agreed to recommend to Lothian NHS Board that it approve and adopt the annual accounts for year ended 31 March 2012.

Mr Davison and Mr Egan left the meeting.

17.5 NHS Lothian, Audit Committee Annual Report from the Chair – Year Ending 31 March 2012 – the Committee approved the previously circulated NHS Lothian, Audit Committee Annual Report from the Chair – Year Ending 31 March 2012.

17.6 Lothian NHS Board Audit Committee – 2011/12 Notification to the Health & Wellbeing and Cities Strategy Audit Committee – the previously circulated letter and attached action plan was received.

17.6.1 The Committee agreed to approve the letter.

18. Any Other Competent Business

18.1 Mr Renwick – Mrs Goldsmith thanked Mr Renwick on behalf of the Committee for his invaluable support and work over the years he served as Chair of the Audit Committee.
19. **Date of Next Meeting**

19.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 9 October 2012 at 9.00am in Waverley Gate, Edinburgh.
Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 15 August 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (Chair); Mr P Johnston; Dr M Bryce; Mr E Egan; Dr D Farquharson; Mrs S Goldsmith; Professor J Iredale; Professor A McMahon; Mr I Whyte and Dr C J Winstanley.

In Attendance: Miss L Baird; Mrs M Christie; Mr B Currie; Mrs L Khindria; Ms C McLeod; Mr D Small.

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

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.

22. Minutes of the Previous Meeting

22.1 The previously circulated minutes of the meeting held on 6 June 2012 were approved.

23. Matters Arising

23.1 Hub Partnership – The Committee discussed the replacement of primary and community facilities and the subsequent impact that would have on staffing levels. It was anticipated that this issue would be mitigated by backlog maintenance works.

23.2 Replacement of 16 Slice CT Scanner, Western General Hospital – Members were assured that following previous discussions the replacement of the 16 Slice CT Scanner at the Western General Hospital would be beneficial for both NHS Lothian and the University of Edinburgh.

23.3 Burns Unit, St John’s Hospital – The Committee noted that the business case for the Burns Unit at St Johns Hospital had been deferred until the October. The business case required to go through due process and be considered by the Corporate Management Team on 5 September 2012.

23.3.1 Following the receipt of queries from the St. John’s Stakeholder Group the Committee discussed the circulation of the reports and potential for engaging the
local public during the process of redesign to gauge whether the direction of travel addresses the service users needs.

23.4 Local Reinvestment Programme – There was some discussion surrounding financial and non-financial incentives for services and how local reinvestment plans would be approached in future years. Mrs Goldsmith agreed to bring forward a report on approaching LRP as NHS Lothian moved forward to the next meeting.  

SG

23.5 Capital Investment Programme – Statutory Standards – Following the recent holiday period the report had been delayed. There was some discussion surrounding the timelines for action and the reputation risk that NHS Lothian faced in not addressing these. Members agreed that the report would be brought forward to the October meeting for consideration.  

AB/SG

Dr Winstanley entered the meeting.

23.6 Endoscopy Suite Royal Infirmary of Edinburgh: Upgrade of Decontamination Facilities – The Committee agreed that the target of 15 August 2012 had been too ambitious therefore an upgrade of decontamination facilities would be brought forward to the October 2012 meeting.  

AKM

24. Planning

24.1 Business Case Update – A detailed update on the progress of all business cases and whether or not they were meeting their trajectories was received. There was some discussion in respect of the Royal Edinburgh Hospital Campus development, the constraints of Phase 1 approval and the need to progress the master plan in the immediate future. It was anticipated that the master plan would be available in late January/ early February 2013.  

DS

24.1.1 Concerns that there was a pattern emerging in respect of poor communication throughout services during the process of redesign were raised. Mrs Goldsmith agreed to include a column for spend approved to date in future reports to give the Committee a complete overview of progress to date.  

SG

24.1.2 Gullane General Practitioner Practice Business Case – Members noted that there had been some issues surrounding the title of the land indentified for Gullane General Practitioner Practice. It was noted that Mr Wilson Director of Communications had determined that all calls in respect of this matter would be referred to the Local Authority.  

24.1.3 East Lothian Community Hospital – It was agreed that a detailed update would be brought forward within the next business case update. Members agreed to be mindful as the project moves forward to ensure that the priorities and aspirations of the Local authority remain in line with those of NHS Lothian.  

DS/SG

24.2 Royal Hospital for Sick Children and Department of Clinical Neurosciences Project Update – The Committee debated the terminology used in previous reports and the resulting confusion in respect of the fixed contract sum. Members noted that the
contract becomes fixed following the completion and signing off of the SA enabling works. At present £11 million was fixed for construction, the subsequent £2.5 million for flood prevention was not linked to Consort and was a known risk. All other additional items reflected progress made in the design process and related to risks materialising. Members agreed it was imperative that the pressure remained on Consort to enable the Board to achieve their revised target of June 2017.

**24.2.1** The Committee discussed the legacy of NHS Lothian in relation to the New Royal Hospital for Sick Children and the associated reputational risks and scrutiny that the Board may face as the project nears completion. It was determined that there would be value in organising a separate session on the new Royal Hospital for Sick Children for all Board Members. The session would be held before the September 2012 meeting of the Board and last approximately an hour.

*Mr Currie left the meeting.*

**25. Business Cases**

25.1 **Tranent Health Centre Extension** – It was noted that an extension of an existing health centre fell within the previous rules and therefore the amount that the practice contribution could not be evaluated to take into account inflation.

25.1.2 Members agreed that it would be beneficial if money identified for business cases could be measured against the patient need versus using money to mitigate critical backlog maintenance risks. Members were assured that the extension of Tranent Health Centre would address some of the backlog maintenance issues at that site.

25.13 It was agreed that Mr Small and Mrs Goldsmith would bring forward a report specifically detailing the accommodation optimism bias within the business case update for the next meeting.

25.14 The Committee agreed to:

- Note that the East Lothian Community Health Partnership Sub-Committee supported the detailed project and financial plans contained within the Standard Business Case on 27 June 2012.

- Note that the Lothian Capital Investment Group supported the detailed project and financial plans contained within the Standard Business Case on 26 July 2012.

- Note that the Corporate Management Team supported the detailed project and financial plans contained within the Standard Business Case on 1 August 2012.

- Support the detailed project and financial plans for the two-storey extension of Tranent Health Centre, as detailed in the Standard Business Case.

*Mr Small and Dr Winstanley left the meeting.*

25.2 **Blackburn Partnership Centre** – There was some discussion on securing local authority services on the Blackburn site, the reliance on partnership working and the delay in formal confirmation from Council colleagues following the election period. Mrs Christie agreed to bring forward a report on the progress of the business case in the next business case update.

*MC/SG*
25.2.1 The Committee agreed to:

- Note that the initial agreement puts forward the strategic case for the partnership centre and outlines the four main options for further consideration.
- Note that the initial agreement was approved by the West Lothian Community Health and Care Partnership Board, Lothian Capital Investment Team and the Corporate Management Team.
- Approve the initial agreement for submission to the Scottish Government for final approval.

Mrs Christie left the meeting.

26. Performance

26.1 Performance Management – The Committee noted the previously circulated report outlining the 40 areas of performance outlined within the report. Members specifically discussed the implementation of the Scottish Government waiting times guidance, the pilot to increase Consultant availability and developments with care at home packages over the coming winter period.

26.1.1 Concerns that the dissemination of policy and guidance in particular the waiting times guidance had not reached all staff were raised. Members agreed that further work to ensure that guidance was rolled out to all relevant staff was required.

26.1.2 The Committee received assurance that follow up treatment was provided by external providers and in the see and treat models, to included parallel follow up by NHS consultants for high risk patients. The importance of see and treat in the challenge to tackle outpatient figures was acknowledged.

26.1.3 Following a brief discussion on the application of the European working time directive by external providers, Dr Farquharson agreed to formally request assurance that the reasonable rest policy was employed by Medinet and SPIRE Murrayfield.

Professor Iredale left the meeting.

26.1.4 There was some discussion in respect of setting expectations of the general public in terms of what was deemed to be a reasonable offer for treatment through General Practitioner engagement and the creation of standard information leaflets for patients. The importance of language, patient rights and responsibility of exhort choice were noted as paramount.

26.1.5 Concerns that that the utilisation of internal capacity was not being maximised before approaching external partners were raised. Members received assurance that NHS Lothian was committed to addressing confidence issues through immediate action to employ more staff increasing internal capacity. The Chair specifically noted Dr Farquharson’s commitment to address this matter.

26.1.6 The Committee agreed to note the specific recommendations detailed in item 2.1 to 2.8 of the report.
26.2 Quarter 1 Financial Review 2012/13 – Members received the previously circulated report on quarter one financial review and the detail therein. The major risk was Local Reinvestment plans and financial planning down to service level.

26.2.1 There was some discussion on the consequences of recent decisions from the Chief Scientists Office to reduce the funding allocation for Research and Development, the impact this would have on research posts and the required collaboration with the Director of Research and Development to bring forward a solution. It was determined that Research and Development currently exceed the objectives set out by the Chief Scientists Office and this should be taken into consideration when taking the matter forward.

26.2.2 The Committee noted the key financial pressures detailed in item 3.8 of the report specifically noting the challenges in respect of energy, unplanned activity, public health’s plans to revamp the safe haven and aspirations to change the mindset in relation to the safe haven’s role within NHS Lothian.

26.2.3 Concerns were raised surrounding incremental drift and actions taken to address this in the nursing community, why this had not been rolled out to other staff groups and areas that had been offset by other impacts. Members agreed that a detail piece of work was required to address the ongoing issues with incremental drift and develop a single system approach to resolve it.

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

26.3 Workforce Efficiencies within NHS Lothian – The Committee received an update on the progress of workforce efficiencies within NHS Lothian. Work to reduce substantive posts in collaboration with the workforce efficiencies and planning group were ongoing; for the period 2012/13 there would be a reduction of 206 WTE posts, less than in previous years. Opportunities for school leavers to obtain a guarantee qualification whilst working within the NHS were also discussed.

26.3.1 Work to reduce the number of managerial posts in the organisation to achieve the target of 5.69% reduction in managers was underway. At present there were 6 people on redeployment suitable for alternative employment. Members agreed that they should be mindful in terms of language used to describe the reduction in staff to mitigate any offense caused.

26.3.2 There was some discussion on the potential for the application of an increase to the cost of living of 1% in comparison to the propose 2% proposed from local authority colleagues.

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

26.4 Shared Services – The Committee noted disappointment in the previously circulated report, the lack of representation present and the underwhelming aspirations for shared services. It was agreed that a detailed programme of work should be brought forward for the next meeting. Mrs Goldsmith agreed to relay the Committee’s concerns to Mr Aitken out with the meeting.

SG/RA
26.5 Dashboard - The Committee received an update on the development of the dashboard specifically the implementation of the tracking of waiting times and the early flagging of issues to the Directors of Operation and CMT through the Performance Report.

27. Any Other Competent Business

27.1 Committee Remit - There was a brief discussion surrounding the proposed changes to the remit of the Finance & Performance Review Committee. The Finance and Medical Directors explained that a paper would go to the Board in September. A number of the Committee expressed concerns about changes to remit being proposed without the Committee being consulted. It was agreed that Mr Walker would flag the Committee’s concerns to Dr Winstanley outwith the meeting, specifically noting that the process needed to be debated by the Committee itself and that consideration needed to be given to such changes being clear and transparent.

GW

28. Date of Next Meeting

28.1 It was noted that the next meeting of the Committee would be held on Wednesday, 10 October 2012 from 9.00 a.m. to 11.30 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.
CHAIR’S REMARKS

The Chair welcomed members to the meeting and members introduced themselves. The Chair drew attention to the patient story that had been included in the Committee papers. The Chair reported that this was a very thoughtful story that included both the positive and negative aspects of this patient’s journey. The Chair thanked the patient for their story. It was agreed that this patient story should also be circulated to Lyn McDonald, Director of Operations & Medical Associated Services and the members of the Area Clinical Forum.

12. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF THE PREVIOUS MEETING: 12 JUNE 2012

12.1 The minutes of the previous meeting on 12 June 2012 were approved as a correct record. The Chair thanked Dr Bryce for chairing the previous meeting.

12.2 Dr Winstanley advised that this was Professor Murray’s last meeting as Chair of the Healthcare Governance and Risk Management Committee. Professor Murray’s term with the Board would come to an end at the end of September. The Committee thanked Professor Murray for the wisdom and knowledge she had bought to the Committee over the years.

13. MATTERS ARISING

13.1 The Committee noted the updates to the cumulative action note. It was noted that the mandatory update would come to the October meeting. Dr Bryce reported that she had met with the Chair of the Finance and Performance Review Committee to discuss the way in which business cases were presented. She had explained that it was important to make clear which cases were linked to statutory compliance.
13.2 Mr Egan explained that he was concerned that staff were not complying with the working time directive. Committee members felt that there should be a mechanism to check the number of hours that staff had worked. It was agreed that the Chair would discuss this with Alan Boyter, Director of Human Resources and Organisational Development. The Chair reported that if executive directors could not attend meetings a deputy should be arranged to attend in their place.

PM/AB

14. EMERGING ISSUES

14.1 Dr McCallum explained that there had been a recent health protection/infection control issue within a local dental practice. She introduced Brett Duane and Emma O’Keefe (Speciality Registrars in Dental Public Health) to the Committee. Mr Duane explained the health protection issue. He advised that a support plan had been put in place and all patients at the practice had been informed. An NHS 24 helpline had been set up to deal with patient enquiries. He explained that NHS Lothian would be working with other Health Boards to share learning.

14.2 Members asked whether this could be happening at other practices. Mr Duane explained that a new inspection process was being developed where the focus of inspections would be on observing practice. He advised that ways of providing support to other dental care professionals was also being considered.

14.3 It was agreed that a further update should come back to the Committee in December 2012.

AKM

15. PERSON CENTRED CARE

15.1 Draft Process for Assuring Confidential Qualitative Data

15.1.1 Dr McCallum spoke to the draft Process for Assuring Confidential Qualitative Data. It was agreed that this report should be shared with the Area Clinical Forum and the Staff Governance Committee. Dr Farquharson suggested adding a one page summary sheet with key messages.

15.1.2 The Committee agreed that there was a requirement for guidance on maintaining confidentiality and anonymity in qualitative data generated by NHS Lothian intended for circulation in the public sphere. The Committee did not approve the content of the guidance at this stage as this was a draft document.

15.2 NHS Lothian Self-Directed Support Test Site Report

15.2.1 Professor McMahon and Ms Cherry attended the meeting to speak to the report. They explained that NHS Lothian had received funding from the Scottish Government to deliver a three year test site exploring the implications of Self Directed Support for Health Boards and their patients, this also included NHS Fife. The Committee noted the key points and the challenges. Ms Cherry highlighted that this was a key opportunity to work with local authorities and the third sector. NHS Lothian would host a national conference reporting on the work of the test site.
and exploring the possible impact it may have on healthcare. This was currently in planning for 18th September 2012.

15.2.2 Members of the Committee commented that the pilot size was small and further data would be required. There were also concerns that patients may not be fully informed of exactly what they could access. Dr McCallum also referred to advocacy and explained that some patients would need further support to make informed decisions. The Chair suggested liaising with staff in communications to ensure that the public was well sited on the support available to them.

15.2.3 Ms Macfarlane asked about user involvement in the Self Directed Support conference and about self carers.

16. **SAFE CARE**

16.1 **Healthcare Associated Infection Update**

16.1.1 Dr McCallum spoke to the report on Healthcare Associated Infection. She went through the key issues and advised that there had been a rise in reported *Clostridium difficile* Infection in June 2012 that was distributed across the organisation. This was being addressed and a problem assessment group had been established to review the rise in cases and explore the requirement for further improvements in patient care, patient pathways and in the clinical environment.

16.1.2 Dr McCallum reported that hand hygiene compliance rates were consistently improving. The national hand hygiene audit report, published in May 2012, indicated that NHS Lothian was achieving a hand hygiene compliance of 97%, which exceeded the national compliance rate of 96%. She advised that the standard operational procedure for the escalation of non-compliance with hand hygiene had been approved in principle by the Local Negotiating Committee. Mr Egan raised concern regarding the escalation process and felt that this should be led by executive directors and should continue to come to this Committee.

16.1.3 There followed some discussion on the dress code policy and members agreed that this should be clarified and staff should be made aware of the rules in relation to clothing and jewellery.

16.1.4 The Healthcare Governance and Risk Management Committee agreed to support the activities outlined in the report, under the overall direction of the Director of Public Health and Health Policy, in delivering the agenda to reduce and manage Healthcare Associated Infection.

16.2 **Scottish Patient Safety Programme (SPSP) Highlights**

16.2.1 Annette Henderson gave a presentation to the Committee on the Scottish Patient Safety Programme (SPSP). The Committee noted the report and commended the work of the Scottish Patient Safety Programme. Members suggested that the work of the Scottish Patient Safety Programme be highlighted in Health Link.
16.3 The Management of Significant Adverse Events - Learning from NHS Ayrshire and Arran

16.3.1 Dr Farquharson spoke to the report on the Management of Significant Adverse Events - Learning from NHS Ayrshire and Arran. He explained that the Cabinet Secretary for Health, Wellbeing and Cities Strategy had instructed Healthcare Improvement Scotland to carry out a review of the clinical governance systems and processes in NHS Ayrshire & Arran, in particular those that related to their management of critical incidents, adverse events, action planning and local learning. The Committee went through the report and noted the recommendations and the Ayrshire and Arran Key Report Findings.

16.3.2 The Committee noted that the report would need to be updated to take into account the new management structure in NHS Lothian. Mr Egan also emphasised that it was important that staff always know who to contact if they have any concerns regarding adverse events. Dr Winstanley suggested forming a small working group with members of the committee, to discuss adverse incidents and the common themes.

17. EFFECTIVE CARE

17.1 Quality Dashboard

17.1.1 Dr Farquharson referred to the Quality Dashboard in Appendix 1. Members suggested adding more colour but commented that this would be a useful way of presenting the information. Dr Bryce asked whether it would be possible to capture more information on compassionate care.

18. OTHER MINUTES: EXCEPTION REPORTING ONLY

18.1 The Committee noted the following sets of minutes:

- Minutes of the Area Drug and Therapeutics Committee 25/05/2012
- Minutes of the Clinical Management Group: 08/05/2012
- Minutes of the Health and Safety Committee: 28/05/2012

19. EXCEPTION REPORTING ONLY

19.1 The Committee approved the following items:

- NHS Lothian Quality Improvement Strategy 2011-2014
- Quality Improvement teams Annual Report
- Compliance with Neurology Standards
- NHS Lothian Public Protection Services Update
20. ANY OTHER COMPETENT BUSINESS

20.1 The Chair thanked the Committee, she had enjoyed working with the Committee and wished everyone well. The Chair thanked Mrs O’Connor for her support as administrator of the Committee. She also thanked Mr Egan for all his hard work and support for the Committee as this was also his last meeting.

21. DATE OF NEXT MEETING – Tuesday 2 October 2012 to be held from 9am – 11am in Meeting Room 7 at Waverley Gate

Other Dates for 2012:
4 December 2012
All to be held from 9am – 11am in Meeting Room 7 at Waverley Gate
NHS LOTHIAN

SERVICE REDESIGN COMMITTEE

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

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

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

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

Declaration of Financial and Non-Financial Interest

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

1. Minutes of the Previous Meeting

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

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

2. Matters Arising from these Minutes

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

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

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

3. Telehealth and Telecare in Lothian

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

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

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

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

3.4 The Committee agreed to support the recommendations subject to the inclusion of the following additional points:

- The inclusion of a matched hard economic analysis of costs under item 2.2.
- The addition of linkages with the integration agenda and the clinical strategy under item 2.4.

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

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

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

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

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

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

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

5. **Clinical Strategy**

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

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

5.3 The Chair agreed to write to Dr Farquharson copying in Mr Walker, Chair of Finance and Performance Review Committee and Professor Murray, Chair of the
Healthcare Governance and Risk Management Committee to request the following:

- a brief paper on waiting times for the next meeting detailing the Board’s approach to developing long term sustainable solutions to meet waiting times.
- An analysis of the organisation’s response to the current Legionella incident, and what was lessons there were from this for service redesign.  

Ms Anderson left the meeting.

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

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

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

6.3 Dr Hardie explained that Dr McCallum had requested the following amendments to the proposed remit:

- include in the first point “the equitable provision of prevention, treatment and care”.
- include “provide assurance that feedback from patients and public representatives was regularly sought on the outcome of service redesign.”

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

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

7. Items for Information

7.1 Lean in Lothian Annual Report – The Committee noted the good examples of work detailed within the previously circulated Lean in Lothian Annual Report.
The Committee requested that the Modernisation Team bring forward a report on the progress of LEAN and its sustainability for the future.

**7.2 Minutes of the Transport Meetings held on 15 March 2012** – The Committee noted the previously circulated minutes of the Transport meetings held on 15 March 2012 and the information detailed therein.

**8. Date of Next Meeting**

8.1 It was noted that the next meeting of the Committee would be held on Monday, 8 October 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the Meeting of the Staff Governance Committee held at 2.00pm on Wednesday, 29 August 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr E Egan (Chair); Mrs J McDowell; Mr I Whyte; Mrs M Hornett and Dr C J Winstanley.

In Attendance: Miss L Baird; Dr E Doyle (for item 3); Dr C Kalman; Mrs R Kelly; Mr S McLaughlin and Mr A Notman.

Apologies for absence were received from Mr S Wilson; Dr D Farquharson and Mr A Boyter.

Declaration of Financial and Non-Financial Interest

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

13. Minutes of the Previous Meeting

13.1 The Minutes of the previous meeting of the Staff Governance Committee held on 30 May 2012 were approved as a correct record.


14.1 The Committee discussed the previously circulated report on the annual appraisal system for career grade doctors and the ongoing work to support the introduction of relicensing and validation of doctors by the General Medical Council.

14.2 Members noted that if a shortfall of appraisers occurred the current resource would be utilised to make up the shortfall. Concerns that a small cohort of staff would be over extended were discussed.

14.3 It was determined that doctors would be given the opportunity to defer for the period of a year; ultimately non compliance would result in removal from the medical register. Overall doctors had become resigned to the prospect of the relicensing process.

14.4 Resource consequences surrounding additional support for Dr Farquharson, Medical Director during the period of appraisal were under consideration. The
Chair advised that it was imperative that Dr Doyle and Dr Farquharson advised the Committee of their requirements at the earliest convenience.  

Dr Doyle left the meeting.

15. Matters Arising

15.1 eESS Human Resources update – Mrs Kelly informed the Committee that the new eESS Human Resources go live date had been deferred until it was deemed fit for purpose. NHS Lothian remained committed to the implementation of eESS however given the recent issues surrounding waiting times and the management culture a decision to delay going live until March 2014 was being suggested. Mrs Kelly commented that the delay would benefit NHS Lothian and enhance the functionality of eESS including the interface with the new ePayroll System. It was agreed that Mrs Kelly would investigate developing Empower as an interim measure.

15.2 Assessing the Equality Impact of Workforce Policies – In response to a previous request regarding the rapid impact assessment of HR Policies the Committee were advised that the remaining HR policies would be assessed within the next 6 to 12 months. It was noted that a number of the policies had pre dated the rapid impact assessment process therefore exempting them from assessment at the time of their implementation.

15.2.1 Following a brief discussion on how to address policies that fell out with the remit of the Committee, Members accepted that detailed discussion at a future meeting was required to identify a suitable home for these policies. Ms McDowell and Mr Egan would pick this matter up out with the meeting.

15.2.2 The Committee agreed to support the recommendations detailed within item 2 of the report.

16. Revised Staff Governance Standard

16.1 The Committee noted the 4th Edition of the Staff Governance Standards launched in June 2012. There was some discussion surrounding the main changes to the standards and proposals to raise staff awareness.

16.2 The Committee discussed the position of the Employee Director on the Remuneration Committee and conflicts of interest that may arise. Mr Egan advised that he had recommended his successor remain on the Committee as a form of assurance and creditability. The Chairman agreed to take forward the recommendation at the September 2012 Board meeting.

16.3 Plans to revamp how Boards monitor against the standard are anticipated by autumn 2012. Mrs Kelly agreed to bring a report on this matter to a future meeting.

16.4 The Committee agreed to support the recommendations detailed within the report.
17. **Review of Management Culture – Update**

17.1 The Committee received a verbal update on the recommendations following the Bowles report. It was determined that the key priorities were:
- Vision and values for all staff.
- Management capacity and competency.
- Governance of information provided to Board Committees to enable them to discharge their duties.
- Staff communication through various formats.

17.2 There was some discussion on the consequences of identifying managers who did not hold the necessary skills to carry out their duties following the review of management competency. Assurances that employment rights would not be affected by the review were received.

17.3 The Committee agreed to note progress to date.

18. **NHS Lothian Statistical Information on Staff Incidents for April to June 2012**

18.1 The Committee noted the standard quarterly report for statistical information on staff incidents within NHS Lothian and the proposed RIDDOR consultation.

18.2 Concerns that the failures to follow process had resulted in staff injury were reiterated. Members went on to specifically discuss recurring issues within the Laundry.

18.3 It was noted that the Health and Safety Annual Report would be brought forward for consideration at the next meeting.

19. **Review of Board Appeals Process**

19.1 The Committee noted the previously circulated update on the outcome of the review of the board of appeals process commissioned by the Director of Human Resources and Organisational Development and the Employee Director.

19.2 Members were advised that the next steps would be to:
- Address timescale issues to ensure that targets are achievable.
- Set standing dates for appeal panels.
- Review the disciplinary Policy.
- Produce standard paperwork.
- Implement a debriefing process following appeals.
- Provide training for Non-Executives through the Central Legal Office, as required.

These recommendations will now be taken forward.
19.3 The Committee agreed to be mindful of the demands that the Non-Executives faced ensuring that duties were split equally rather than taken on by a small cohort. Mrs Kelly agreed to monitor the workload for Board Appeals and feedback the outcome to Dr Winstanley out with the meeting. RK

19.4 In response to concerns raised regarding the consistent application of suspensions and notification of suspensions across NHS Lothian, Mrs Kelly agreed to take this matter forward with colleagues out with the meeting. RK

20. National Fraud Initiative

20.1 The Committee were advised that it was time to participate in the mandatory National Fraud Initiative anticipated in October 2012. All staff would be informed in advance of the proposed work through articles in the team brief, payslips, the intranet and the NHS Lothian website.

21. Items for Information

21.1 Health and Safety Committee Minutes – the Committee noted the minutes of the Health and Safety Committee meeting held on 29 May 2012 and the information therein.

21.2 Confidentiality and Anonymisation of Qualitative Data Guidance – the Committee noted the previously circulated Confidentiality and Anonymisation of Qualitative Data guidance for information.

22. Any Other Competent Business

22.1 Chair of Staff Governance Committee – The Committee acknowledged that this would be Mr Egan’s last meeting as Chair of the Staff Governance Committee. Members proceeded to thank Mr Egan for his commitment and support during his term of office.

23. Date of Next Meeting

23.1 It was noted that the next meeting of the Staff Governance Committee would be held on Wednesday, 31 October 2012 at 9.30am in Meeting Room 7, Waverly Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the West Lothian Sub Committee held on 21 June 2012 at 2 – 4pm in Strathbrock Partnership Centre.

Present

- Theresa Douglas (TD) Chair, West Lothian CHCP
- John Richardson (JRi) Public Involvement Representative
- Lorraine Gillies (LG) Community Planning & Development Manager
- John Reid (JRc) Housing Policy and Development Manager
- Pat Donald (PD) Acting AHP Manager, West Lothian CHCP
- Frank Toner (FT) Councillor, West Lothian Council
- Jennifer Scott (JS) Head of Social Policy, WLC
- James McCallum (JMc) Clinical Director
- Julie Cassidy (JC) Public Involvement Co-ordinator
- Alan Bell (AB) Senior Manager Social Policy
- Marion Christie (MC) Head of Health / General Manager, WLCHCP
- Lindsay Seywright (LS) Assistant Principal West Lothian College
- Ian Buchanan (IB) Chair, Public Partnership Forum Health & Care

Apologies

- Jane Houston (JH) Partnership Rep
- Claire Kenwood (CK) Assoc. Clinical Director
- Moira Niven (MN) Head of Education Services
- Jane Kellock (JK) Manager, C&F/Health Improvement
- Gill Cottrell (GC) Chief Nurse
- Marjory Simpson (MS) Administrative Manager
- Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
- Raj Rashid (RR) Together for Health
- Jim Forrest (JF) CHCP Director
- Stuart Murdoch (SM) Scottish Ambulance Service Rep
- Morag Bryce (MB) Consultant in Public Health
- Graham MacKenzie (GMacK) Director Of Operations

In Attendance

- Rhona Anderson (RA) CHCP Development Manager
- Grace-Ann Wallace (GAW) Education Rep for MN
- Nick Clater (NC) Multi Agency Adult Protection Service Development Officer, West Lothian Council (for item on Lothian Independent Advocacy Plan)

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.

5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**
   The minutes of the meeting held on the 26/04/2012 were approved as being an accurate record.

6. **MATTERS ARISING FROM PREVIOUS MINUTE**
   There were no matters arising from previous minutes.

7. **CONFIRMATION OF ACTION POINTS**

   **Item 15  Information on delayed discharges**
   AB will ensure any future commentary is more comprehensive.

   **Psychological Therapies**
   Reporting has been suspended at the moment. Report will be available later in the year.

   **Item 12.0 SOA 6**
   AB to seek clarity from JH regarding query about hospices.

   **Covalent reports**
   AB has discussed with IT. Plan is in place. Trial run will take place before next presentation.

   **Item 16.0 GMS**
   Action complete.

8. **MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING**
   No minutes available. However JC reported that the PPF is reviewing its action plan and renewing for 2012/14. This will be brought to the next Sub-Committee for approval.

9. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**
   Minutes of meeting of 8 March 2012 were noted. Page 2 TD commented on the terminology used in paragraph 192 (Challenging Behaviour Practice) and expressed concern that this form of words was not person-centred and could be considered stigmatising. MC and JMcC to feed this back to the group.

10. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT**
    Jennifer explained that the meeting on 14 June was devoted to consultation on the joint commissioning plan for Children & Families and that a final draft plan will be circulated. JS and AB to discuss further.

11. **MINUTES OF CHCP COMMUNICATION GROUP**
    No minutes available as meeting was cancelled.
TD stated that this consultation exercise was incredibly important for the CHCP. TD emphasised that the appendix did not constitute a formal response but illustrated initial thoughts from the management team which had been collated when the original timescale of July had been in place. The deadline has since been extended until 11 September.

MC stressed the need for open dialogue so that comments can be pulled together for West Lothian.

TD pointed out that many of the features proposed in the document already existed in West Lothian eg health & social care partnership, jointly accountable post, agreed outcomes, equal representation from Health and Council on CHCP Board etc.

On the first question regarding the focus of the proposals it was agreed that it would be detrimental in West Lothian to focus on age bands and that all current groups should be included.

IB reported that the consultation document had been on the agenda of the last PPF meeting and would be discussed again in August. Some themes had been established through this initial discussion, namely

- Question of public involvement – will NHS Lothian’s participation standard be extended?
- Where does the voluntary sector fit?
- Potential for culture clash between partners (Health and Social Care) regarding commissioning if not addressed at the beginning of the process.
- Communities are not always geographic – demographic changes apply to people and doctors (eg retirement). Document proposes additional layer of organisation involving GPs. Perhaps staff other than doctors may take on more duties therefore the role of GPs should not be overburdened. How would other roles fit around this?

TD thanked IB for his very helpful comments.

JMc stated that locally there was no interest in creating an extra level of bureaucracy and that he hoped that we would build on what already works well in West Lothian.

LS reported that work was ongoing between the College and Council in relation to the strategic assessment exercise and that the College will be offering Health & Social Care courses instead of separate Health and Social Care courses. There is also a sizeable input regarding health and wellbeing in the Curriculum for Excellence.

LG stated that she would add comments to the response regarding strategic assessment and community consultation.

AB also stated support for local determination over being prescribed centrally.
JC mentioned the recent SG consultation regarding the AHP national delivery plan. It was agreed that AHPs should be at the core of the CHCP and that both should mirror each other.

JRe highlighted the relationship between housing and health in relation to the support of older people eg housing with care, supported housing etc.

Homelessness was also recognised as connecting with the health and wellbeing agenda.

JMc stated that the West Lothian experience was different from other areas within Lothian as the CHCP has already delivered a health and social care partnership with many of the elements outlined in the consultation document. He suggested that consideration should be given to what happens to people as they travel through services and their pathways. It was recognised that the proposals provided opportunities in relation to the use of community hospitals as well as other acute services.

TD concluded that this was an exciting time and the consultation provided a fantastic opportunity to develop the CHCP further. TD encouraged members to feed in to the consultation process with comments.

13. **CARE ACTIVITY NETWORK (CAN) GOING FOR GOLD EVENT**

The main objective of the West Lothian Care Activity Network (CAN) is to increase levels of physical activity within care settings (care homes, day care, sheltered housing and care at home). Following on from the success of the first West Lothian CAN Going for Gold event held in May 2011, the network organised another event in May 2012.

The legacy from the event in 2011 has resulted in more care settings actively participating in activities throughout the year, increasing levels of physical activity and impacting positively on physical and mental wellbeing for older people.

JS spoke to the report outlining that the event had been a great success and had also involved young people.

The Sub Committee agreed the recommendations and JS was asked to take the congratulations of the Sub Committee back to the team.

At this point in the meeting it was agreed to change the order of the agenda and take the item on the Lothian Independent Advocacy Plan when Nick Clater arrived to speak to the report.

14. **CARE INSPECTORATE PRACTICE GUIDE: INVOLVING CHILDREN AND YOUNG PEOPLE IN IMPROVING CHILDREN’S SERVICES**

JS highlighted that West Lothian was featured in the report as an example of good practice on pages 21 and 22. JS also reported that the peer mediation project had received an award.

The Sub Committee agreed the recommendations and that the LAC strategy group will take this publication forward and develop an action plan.
15. SUPPORTED TARGETED PHYSICAL ACTIVITY
JMc apologised that he had been unable to attend the last Sub Committee meeting when this was discussed. He explained that the project adopted an upstream approach. Evidence demonstrated that First Steps and related projects (COPD, Mental Health) achieved very good outcomes in relation to blood pressure, weight, respiratory capacity and mental health. The project has also succeeded in making exercise accessible for a priority population.

JRi asked how many West Lothian Leisure outlets there were in West Lothian and queried whether community facilities may be able to be used.

JMc explained that currently all of the West Lothian Leisure facilities plus Strathbrock Partnership Centre, Bathgate Primary Care Centre and Ward 17 in St John’s were used. The Pitstop is also used and it is intended to use West Lothian Leisure staff to deliver in community centres in the future. JMc also explained that not all exercise was gym related and could include swimming, walking groups etc.

LS asked if there might be opportunities to link with the College to increase active ways to improve health.

GAW outlined work that was ongoing around physical activity and children involving Education, Health Improvement Team and West Lothian Leisure.

TD queried the extent of public involvement that has taken place and that for audit trail purposes this needed to be reflected in future reports. It was agreed that JMc and JC would discuss further.

The Sub Committee agreed the recommendations subject to the following amendments:

- when gaining buy in from target groups as outlined in the second bullet point the public/local people should be more actively involved
- that the West Lothian Leisure report on the social return on investment should be considered for evaluation purposes
- numbers of people going through the project and percentages of those who continue to exercise should be included.

16. LOTHIAN INDEPENDENT ADVOCACY PLAN 2012-16
NC spoke to the report and outlined the background to the development of the plan which had been carried out by the Lothian Independent Advocacy Plan Steering Group. NC highlighted that it had been agreed that

- the action plan needed to link more to an outcome-based approach
- information needed to be provided about advocacy and agencies for a wider population
- wider training needed to be provided for staff
- advocacy needed to be made more accessible for people using social media
- continue to identify gaps eg advocacy for people with drug and alcohol problems, homeless, children and young people, patients rights groups, hard-to-reach groups etc.
NC also reported that the action plan will be monitored on a monthly basis and reviewed annually.
The Sub Committee agreed the recommendations subject to the following amendments –

- the plan should be outcome based
- the plan should be brought back to the Sub Committee in 6 months.

17. **TOGETHER FOR HEALTH (T4H)**
RR had been unable to attend the meeting to speak to the report. TD praised the paper and highlighted the good work that is being carried out by the project. It was agreed that MC will feed back comments to RR and advise that outcome measures should be included in the next report.

18. **ANY OTHER COMPETENT BUSINESS**
TD thanked everyone for their support during her period as Chair and encouraged members to make the most of the opportunities for the CHCP in the future.

MC thanked TD for her strong leadership and direction and on behalf of the Sub Committee wished her well for the future.

19. **DATE, TIME OF NEXT MEETINGS**

CHCP Sub Committee meetings at 2pm – 4pm

2012

30.8.2012
18.10.2012
06.12.2012

Meeting closed at 3.50pm
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD held within THE STRATHBROCK PARTNERSHIP CENTRE, BROXBURN, on TUESDAY, 29 MAY, 2012.

Present – Theresa Douglas (Chair), Jane Houston, Anne McMillan and Frank Toner

Apologies – Shulah Allan, Mike Boyle, Janet Campbell and John McGinty

In Attendance – Jim Forrest (CHCP Director), Marion Christie (Head of Health Services), Gill Cottrell (Chief Nurse), Lynne Hollis (Associate Director of Finance, NHS Lothian), Dr. James McCallum (Clinical Director), Fiona Duffy (Corporate Communications, West Lothian Council), Kiera Byrne (Lanfine Unit, NHS Lothian); and John Richardson (PPF)

1. ORDER OF BUSINESS

   The Chair welcomed Councillors McMillan and Toner to their first Board meeting, and wished them well for the future.

   The Chair advised that Shulah Allan was to be replaced as an NHS Lothian member of the Board by Morag Bryce, and that a further appointment by NHS Lothian would be confirmed in due course as her own replacement.

   The Chair reminded members that the intention was that Councillor Toner would be taking the Chair with effect from 1 July, or following his later appointment to the Board of NHS Lothian, by the Scottish Ministers.

   Finally, the Chair advised that agenda item 15 (Lanfine Redesign) would be taken immediately after agenda item 8.

2. MINUTE OF MEETING OF THE BOARD – 10 APRIL 2012

   The Board approved the minute of its meeting of 10 April 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 item 1 (NHS Lothian Breast Screening Outcomes) should be deleted, accepting the advice of the Chair that the detail of information requested could not be provided.
3. In relation to item 12 (Falls Co-ordinator), to note that further information had been attached to the Running Action Note as an appendix, and to accept the advice of the Chair that this item should be deleted since the level and detail of information requested could not be provided.

4. To agree that items 1, 4, 7 and 12 should be marked as completed and should be deleted.

5. To agree that the remaining items on the Running Action Note should be carried forward.

4. MINUTE OF MEETING OF CHCP SUB-COMMITTEE – 8 MARCH 2012

The Board noted the minute of the meeting of the CHCP Sub-Committee held on 8 March 2012.

5. MINUTE OF MEETING OF THE PRIMARY CARE Joint MANAGEMENT GROUP – 8 MARCH 2012

The Board noted the minute of the meeting of the Primary Care Joint Management Group held on 8 March 2012.

The Board noted further information provided in relation to paragraphs 190.2 (Diamond Jubilee), 194 (PCCO Responsibility for PVG Policy), 196 (LUCS Update), and 197.2 (Paediatric Services at St. John’s Hospital).

6. MINUTE OF MEETING OF THE CHCP COMMUNICATIONS GROUP – 7 FEBRUARY 2012

The Board noted the minute of the meeting of the CHCP Communications Group held on 7 February 2012, and further noted that any proposed change to the CHCP logo would require to be brought to the Board for its consideration.

7. LANFINE REDESIGN

The Board considered a report (which had been circulated) by the Head of Health Services explaining the service redesign project launched in May 2010 for the Lanfine Unit, as recorded in the Lothian Physical and Complex Disability Strategy.

The report outlined the service provided by the Unit, the consultation process that had been followed to inform the service redesign, and the key areas for action which had been identified, and which were to be delivered through a Project Board and Working Groups.

The report went on to provide more information about the areas identified for improvement, the way in which the Board and Working
Groups were planning to implement the redesign, and identified the key risks in implementing the service redesign.

The Board noted that the Project Plan would be submitted to NHS Lothian’s Improving Care, Investing in Change Committee on 6 June 2012, and was expected to be in place by the end of September 2012.

Decisions

1. To endorse the:

(a) development of a coordinated integrated network of high quality, responsive and flexible services for people with Progressive Neurological Disorders and their families, with clear referral pathways, in partnership with Local Authorities and the third sector

(b) development of an ethos which is explicitly inclusive of families and carers as equal partners,

(c) reconfiguration of the Lanfine service to become as multifunctional as feasible within available resources while maintaining and developing those elements of the current service which work well and are not adequately provided elsewhere in the network. A broadened multifunctional service might include inpatient, outpatient, day patient, respite, drop-in, crisis care, inreach and outreach components.

2. To agree that a report should be brought to the Sub-Committee in October 2012.

8. CHAIR’S REPORT

The Board considered a report (which had been circulated) by the Chair informing Board members of CHCP activity carried out by her since the last Board meeting.

The report outlined the visits which had taken place to the Drug Treatment and Testing Order Team and the Criminal Justice Supported Tenancies Team; a presentation made to the Journal Club on her role as Chair of the CHCP; and meetings of the St. John’s Hospital Stakeholder Group.

The report concluded by reminding members that this was to be her final meeting, and she recorded her thanks in particular to former Councillor Ellen Glass who served as Member and Vice-Chair of both the CHCP Board and the Sub-Committee, and to former Councillor John Cochrane for his contribution as a member of the Board.

The report concluded by recording her thanks to all CHCP Board members and supporting officers for their assistance, and for their patience, support and good humour.

Decisions
1. To note the contents of the report.

2. To note the Chair’s regret at her departure and her best wishes to the whole CHCP for the future.

9. REVIEW OF NHS PHARMACEUTICAL CARE OF PATIENTS IN THE COMMUNITY IN SCOTLAND

The Board considered a report (which had been circulated) by the Clinical Director outlining the consultation by the Scottish Government on the review of NHS Pharmaceutical Care of Patients in the Community in Scotland, and giving details of the West Lothian CHCP response.

The report summarised the review which was being carried out by the Scottish Government, and the questions in the survey which had been put out for public consultation.

It explained the consultation process which had been followed within the CHCP and the proposed response by the CHCP was contained in Appendix 1 to the Report.

Decisions

1. To note the detail of the response, the breadth of opinion sought and its submission on 4 May 2012.

2. To note that the final report will be submitted to the Scottish Government in October 2012.

10. 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 explained the conclusion of the redesign process of council services within the CHCP, following the temporary management arrangements which had been in place for over 18 months.

It confirmed that consultation had taken place with the Trade Unions, staff briefings had taken place, and appointments had been and would be made to the newly-structured service by the application of the council’s Workforce Management Policy and Procedure.

An illustration of the finalised senior management structure was attached as an appendix to the report.

Decisions

1. To note the redesign of council services within the CHCP.
2. To note that the redesign completed a formalisation of a structure which had been in place already for approximately 18 months.

11. 2011/12 REVENUE BUDGET MONITORING REPORT AS AT 31 MARCH 2012

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services containing a joint report on financial performance in respect of CHCP figures for the period to 31 March 2012.

The report advised that the anticipated draft out-turn for the CHCP as a whole was for an under-spend of £1.647m.

In relation to the overall social policy budget, the forecast was for an under-spend of £2.060m. In relation to the share of the CHCP budget for NHS Lothian, it was forecast that the budget would break even.

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

Decisions

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

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

3. To agree that the Chair and the CHCP Director would investigate the possibility of providing in future reports a break down of prescribing budget and spending by CH(C)P areas to allow comparisons to be made.

4. To congratulate all CHCP staff on the budget out-turn achieved.

12. INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND – CONSULTATION ON PROPOSALS

The Board considered a report (which had been circulated) by the CHCP Director updating the Board on the Scottish Government proposals to integrate health and social care services.

The report set out the background to the consultation which had been started, the proposals made for requiring local authorities and health boards to set up Health and Social Care Partnerships, and the key objectives of the proposals.

The consultation document was attached to the report as an appendix, and the report went on to highlight the key elements of the proposals.
The report concluded by explaining that the West Lothian CHCP had a long history and proven track record of successful partnership working, and was well placed to respond to and implement the new arrangements.

As a result, the CHCP Director had been invited to join a short life working group to consider the practical effects of further integration and potential implications for financial and other governance for both partners.

The CHCP Director advised the Board that if the Scottish Government insisted on the deadline for consultation responses then there would not be sufficient time to bring the draft response back to a Board meeting, but that members would be sent a copy by e-mail for comment prior to submission.

He further advised that there was a possibility that the Scottish Government would extend the deadline for consultation responses to be sent, and if that were the case then it would be possible to bring the draft response to the next meeting of the Board in August 2012.

Decisions

1. To note the Scottish Government proposals to progress the integration agenda.
2. To support the continued work to further integrate health and social care services in West Lothian.
3. To note that in the event that a present consultation response deadline was unchanged, Board members would be invited to comment on a draft response by e-mail, since the next Board meeting fell after that deadline.
4. To further note that in the event that the consultation deadline was extended by a month, then a draft response would be brought to the Board meeting in August for consideration.

13. RESHAPING CARE FOR OLDER PEOPLE – JOINT COMMISSIONING PLAN

The Board considered a report (which had been circulated) advising the Board of the development of a draft joint commissioning plan for older people’s services in West Lothian.

The report explained the definition and background to strategic and joint commissioning, the aims of the joint commissioning plan for older people’s services, its focus on establishing health and social care service priorities across West Lothian, and the aim of addressing the demographic challenge of older people living longer, remaining active for longer with increased and changing expectations at a time when
public resources were being reduced.

The draft Older People’s Joint Commissioning Plan was attached as an appendix to the report.

The report concluded by advising that a wide consultation process would be followed, engaging with service users, carers, providers, partner agencies and community representatives, and that the plan would then be finalised and reported through appropriate governance arrangements for approval.

Decisions

1. To note the draft Older People’s joint commissioning plan.

2. To endorse the progression of this through a wide consultation process which will engage with service users, carers, providers, partner agencies, and community representatives.

3. To note that there remained areas of the draft Plan for which further detail was still required before final approval (e.g., personalisation, setting targets and desired outcomes).

4. To note and agree that any changes proposed to be made to the draft Plan should be brought to the Board for consideration.

5. To note that in any event the draft Plan would be brought back to a meeting of the Board in 6 months time, and every 6 months thereafter.

6. To note that the draft Plan would contribute to the present agenda for further integration of council and health services.

7. To note Jane Houston considered that it was imperative that the majority of the services to be commissioned and the majority of the public funds to be used should be through public sector staff.

14. 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 work on Delayed Discharge and noted the praise which had been posted on the Scottish Government website for the approach taken in West Lothian; the successful application to the Scottish Government Violence Against Women Fund; the CHCP website; and the Foster Care Fortnight.

The report concluded by conveying thanks to the retiring Chair from CHCP staff for the way in which she had fulfilled her role over the preceding four years, recognising her professionalism, leadership and commitment to the delivery of high quality health and social care
services to the people of West Lothian.

Decisions

1. To note the excellent performance by West Lothian CHCP in relation to managing hospital discharge.

2. To note the successful application to the Scottish Government Violence Against Women Fund.

3. To note the increasing usage of the CHCP website.

4. To note the Foster Carer Recruitment Campaign.

5. To record the Board’s appreciation for the valued service of the retiring CHCP Chair, and to wish her well for the future.
CHAIRMAN'S REPORT

1. Internal

1.1 Interviews for Chief Executive

On 31 July I chaired a panel comprising Non-Executive Board members and an external adviser to interview candidates for the post of NHS Lothian Chief Executive. The panel selected Mr Tim Davison, Chief Executive of NHS Lanarkshire (and interim Chief Executive of NHS Lothian) who has accepted the offer.

1.2 New Board Members

During this period I had introductory meetings with most of our eleven newly appointed Board members.

1.3 Opening of Musselburgh Health Centre

On 28 August I hosted the opening of the Musselburgh Health Centre by the Health Minister, Michael Matheson.

1.4 MSP Briefing

Our quarterly briefing session for MSPs in our region took place on 7 September, with a good attendance and wide ranging discussion.

1.5 Vice Chair

Eddie Egan, the Vice Chair, finishes his term on the Board at the end of September. I wish to record my immense gratitude to Eddie for the five and a half years that he has served in that role. His knowledge of the NHS is of course unrivalled, and as my Vice he has been wise, loyal, and supportive.

The role of the Vice Chair is principally to represent the Chair when he/she is unavailable. Expressions of interest in the role are sought, and should reach my office by email by 5 October 2012. The appointment carries no additional remuneration. If there is more than one applicant, an interview process will be arranged.
2. **External**

2.1 **LEAP at Malta House**

During this period I supported management colleagues in discussions with the Church of Scotland regarding their intended sale of Malta House. The Lothian and Edinburgh Abstinence Programme (LEAP) is based at Malta House. I also had contact at their request with neighbours’ representatives and with the City of Edinburgh Council.

2.2 **New Council Leaders**

I have been aiming to visit the four new council leaders in our region since the May elections, but with busy diaries this is taking time. On 21 August I visited Councillor McGinty at West Lothian Council. On 11 September I met Councillor Burns at City of Edinburgh Council. The main focus of both discussions was health and social care integration.

2.3 **Military Liaison**

Colonel David McArthur, the Army’s liaison officer at the Scottish Government, came to see me at his request on 27 August. We discussed LEAP, Veterans First Point, the Smart centre, attached military doctors, serving reservists, and transition of retiring service personnel to local health support.

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Charles Winstanley  
Chairman  
12 September 2012
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 August 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 The Board is asked to note:

- The overspend of £1.8m for the five months to the end of August 2012; and
- The Corporate Management Team (CMT) are undertaking the detailed scrutiny of the financial position, including savings delivery and actions required to deliver financial balance.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an overspend of £1.8m for the first five months of the financial year. This comprises an operational overspend of £0.3m and 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 31st August 2012

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Baseline</th>
<th>Outstanding Efficiency Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>University Hospital Division</td>
<td>(1,256)</td>
<td>(321)</td>
<td>(936)</td>
</tr>
<tr>
<td>CHPs/CHCP/PCCO</td>
<td>1,528</td>
<td>1,607</td>
<td>(79)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>(1,062)</td>
<td>(591)</td>
<td>(471)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(968)</td>
<td>(968)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Under/(Over) Spend</strong></td>
<td><strong>(1,759)</strong></td>
<td><strong>(273)</strong></td>
<td><strong>(1,486)</strong></td>
</tr>
</tbody>
</table>
Baseline position

3.2 The baseline financial position improved by £0.4m during the month, reflecting the continuing underspend on prescribing and the release of non-recurring funding to offset capacity pressures. These benefits were offset by increases in clinical costs, ongoing pressures in facilities and the impact of unplanned activity outwith NHS Lothian.

3.3 Prescribing (£1.9m underspent) continues to support the overall financial position. Generic price reductions implemented by Scottish Government Health Directorates (SGHSCD) in April and additional benefits as drugs come off patent are the key drivers. Further price benefits are expected and have been reflected in the forecast year end outturn of £5.2m. The budget will be formally reviewed in light of these factors, which were not known at the time the financial plan was agreed and the budget was set. It is proposed that any agreed reduction to the budget will be offset against the residual efficiency savings gap of £4.8m.

3.4 The financial implications associated with the system wide pressures on core capacity remain a concern. Following agreement with the Unscheduled Care Board (UCB), funding of £1.6m was released during August, improving the year to date results by £0.5m. The UCB continues to work towards finalising the plans for additional capacity requirement for the remainder of the year, including a quantification of the projected costs and this is set out in a separate Board paper.

3.5 The issues identified during the Q1 review remain evident in the operational 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 (£1.2m) - whilst some one off costs were incurred in August, the overall trend shows 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 (£0.9m) – 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.

Efficiency & Productivity

3.6 Non delivery of the local reinvestment plans (LRP) remains one of the key risks for the organisation as implementation of plans continues to slip, with a shortfall of £11.8m forecast in the quarter 1 review. For the five month period to August, efficiencies of £8.0m have been delivered against a plan of £9.5m, an under delivery of £1.5m. In month a shortfall against plan of £0.7m is reported, this level of slippage in a single month gives cause for concern and urgent action is being taken, with a particular focus on outpatients, acute medicines and nursing. The year to date and full year position against plan is set out in Table 2 below:
### Table 2: Efficiency & Productivity 2012/13

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target</th>
<th>Schemes identified</th>
<th>Target £k</th>
<th>Actuals £k</th>
<th>Slippage £k</th>
<th>Full Year Savings Identified £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Interventions Low</td>
<td></td>
<td></td>
<td>537</td>
<td>537</td>
<td>81</td>
<td>(81)</td>
</tr>
<tr>
<td>Clinical Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary &amp; Community Care Bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction</td>
<td></td>
<td></td>
<td>650</td>
<td>650</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>3,233</td>
<td>2,767</td>
<td>339</td>
<td>323</td>
<td>(16)</td>
<td>434</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>1,894</td>
<td>619</td>
<td>237</td>
<td>(382)</td>
<td>0</td>
</tr>
<tr>
<td>Prescribing</td>
<td>6,211</td>
<td>6,211</td>
<td>1,224</td>
<td>922</td>
<td>(302)</td>
<td>1,341</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>1,056</td>
<td>460</td>
<td>462</td>
<td>2</td>
<td>637</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>687</td>
<td>372</td>
<td>230</td>
<td>(142)</td>
<td>237</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td>1,945</td>
<td>1,945</td>
<td>918</td>
<td>598</td>
<td>(320)</td>
<td>424</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,779</td>
<td>1,779</td>
<td>472</td>
<td>313</td>
<td>(159)</td>
<td>333</td>
</tr>
<tr>
<td>Primary &amp; Community Care Bed</td>
<td>5,171</td>
<td>5,169</td>
<td>1,812</td>
<td>1,761</td>
<td>(51)</td>
<td>3,590</td>
</tr>
<tr>
<td>UHD Local</td>
<td>3,893</td>
<td>3,899</td>
<td>1,420</td>
<td>1,384</td>
<td>(36)</td>
<td>1,150</td>
</tr>
<tr>
<td>LAMS</td>
<td>2,000</td>
<td>2,000</td>
<td>1,800</td>
<td>1,800</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Planned Savings</strong></td>
<td><strong>32,702</strong></td>
<td><strong>28,594</strong></td>
<td><strong>9,517</strong></td>
<td><strong>8,030</strong></td>
<td><strong>(1,487)</strong></td>
<td><strong>8,168</strong></td>
</tr>
<tr>
<td>Residual Gap</td>
<td>4,838</td>
<td>0</td>
<td>0</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>9,517</strong></td>
<td><strong>8,030</strong></td>
<td><strong>(1,487)</strong></td>
<td><strong>8,168</strong></td>
</tr>
</tbody>
</table>

3.7 On a full year basis, schemes valued at £28.6m (76% of the annual target) have been agreed. Ongoing discussion, detailed reporting and agreement of further management action required, particularly for those workstreams where there is little evidence of delivery to date, will continue to be taken forward by the monthly Efficiency & Productivity Group under the leadership of the Director of Finance. In addition work is underway to assess further options to bridge any gap.

**Waiting times**

3.8 The total cost of delivering additional waiting times activity was £9.6m to the end of August, an increase of £2.2m in the month and within the overall expenditure forecast of £20m for the year. Discussions with SGHSCD over brokerage to support the anticipated deficit of £10m remain ongoing. Slippage against the projected spend is likely to represent a shift in phasing of delivery plans rather than an improvement on forecast.

3.9 An initial review of the independent sector costs incurred to date has been undertaken which highlighted a higher than average cost per case than forecast due to case complexity. Options to mitigate this are being investigated, including a shift to in house alternatives and increased use of Medinet.
Capital

3.10 The Quarter 1 review of capital identified significant slippage in the programme and the Corporate Management Team (CMT) agreed the following priority actions:

- An additional £3.2m allocated to accelerate replacement of medical equipment; and
- Development of a Lothian wide prioritised programme to address and resolve key areas of risk in backlog maintenance and ensure compliance with statutory standards. This will be presented to the LCIG meeting in September and both CMT and the Finance & Performance Review Committee (F&PR) in October.
- There is significant slippage on the enabling works for the RHSC and DCN Project. This funding will be returned to the SGHD to be reinstated next year. The slippage is not reflected in the August figures.

3.11 Expenditure of £7.6m was incurred for the first 5 months of the financial year. Appendix 3 includes details of the programme on a scheme by scheme basis.

Payment Performance

3.12 The methodology for calculating payment performance statistics has been amended in line with guidance from the Department for Business Innovation & Skills on prompt payment guidance for public sector organisation and to ensure consistency with other Scottish health systems. This approach has been agreed with Audit Scotland. The target applies to valid invoices rendered to the correct address and the days will now be counted from the date of receipt at the organisation's designated address.

3.13 The statistics for August are reported in table 3 below:

<table>
<thead>
<tr>
<th>Table 3: Prompt payment statistics for August 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>August Month</td>
</tr>
<tr>
<td>%Age By Volume 30 Days</td>
</tr>
<tr>
<td>%Age By Value 30 Days</td>
</tr>
<tr>
<td>%Age By Volume 10 Days</td>
</tr>
<tr>
<td>%Age By Value 10 Days</td>
</tr>
</tbody>
</table>

4 Key Risks

4.1 The key ongoing risks already highlighted in previous monthly finance reports include:

- 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;
- Delivery of the agreed recurrent efficiency schemes and the need to identify further plans to address the shortfall; and
• Continued management of the financial exposure on waiting times’ related additional activity delivery.

4.2 In addition, there are a number of other issues highlighted during the Quarter 1 review, including:

• The potential cost of changes to pay terms & conditions (including revised on call arrangements);
• The increasing trend expenditure on clinical supplies, hotel and equipment costs;
• Ongoing monitoring and review of GP prescribing costs, and any changes to the current forecast benefit from price reductions.

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
12 September 2012
Susan.goldsmith@nhlothian.scot.nhs.uk

List of Appendices

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

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £k</th>
<th>YTD</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNIVERSITY HOSPITALS DIVISION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Associated Services</td>
<td>122,458</td>
<td>50,143</td>
<td>50,878 (735)</td>
<td>(333) (402)</td>
</tr>
<tr>
<td>REAS &amp; MOE</td>
<td>66,873</td>
<td>26,621</td>
<td>26,910 (289)</td>
<td>(244) (45)</td>
</tr>
<tr>
<td>Surgical Directorate</td>
<td>78,632</td>
<td>35,620</td>
<td>35,582 38</td>
<td>420 (382)</td>
</tr>
<tr>
<td>Labs, A&amp;T, Critical Care &amp; HSDU</td>
<td>120,121</td>
<td>51,078</td>
<td>50,857 221</td>
<td>279 (58)</td>
</tr>
<tr>
<td>Women, Children &amp; Neuroscience</td>
<td>90,479</td>
<td>36,673</td>
<td>37,527 (853)</td>
<td>(538) (315)</td>
</tr>
<tr>
<td>Radiology, Cancer, Head &amp; Neck</td>
<td>98,839</td>
<td>40,921</td>
<td>40,700 221</td>
<td>(50) 272</td>
</tr>
<tr>
<td>Corporate</td>
<td>(8,145)</td>
<td>(10,026)</td>
<td>(10,167) 141</td>
<td>145 (4)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>569,257</strong></td>
<td><strong>231,030</strong></td>
<td><strong>232,286 (1,256)</strong></td>
<td><strong>(321) (936)</strong></td>
</tr>
</tbody>
</table>

| **CHPs/CHCP/PCCO**    |                  |     |                      |                |
| East Lothian CHP      | 69,084           | 28,981 | 28,946 36           | 88 (53)        |
| Edinburgh CHP         | 241,619          | 101,894 | 101,133 761        | 759 2          |
| Midlothian CHP        | 70,022           | 29,729 | 29,291 438         | 438 0          |
| West Lothian CHCP     | 99,400           | 39,934 | 39,545 390         | 418 (29)       |
| Primary Care Contractor Organisation | 10,697 | 38,345 | 38,440 (95) | (95) 0 |
| Corporate             | 2,484            | (7,765) | (7,764) (1)       | (1) (0)        |
| **Total**             | **493,304**      | **231,119** | **229,591 1,528** | **1,607 (79)** |

| **CORPORATE BUDGETS** |                  |     |                      |                |
| Chief Executive       | 641              | 338  | 335 2               | 2 (0)          |
| Consort               | 45,703           | 18,097 | 18,266 (169)      | (169) 0        |
| Communications        | 1,142            | 390  | 363 26             | 50 (24)        |
| Ehealth               | 26,671           | 8,167 | 8,185 (18)        | (18) (0)       |
| Facilities Management | 79,432           | 31,219 | 32,525 (1,306)   | (1,154) (152)  |
| Finance & Capital Planning | 10,626           | 4,461 | 4,396 65          | 125 (60)       |
| Human Resources       | 11,335           | 3,854 | 3,897 (43)       | 25 (68)        |
| Medical Director      | 976              | 77   | 45 32             | 32 0           |
| Nursing               | 3,768            | (572) | (632) 59          | 59 (0)         |
| Pharmacy              | 12,136           | 4,844 | 4,687 158        | 309 (151)      |
| Planning              | 3,042            | 756  | 608 148          | 148 0          |
| Public Health         | 3,255            | 1,291 | 1,308 (17)      | (1) (16)       |
| Other                 | 155              | (13) | (13) 0           | 0 0            |
| **Total**             | **198,884**      | **72,908** | **73,970 (1,062)** | **(591) (471)** |

| **STRATEGIC BUDGETS** |                  |     |                      |                |
| SLAs/UNPACs/NCA       | 10,051           | 4,188 | 5,061 (873)       | (873) 0        |
| Depreciation, Capital Grants & Asset Impairment | 38,839 | 16,110 | 16,196 (85) | (85) 0 |
| Provisions for Pension Costs & Claims | 15,745 | 1,288 | 1,298 (10) | (10) 0 |
| Commissing from 3rd Sector | 8,929 | 6,335 | 6,299 36       | 36 0           |
| Reserves & Uncommitted Allocations | 17,094 | (2,081) | (2,045) (35) | (35) 0 |
| **Total**             | **90,658**       | **25,841** | **26,809 (968)** | **(968) 0**    |

| **TOTAL**             | **1,352,103**    | **560,897** | **562,656 (1,759)** | **(273) (1,486)** |
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>Scheme Name</th>
<th>Agreed Programme (£k)</th>
<th>Actual Expenditure (£k)</th>
<th>Remaining Anticipated Expenditure (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital *</td>
<td>2,234</td>
<td>3,319</td>
<td>(1,085)</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>10,000</td>
<td>(49)</td>
<td>10,049</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>269</td>
<td>(22)</td>
<td>291</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>2,000</td>
<td>239</td>
<td>1,761</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>3,917</td>
<td>728</td>
<td>3,189</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>4,663</td>
<td>1,861</td>
<td>2,802</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>11</td>
<td>(16)</td>
<td>27</td>
</tr>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>2,245</td>
<td>4</td>
<td>2,241</td>
</tr>
<tr>
<td>Radiotherapy - Other</td>
<td>226</td>
<td>0</td>
<td>226</td>
</tr>
<tr>
<td><strong>Total - Committed</strong></td>
<td><strong>25,565</strong></td>
<td><strong>6,064</strong></td>
<td><strong>19,501</strong></td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>1,467</td>
<td>100</td>
<td>1,367</td>
</tr>
<tr>
<td><strong>Total - Approved, not committed</strong></td>
<td><strong>1,467</strong></td>
<td><strong>100</strong></td>
<td><strong>1,367</strong></td>
</tr>
<tr>
<td>HUB Enabling</td>
<td>387</td>
<td>0</td>
<td>387</td>
</tr>
<tr>
<td>HUB Subordinated Investment</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total - Programmed, but unapproved</strong></td>
<td><strong>387</strong></td>
<td><strong>0</strong></td>
<td><strong>387</strong></td>
</tr>
<tr>
<td><strong>Total - SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td><strong>27,419</strong></td>
<td><strong>6,165</strong></td>
<td><strong>21,254</strong></td>
</tr>
</tbody>
</table>

## Over/ (Under) Commitment on Specific Funding

<table>
<thead>
<tr>
<th>Description</th>
<th>Expenditure (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Rolling Programmes</td>
<td>Agreed Programme (£k)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Statutory Compliance</td>
<td>1,265</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>7,170</td>
</tr>
<tr>
<td>E-Health Strategic Priorities</td>
<td>2,000</td>
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<tr>
<td>Invest to Save</td>
<td>200</td>
</tr>
<tr>
<td>Traffic Management</td>
<td>115</td>
</tr>
<tr>
<td>National PACS Refresh 2007-17</td>
<td>85</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,835</strong></td>
</tr>
<tr>
<td>Committed</td>
<td></td>
</tr>
<tr>
<td>Expansion of renal capacity RIE *</td>
<td>(297)</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>746</td>
</tr>
<tr>
<td>Observation Ward A&amp;E RIE *</td>
<td>(16)</td>
</tr>
<tr>
<td>Birthing suite (RIE) *</td>
<td>(355)</td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>39</td>
</tr>
<tr>
<td>Guillian Medical Centre</td>
<td>1,245</td>
</tr>
<tr>
<td>RVH Ward 1 to Jardine Clinic REH</td>
<td>752</td>
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<tr>
<td>LAMS</td>
<td>682</td>
</tr>
<tr>
<td>RVH Relocations</td>
<td>530</td>
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<tr>
<td>Other Radiotherapy (Phase 8)</td>
<td>130</td>
</tr>
<tr>
<td>Other Donations</td>
<td>461</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,917</strong></td>
</tr>
<tr>
<td>Approved, not committed</td>
<td></td>
</tr>
<tr>
<td>BCI Mammography Upgrade WGH</td>
<td>1,387</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,387</strong></td>
</tr>
<tr>
<td>Programmed, but unapproved</td>
<td></td>
</tr>
<tr>
<td>HEI</td>
<td>500</td>
</tr>
<tr>
<td>Tranent</td>
<td>389</td>
</tr>
<tr>
<td>Maternity Unit &amp; Burns Unit (SJH)</td>
<td>565</td>
</tr>
<tr>
<td>Other Equipment (Revenue Sweep)</td>
<td>132</td>
</tr>
<tr>
<td>Purchase of Items for Cancer Treatments</td>
<td>146</td>
</tr>
<tr>
<td>Reconfiguration of Greenbank Unit (Royal Edinburgh Hospital)</td>
<td>350</td>
</tr>
<tr>
<td>Joint CAMH Learning Disabilities</td>
<td>0</td>
</tr>
<tr>
<td>Endoscopy RIE</td>
<td>153</td>
</tr>
<tr>
<td>Endoscopy WGH</td>
<td>0</td>
</tr>
<tr>
<td>Closure of Edenhall</td>
<td>284</td>
</tr>
<tr>
<td>Balfour Pavilion</td>
<td>650</td>
</tr>
<tr>
<td>Community Dental &amp; Paediatry Decontamination</td>
<td>750</td>
</tr>
<tr>
<td>RIE Bed Capacity</td>
<td>0</td>
</tr>
<tr>
<td>Macmillan Centre SJH</td>
<td>430</td>
</tr>
<tr>
<td>Teenage Cancer Trust, WGH</td>
<td>899</td>
</tr>
<tr>
<td>Completed Schemes under Review</td>
<td>(152)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,095</strong></td>
</tr>
</tbody>
</table>

**TOTAL - SCHEMES FUNDED BY FORMULA & OTHER FUNDING**

| Over/ (Under) Commitment on Formula      | (4,282)               |
|GRAND TOTAL                              | 48,653                | 7,631                  | 41,022                                |
|Over/ (Under) Commitment                 | (4,282)               |

* VAT recovery is included in the remaining anticipated expenditure for this project.
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 but will be dealt with through the Corporate Management and Joint Management Team meetings routinely.

2.3 To note the inclusion for the first time on a range of other key areas of work including data 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 is 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.

2.4 To note that information and agreed actions for dealing with surveillance scopes is highlighted within this paper, but a fuller position is provided in the waiting times paper that will be discussed at the board.

2.5 To note that waiting times performance has also been incorporated into this report but will be addressed as a separately as an agenda item at the Board meeting itself.

2.6 Note that as previously reported, the Health Intelligence Unit is continuing to develop Dashboards for Board members, initially on outpatient and inpatient/day cases and these will ultimately be used as the source of data for Performance Reports and note that through eHealth colleagues a system is in place in relation to systems/information governance.
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 seven occasions (table key: ✓ ✓)
- **Is on trajectory to meet**, but has not yet met the final target, on ten occasions (table key: ✓)
- **Is off trajectory** on seven occasion (table key: ✗)
- **Does not meet** the overall target on thirteen 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

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 The targets highlighted are those which have been highlighted previously as requiring additional focus, some of which is being taken forward directly with the Scottish Government, e.g. Psychological Therapies and Suicide Reduction. Further updates will be provided at the meeting where appropriate.

- **Child Healthy Weight** (Responsible Director: Director of Public Health and Health Policy)
- **Fluoride Varnishing** (Responsible Director: Director of Public Health and Health Policy)
- **CO2 emissions** (Responsible Director: Director of Human Resources & Organisational Development)
- **Psychological Therapies (18 weeks RTT by December 2014)** (Responsible Director: (Director, West Lothian Community Health and Care Partnership)
- **Early Access to Antenatal Care** (Responsible Director: Director of Strategic Planning & Primary Care)

4.1.2 Detecting Cancer Early (Responsible Director: Director of Public Health and Health Policy)

The move to tumour specific phase of the campaign has been agreed and will start with breast cancer and the national television campaign will be launched on 4 September. This will run for five weeks and it immediately proceeds the annual breast cancer awareness month.
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.

The Scottish Government Health Department will move the social marketing campaign to the tumour specific phase of the campaign from the 4th September, 2012. This will start with Breast cancer. Work is in hand with the Breast service on new patient clinic capacity, breast radiology, theatre sessions, and also work is developing at screening uptake and further actions to maximise results from screening.

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)

By March 2013 Health Boards need to provide insulin pumps to 25% of patients with type 1 diabetes who are aged under 18. Health Boards are also required to increase provision to adults by 2015. The intention being to triple insulin pump availability across all ages in Scotland to 2,000 by 2015.

Whilst the Scottish Government provided financial support to Boards for the purchase of pumps and consumables for patients under age 18, it did not provide staff funding (or any resource to support adult pump initiations). This has brought service and financial pressures, particularly to the children’s service.

Lothian has consistently been among the highest providers of pumps across all Boards and the biggest provider within the largest Boards. NHS Lothian has increased pump availability across all ages at a rate of 20-30 a year.

The adult service and the children’s service now run separate pump waiting lists for their patients, having had a joint list for some years. This allows each service to focus on the specific needs of its clients. The Lothian paediatric diabetes service has been working to increase pump provision to the under 18s, securing extra funding to employ 4.2WTE staff needed to increase uptake and to support patients and families in managing the pump use.

The adult pump service is on target to meet the CEL target of 232 patients on pump therapy by March 2015. However, the increasing demand for pumps among adults is generating a lengthening waiting list (projected to increase to 3 years by the end
of 2012). The adult service is currently considering options to reduce the wait. These will be presented for consideration as part of the 2013/14 planning process.

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 (table 1).

### Table 1

<table>
<thead>
<tr>
<th>Patients under 18</th>
<th>Patients over 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients with Type 1 diabetes at Dec 2011</td>
<td>Number of patients with Type 1 diabetes at end Aug 2012</td>
</tr>
<tr>
<td>363</td>
<td>410</td>
</tr>
<tr>
<td>Number of patients with Type 1 diabetes at Dec 2011</td>
<td>Number of patients with Type 1 diabetes at end Aug 2012</td>
</tr>
<tr>
<td>3,821</td>
<td>3,863</td>
</tr>
</tbody>
</table>

In addition, 7 patients (5 adults and 2 children) have been taken off pump treatment for clinical and other reasons, 20 children under 18 have declined the offer of a pump and 4 previous adult pump users are deceased.

It is intended to use the information gathered for the Scottish Government to provide the Corporate Management Team with monthly updates on Lothian’s progress against attainment of the insulin pump targets.

4.1.4 **Wheelchair: referral to assessment and assessment to fitting** (Responsible Director: Joint Director Edinburgh CHP)

The mobility service continues to achieve over 98% compliance within 18 weeks RTT. All non-compliant episodes are reviewed retrospectively and prospectively. The service has experienced a significant reduction in the level of recurring funding available since the completion of the Wheelchair and Seating Services Modernisation Programme. Patients who are assessed for equipment are prioritised based on their clinical need. The service has modified its performance monitoring processes and now reviews patients within 6 weeks of their breach date to ensure continued compliance against the 18 week RTT.

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

The number of T10-related attendances in Lothian over the five months has varied markedly, with 19,031 reported in March, 17,164 in April, 18,269 in May, 17,629 in June and 16,789 in July. Lothian attendances were also above the equivalent period for 2011-2012 but have dropped for the first time this July showing a % change of -1.7.
NHS Lothian
T10 sites

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</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>
</tr>
<tr>
<td>2012/13</td>
<td>17,164</td>
<td>18,269</td>
<td>17,629</td>
<td>16,789</td>
</tr>
<tr>
<td>Change</td>
<td>31</td>
<td>323</td>
<td>539</td>
<td>-295</td>
</tr>
<tr>
<td>% Change</td>
<td>0.2</td>
<td>1.8</td>
<td>3.2</td>
<td>-1.7</td>
</tr>
</tbody>
</table>

Actions that have been taken over recent weeks to look at the wider unscheduled care agenda include:

- the Unscheduled care board met again on the 13th August and a paper on Unscheduled care will be considered at the Joint Management Team on the 20th September and will be further discussed at the Board meeting on the 26th September
- actions have been taken around the management of frail elderly patients pathways and further work will be done in relation to other patient groups and condition specific pathways such as alcohol related brain damage
- agreement has been reached re both in patient bed use and wider community support
- work is continuing on developing the model of care for the front door and first 48 hour assessment process at RIE and WGH and a pilot of increased consultant time at the front door of the RIE between 8 am and 10 pm during week days and also during the weekends will running during the month of September to test out any change in decision making and patient pathways.
- work continues to link the front door of the RIE and the other Emergency Departments, minor injuries unit and out of hours service, Lothian Unscheduled Care service

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

There were 128 suicides in Lothian in 2011 (16.5% of the Scottish total). This is an increase on 2010 (122) but lower than 2008 (136). 2008 was the highest yearly total in the last 25 years. The 2011 total is made up of 96 males and 32 females. Much of the variation in the Lothian figures over the last 5 years appears to be due to changes in male suicide. Female deaths from suicide have been between 30 and 34 in that period.

The standardised rate of deaths will vary from year to year sometimes considerably at smaller geographic areas. It is important therefore to consider rates over a longer time period. The European age standardised rate per 100,000 population for Lothian for 2007-2011 is lower than Scotland for males but it is no longer statistically significantly lower as it was last year (20.7 vs 22.6). The rate for females is only slightly lower than Scotland (7.2 vs 7.5).

The national target is to reduce the three year rolling average rate in Scotland by 20% between 2000-02 and 2011-2013. Over this time period in Scotland there was a 17% fall in suicide rates overall (19% for males and 9% for females).

Estimates against this target for Lothian and its local authority areas are not officially published because for smaller geographic areas 3 years is felt to be too
short a time period. A bespoke analysis has been made and the Lothian health board area as a whole shows a drop between the two time periods for total suicides and for males and females. This is replicated in all other areas in Lothian except East Lothian where rates for males and females are higher. However, it may be that East Lothian had a much lower rate at the baseline period than other areas in Scotland. At the health board level much of the decrease between the two time periods was in the first half and there appears to have been a flattening of the rate in the second half of the period.

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 from June to July has improved from 92.5% to 94.9%:
- As reported to the Board in July the Chief Executive has set up an Unscheduled Care Group and the Nurse Director has been given the Executive lead for Unscheduled care but also working with the Joint Director for Edinburgh CHP.
- It has been agreed that the initial focus of this group will be around older people and pathways of care
- The initial work will look at setting up community older people teams, reduce boarding and work towards 7 day discharging, whilst having have clear metrics for measuring success
- The Nurse Director with support from colleagues across the system has developed an initial plan for Unscheduled care which will be presented to the Board on the 26th September.

In addition to the presentation of 4 hour breaches we have also agreed that we should look at the number of patients waiting over 8 hours and 12 hours. This is contained in this report for the first time.

4.2.2 12hr Breaches – Month-to-date for August 2012 (Responsible Director: Nurse Director)

<table>
<thead>
<tr>
<th></th>
<th>Not a Breach (please specify)</th>
<th>Wait for bed - Non Monitored</th>
<th>Wait for diag test result - Other</th>
<th>Wait for NHS transport</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIEAE 06/08/2012</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>RIEAE 15/08/2012</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>RIEAE 23/08/2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>RIEAE 24/08/2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>RIEPAA 19/08/2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>RIEPAA 26/08/2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>RIESOE 19/08/2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
For the month of August there have been 9 people waiting longer than 12 hours but 75 waiting longer than 8 hours. This compares to 15 and 80 respectfully for the whole of July.

Actions being taken to reduce the incidence of these long waits include:

- revised proposal for emergency medicine workforce plan presented to JMT supported. Plan will ensure continued safe provision of services of emergency departments which will also support patient flow with expansion of nursing cohort as well as different trained doctor model in response to Modernising Medical Careers.

- trial in September of a different medical model within the acute medical unit at RIE involving improved matching of senior consultant input with demand and extending consultant presence until 10pm and increasing consultant input at weekends. If successful this will inform the unscheduled care proposals for other site.

- focus on improvement in reducing the time to assessment and consultant plan (SBAR) within acute medical unit as a means to support flow.

4.2.3 Cancer Waiting Times (Responsible Director: Medical Director)

Overall, cancer waiting times are:

- 62 days – 93.6%
- 31 days – 96.6%

Quarter 2 cancer performance reviews were undertaken with clinical management teams who have not achieved 100%. Actions / issues following discussions at the meetings have been circulated to the clinical management teams, and a paper will be submitted to the divisional waiting times group.

Q3 2012 cancer performance review meetings are scheduled to take place with clinical management teams during the week of 29 October 2012 (data submission due 6 November 2012). Q4 2012 cancer performance review meetings are scheduled to take place with clinical management teams during the week of 4 February 2013 (data submission due 13 February 2013). An event involving cancer trackers / managers has been scheduled to take place on 3 October 2012.

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.
A number of measures are being taken forward to improve performance, including:

- A review of operational management responsibility for the stroke pathway is being progressed, and approval sought from JMT for the proposed configuration of the integrated stroke unit at WGH.
- Increased referrals to ECSS (Edinburgh Community Stroke Service).

### 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 106 and 130 delays in July and August respectively. An increase of some 30% and 60% from the 81 delays in May. In May the national rules changed slightly to include patients delayed three or less working days, these were hitherto excluded from the census count, making direct comparison with previously reported figures from April 2012 and before, unrepresentative.

The table gives a summary of headline figures from the July and August 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></td>
<td>July</td>
<td>152</td>
<td>46</td>
<td>106</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>August</td>
<td>181</td>
<td>51</td>
<td>130</td>
<td>17</td>
<td>35</td>
</tr>
</tbody>
</table>

The table below sets out the performance across the Partnership areas for July and August. In line with information governance guidance, numbers less than 5 are not reported; however detailed figures can be provided to NHS Lothian Board members on request.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Non-Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>85</td>
<td>104</td>
<td>14</td>
<td>16</td>
<td>≤5</td>
</tr>
<tr>
<td>Over 6 wks</td>
<td>10</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over 4 wks</td>
<td>23</td>
<td>31</td>
<td>≤5</td>
<td>≤5</td>
<td>≤5</td>
</tr>
</tbody>
</table>

In City of Edinburgh, the single largest pressure is care homes, with two-thirds of delays awaiting suitable being care home placements, with a third of these requiring dementia beds. Home based packages of care delays 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.

Whilst progress against the national standard continues to be measured, there are further developments to monitor bed days occupied due to delayed discharge in order to demonstrate the wider impact on hospital systems. 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.

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 74 years</td>
<td>1,966</td>
<td>2,638</td>
<td>2,887</td>
<td>2,777</td>
<td>2,754</td>
</tr>
<tr>
<td>75+ years</td>
<td>5,424</td>
<td>4,933</td>
<td>6,025</td>
<td>5,271</td>
<td>5,145</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>
</tr>
</tbody>
</table>

The number of patients who are coded as complex continues to run at around 50. This is our highest number of complex delayed discharges, since early 2009. The rise in the number 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 table below sets out the complex delays across Partnership areas.

<table>
<thead>
<tr>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Non-Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex delays</td>
<td>33</td>
<td>35</td>
<td>≤5</td>
<td>≤5</td>
</tr>
</tbody>
</table>

Overall number of patients delayed in hospital

There were circa 325 patients recorded on EDISON whose discharge was delayed; however following the application of ISD reporting rules, Lothian reported 181 delays in August. 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 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, ensuring partnership working to provide suitable care in the community, the use of bed days lots across all delayed discharges, gives a more accurate measure of lost capacity.

![Graph showing hospital data over time](image)

### 4.3.2 Number of patients with Length of Stay (LOS) over 28 days on Acute Hospital sites

Monitoring of this aspect of performance is being used as an improvement measure for the system to support patient flow and delivery of the 4 hour emergency care standard. The expectation is that the total number of patients with LOS over 28 days is reduced over time. The activity reflects approximately 7% of acute site patients but they occupy approximately 30% of available bed days. Monitoring processes are in place at service level to manage routine and complex patients supported by regular performance information. Monitoring has highlighted the need for changes to some processes e.g. Alcohol Related Brain Injury patients who do not need to remain on acute site, the process for applying for Guardianship. In addition to increased focus on this cohort of patients through the introduction of reporting, proposals to pilot supervisory charge nurses to give additional focus on discharge performance will support reducing this total.
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 with:

- Closer monitoring of booking activity to ensure everyone is booked within nine weeks for assessment and treatment.
- Daily and weekly checks in place to ensure that if any patient is booked out with the appointment time they will be rebooked within time.

Also as previously reported, within paediatrics, staff on maternity leave and an increase in referrals to audiology has led to the increase reported. There has also been an increase in pre-op ENT requests impacting on availability.

This continues to be monitored and reported. A Band 5 audiologist has recently been recruited, and will start on 1st October. Furthermore, the 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.

4.3.4 **Current Position – Inpatients and Day cases** (Responsible Director: Medical Director)

The position for inpatients and day cases at the end of July is shown in the figures below with 1658 patients over 12 weeks (June: 1963) and 2196 over 9 weeks (June: 2467).
The position at the end of July shows an improvement in numbers waiting over 12 and 9 weeks, and a continued decrease in waiting list size as reflected in Error! Reference source not found.. An update on this position for August is provided in the Waiting Times paper elsewhere in the agenda.

4.3.5 Current Position – Outpatients (Responsible Director: Medical Director)

The figure below shows that the number of patients waiting over 12 weeks for an appointment decreased slightly at the end of July to 5069 (June: 5177). An updated position on outpatients is available as part of the waiting times paper elsewhere on the meeting’s agenda.
4.3.6 Current Position – Diagnostics (Responsible Director: Medical Director)

In line with the agreement with the Scottish Government Health department waits for some tests covered by the diagnostic standard (upper and lower endoscopy and colonoscopy) will fluctuate between four and six weeks.

At the end of July, there were 566 patients waiting over 4 weeks for endoscopy/colonoscopy tests, 28 of whom had also waited in excess of 6 weeks.

As described in the waiting times paper, additional endoscopy capacity is being put in place to ensure sufficient is available to accommodate both new and return demand and that those of high clinical priority are seen within appropriate timescales.

Work is currently underway to address the number of people currently waiting for surveillance or repeat scopes. This is highlighted within the waiting times paper which will be discussed in full at the Board.

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.

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Business Manager
19 September 2012
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Alex McMahon
Director of Strategic Planning & Primary Care

List of Appendices

Appendix 1: Performance Management Scorecard
### Health Improvement

<table>
<thead>
<tr>
<th>HEAT Target</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Healthy Weight</strong> - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (a requirement that at least 40% of child healthy weight interventions are delivered to children/families in the two most deprived SIMD quintiles by local SIMD datazone-to-be reported annually)</td>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr 11 - Mar 12 682</td>
<td>Apr 12-Jun 12 119</td>
<td>265</td>
<td></td>
<td>AKM</td>
<td>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 Surveillance Programme - School system rather than the 571 initially anticipated from locally held data. A relatively small number of school-based interventions were completed between April - Jun 2012. This is because most schools agreeing to participate expressed a preference to avoid the shorter summer term. Most of the interventions for 2012-13 are planned for September - November 2012 which will bring us back on course. A smaller number of interventions completed between April - June in one of the attached nursery schools will be reported in the next quarter.</td>
</tr>
<tr>
<td><strong>Suicide Reduction</strong> - % of suicides per yr per 100,000 population</td>
<td>2013</td>
<td>20%</td>
<td>2008-10 14.1%</td>
<td>2009-11 13.7%</td>
<td></td>
<td>✓</td>
<td>AKM/M</td>
<td>There were 128 suicides in Lothian in 2011 (16.5% of the Scottish total). This is an increase on 2010 (122) but lower than 2008 (136). 2008 was the highest yearly total in the last 25 years. The 2011 total is made up of 96 males and 32 females. Much of the variation in the Lothian figures over the last 5 years appears to be due to changes in male suicide. Female deaths from suicide have been between 30 and 34 in that period.</td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong> - to deliver universal smoking cessation services to achieve at least 7,011 successful quits (at one month post quit) including 4,207 in the 40% most-deprived within-Board SIMD areas over the period 2011/12 to 2013/14</td>
<td>Mar-14</td>
<td>7,911</td>
<td>Jun-12 3,602</td>
<td>Jul-12 3,905</td>
<td>3,222</td>
<td>✓</td>
<td>JF</td>
<td>Target has been simplified; new data still not available due to change of personnel within ISD. All additional Childsmile targets to be reported annually. A key post, Head of Oral Health Improvement will be filled from September 2013. This has resulted in the current Dental Prevention Manager being displaced and so there will be a pause in recruitment of further staff while the redeployee becomes familiar with their remit.</td>
</tr>
<tr>
<td><strong>Child Fluoride Varnishing</strong> - achieve at least 60 per cent of 3 and 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td>Mar-14</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AKM</td>
<td>Details of local trajectories for the three cancers are still being agreed with the Scottish Government.</td>
</tr>
<tr>
<td><strong>Detecting Cancer Early</strong> - of all those diagnosed with breast, colorectal and lung cancer, 20% are to be diagnosed while in the first stage of the disease</td>
<td>Mar-15</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Details of local trajectories for the three cancers are still being agreed with the Scottish Government. A national event to move this forward is planned for the 29th August.</td>
</tr>
<tr>
<td><strong>Early Access to Antenatal Care</strong> - at least 80% of pregnant women in each SIMD quintile to have booked for antenatal care by the 12th week of gestation by March 2015</td>
<td>Mar-15</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Detail still being agreed with the Scottish Government. A national event to move this forward is planned for the 29th August.</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reduce Carbon Emissions</strong> - % reduction year-on-year (Tonnes of CO2)</td>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 14, 11/12 2.77%</td>
<td>Qtr 1, 12/13 1.88%</td>
<td>5.91%</td>
<td>✓</td>
<td>AB</td>
<td>Performance is above trajectory for 3 weeks RTT in June. A detailed briefing is circulated on a monthly basis as appropriate and can be shared with committee members on request.</td>
</tr>
<tr>
<td><strong>Reduce Energy Consumption</strong> - % reduction year-on-year (Energy GJ)</td>
<td>Mar-15</td>
<td>-2.97%</td>
<td>Qtr 14, 11/12 2.17%</td>
<td>Qtr 1, 12/13 1.19%</td>
<td>1.99%</td>
<td>✓</td>
<td>AB</td>
<td>2</td>
</tr>
<tr>
<td><strong>Access to Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drug and Alcohol waiting times</strong> - 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</td>
<td>Mar-13</td>
<td>90%</td>
<td>Jun-12 80.80%</td>
<td>Jul-12 78.60%</td>
<td>74%</td>
<td>✓</td>
<td>AMcM</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td><strong>Faster access to CAMHS</strong> - deliver 26 wks Referral to Treatment</td>
<td>Mar-13</td>
<td>0</td>
<td>Jun-12 57</td>
<td>Jul-12 67</td>
<td>69</td>
<td>✓</td>
<td>MH</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td><strong>Faster access to Psychological Therapies</strong> - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>JF</td>
<td>Detail still being agreed with the Scottish Government.</td>
</tr>
<tr>
<td><strong>Treatment Appropriate for Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E Attendances</strong> - rate of A&amp;E attendances per 100,000 population</td>
<td>Mar-14</td>
<td>1,911</td>
<td>Jun-12 2,077</td>
<td>Jul-12 1,978</td>
<td>1,951</td>
<td>X</td>
<td>AMcM</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td><strong>MSRA / MSSA Reductions</strong> - achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MSSA) cases to 0.26 or less per 1,000 acute occupied bed days</td>
<td>Mar-13</td>
<td>0.26</td>
<td>Jul-12 0.30</td>
<td>Aug-12 0.29</td>
<td>0.31</td>
<td>✓</td>
<td>AKM</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td><strong>C.diff infections</strong> - achieve a reduction of the rate of Clostridium difficile infections in patients aged 65 and over to 0.39 cases or less per 1,000 total occupied bed days</td>
<td>Mar-13</td>
<td>0.39</td>
<td>Jul-12 0.32</td>
<td>Aug-12 0.33</td>
<td>0.41</td>
<td>✓</td>
<td>AKM</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td><strong>Reduction in emergency bed day rates for patients aged 75+</strong></td>
<td>Mar-15</td>
<td>5,143</td>
<td>Jan-12 5,214</td>
<td>Feb-12 5,201</td>
<td>5,368</td>
<td>✓</td>
<td>AMcM</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
<tr>
<td><strong>Delayed Discharges</strong> - no people to wait more than 28 days to be discharged from hospital into a more appropriate care setting from April 2013</td>
<td>Apr-13</td>
<td>0</td>
<td>Jul-12 28</td>
<td>Aug-12 35</td>
<td>24</td>
<td>X</td>
<td>AMcM</td>
<td>9G have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for 9G QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.</td>
</tr>
</tbody>
</table>
### Delayed Discharges
- No patient to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015.

<table>
<thead>
<tr>
<th>Month</th>
<th>Delayed Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-15</td>
<td>0</td>
</tr>
<tr>
<td>Jul-12</td>
<td>55</td>
</tr>
<tr>
<td>Aug-12</td>
<td>70</td>
</tr>
<tr>
<td>Sep-15</td>
<td><strong>XX</strong></td>
</tr>
</tbody>
</table>

**Note:** Data available monthly (from ISD), one month in arrears. Non validated & may be incomplete data till following month. New eSSCA system has been implemented (July 2012).

### Stroke Unit
- 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation.

<table>
<thead>
<tr>
<th>Month</th>
<th>Stroke Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>90%</td>
</tr>
<tr>
<td>May-12</td>
<td>82%</td>
</tr>
<tr>
<td>Jul-12</td>
<td>67%</td>
</tr>
<tr>
<td>Sep-15</td>
<td><strong>X</strong></td>
</tr>
</tbody>
</table>

**Assessment:**
- **✓✓** Meets the overall target
- **✓** On trajectory to meet, but has not yet met, the final target
- **X** Off trajectory
- **XX** Does not meet the overall target

*Data available monthly (from SSQA at ISD), one month in arrears. Non validated & may be incomplete data till following month. New eSSCA system has been implemented (July 2012).*
## HEAT Standard Target

<table>
<thead>
<tr>
<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>2011-12</td>
<td>17,093</td>
<td>Apr to July 2012</td>
<td>4,932</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Alcohol Brief Interventions
- Maintain the same total level of delivery of ABIs as under the HEAT H4 target for 2011-12, at least 90% of delivery to be in priority settings.

**Current Period**
- 9,938
- 2012: 4,932
- 2012: 3,313

**Assessment**
- ✔

**Lead Drtr**
- AKM

**Comments**
- Quarter 2 (April - June) 2012 cancer Waiting Times Performance provisional figures only at this stage. Due for publication on 25 September 2012.

### Cancer Waiting Times
- 62 day referral to treatment
  - Achieve 95% of patients diagnosed with cancer starting treatment within 62 days of urgently referred with a suspicion of cancer, referred through A&E, or referred from one of the national cancer screening programmes.

**Current Period**
- Breast: 95.00%
- Colorectal: 95.00%
- Lung: 95.00%
- Lymphoma: 95.00%
- Melanoma: 95.00%
- Ovarian: 95.00%
- Upper GI: 95.00%
- Urological: 95.00%

**Assessment**
- ✔

**Lead Drtr**
- DF

### Cancer Waiting Times
- 31-day decision to treat to first treatment
  - Achieve 95% per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat, irrespective of the source or urgency of the referral.

**Current Period**
- Breast: 95.00%
- Colorectal: 95.00%
- Head & Neck: 95.00%
- Lung: 95.00%
- Lymphoma: 95.00%
- Melanoma: 95.00%
- Ovarian: 95.00%
- Upper GI: 95.00%
- Urological: 95.00%

**Assessment**
- ✔

**Lead Drtr**
- DF

### 18 weeks Referral To Treatment
- 90% of patients to wait no longer than 18 weeks from referral to treatment

**Current Period**
- 90%: 89.00%
- Jul-12: 87.00%

**Assessment**
- ✔

**Lead Drtr**
- DF

### 12 week Outpatients
- No patient to wait longer than 12 weeks from referral to a first outpatient appointment

**Current Period**
- 12 weeks: 5177
- Jul-12: 5069
- 0

**Assessment**
- ✔

**Lead Drtr**
- DF

### 4-hour A&E
- % of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&E treatment

**Current Period**
- RRI - 89.9%
- RRI - 94.0%
- RRI - 98.8%
- RRI - 98.8%

**Assessment**
- ✔

**Lead Drtr**
- MH

### Dementia
- Number of people on QOF dementia register - improvements in the early diagnosis and management of patients with Dementia

**Current Period**
- 5,795
- Mar-11: 6,198
- Mar-12: 6,465

**Assessment**
- ✔

**Lead Drtr**
- AMcM

### GP Access
- Patients reporting they had GP access within 48 hours

**Current Period**
- 90%: 94.3%
- 11/12: 98.0%

**Assessment**
- ✔

**Lead Drtr**
- AMcM

### GP Access
- Advance booking more than 2 days in advance

**Current Period**
- 90%: n/a
- 11/12: 80.0%

**Assessment**
- ✔

**Lead Drtr**
- AMcM

---

**Assessment**
- ✔ ✔ Meets the overall target
- ✔ Meets the overall target, but has not yet met, the final target
- X Is off trajectory
- X X 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>Other Local / National Target</th>
<th>Target</th>
<th>Date</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>Jul-12</td>
<td>12</td>
<td>Aug-12</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Total number of Delayed Discharge in Short-Stay setting (monitor locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Jul-12</td>
<td>10</td>
<td>Aug-12</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 12 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12</td>
<td>1963</td>
<td>Jul-12</td>
<td>1658</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 9 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12</td>
<td>2467</td>
<td>Jul-12</td>
<td>2196</td>
<td>0</td>
</tr>
<tr>
<td>Wait for key diagnostic tests &gt; 4 weeks (Monitor Nationally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12</td>
<td>4</td>
<td>Jul-12</td>
<td>0</td>
<td>0</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</td>
<td>146 day cases and 112 outpatients</td>
<td>Jul-12</td>
<td>229 day cases and 186 outpatients</td>
<td>0</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>Jun-12</td>
<td>75.4%</td>
<td>Jul-12</td>
<td>98.5%</td>
<td>98%</td>
</tr>
<tr>
<td>Wait for cardiac intervention to be &lt; 15wks (angiography, angioplasty and CABG) (Monitor Locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12</td>
<td>0</td>
<td>Jul-12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Audiology (Adults) - number of patients waiting over 12 weeks</td>
<td>Ongoing</td>
<td>0</td>
<td>Jun-12</td>
<td>10</td>
<td>Jul-12</td>
<td>8</td>
<td>0</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>124</td>
<td>Aug-12</td>
<td>129</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Assessment

- ✔ Meet the overall target
- ✔ ✔ Meets the overall target, but has not yet met, the final target
- ✗ Is off trajectory
- ✗ ✗ Does not meet the overall target

---

**Summary of Targets & Standards**

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Z:\Secretariat\MEETINGS\Peter\Board\General\Papers\2012\26-09-12\Board (AMcMAM) Appendix 1 - Performance Report 031012
WAITING TIMES PROGRESS AND PERFORMANCE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress made to address the numbers of patients waiting longer than national standards and in other areas.

1.2 The paper outlines the significant progress being made towards addressing this position but emphasises the importance of continued vigilance on maintaining the reduction and ensuring ongoing compliance.

1.3 It also outlines other areas where patients are facing delays and where action is being pursued.

1.4 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 against the plan with provisional information showing ongoing reductions in inpatient waits and marked decreases in outpatient numbers;

2.2 Note the need for ongoing vigilance in driving down waiting times;

2.3 Support the ongoing work to identify areas of long waits not governed by waiting time standards to enable action to be taken in these areas;

2.4 Note the pressures facing the Board and long delays experienced by patients waiting for surveillance and other "repeat" endoscopies and that and that steps are being taken to see those of highest clinical priority;

2.5 Recognise the variables, risks and areas of uncertainty around these actions;

2.6 Support the decisions made in relation to investment in sustainable core capacity;

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

2.8 Receive a summary of the associated financial position relating to waiting times at the end of August 2012.
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 and prepare services for the introduction of the Treatment Time Guarantee. This guarantee, outlined in the Patients’ Rights Act, comes into force from 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. These are underpinned by rigorous weekly performance management meetings chaired by the Chief Executive. Plans are pursued on a daily basis by a Recovery Delivery Team in partnership with the Clinical Management Teams.

4 Current Position – Inpatients and Daycases

4.1 The position for inpatients and daycases at the end of August is shown in the figures below with 1432 patients over 12 weeks (July: 1658).

Figure 1 – Inpatient and Daycase Waiting List

![INPATIENT/DAY CASE WAITING LIST - MONTH END](image)

Source: Management MMI; ISD Data Warehouse

4.2 At the last board meeting a static position for the end of June was reported in relation to those patients waiting over 12 weeks. Board members will recall at that meeting that there were early signs that these numbers were beginning to drop at that time in both of the principal clinical management teams tackling long waits.

4.3 This change in direction has been maintained since that point and has fed through to the figures reported above. This ongoing movement is reflected in provisional management information used in Figure 2.
4.4 In addition to the fall in the number of patients waiting over 12 weeks, the overall list size is also dropping. This is to be welcomed. The continuing reducing trend in the overall list size in both Head and Neck and General Surgery Clinical Management Teams is shown in Error! Reference source not found.. As in previous papers, ophthalmology patients have been removed from the trends presented, due a change in the groups included in the recording within this specialty during the period.

4.5 Board members will be aware that a combination of internal and external capacity has been used to reduce waits. Figure 3 shows the uptake of sessions and the proportion of those sessions used in internal capacity during August in those surgical specialties facing difficulties. There continues to be room for improvement in some areas. Previously it was highlighted that steps were being taken to improve utilisation by changing booking practice in ENT and plastic surgery. The position reported for August suggests these moves have had a positive impact.

4.6 As anticipated at July’s Board meeting, the use of the independent sector increased following lower than planned activity levels in the first quarter of the financial year. Since the initial forecasts the approach taken altered from one where more than half of the activity was expected to be done outside Lothian, to one where 85% of activity to end August has been undertaken locally. One specific change has been the deployment of external staff on Lothian premises which has accounted for almost a quarter of the external activity to date.

4.7 Further information on external usage is provided in section 12.
5 **Current Position - Outpatients**

5.1 Board members heard in July of the ongoing pressure on outpatient waiting lists.

5.2 The figure below shows the trend in outpatient waiting lists. The number of patients waiting over 12 weeks for an appointment at the end of August was 4962, a fall of 107 from the previous month (July: 5069).
5.3 As was reported previously urology and general surgery are under particular pressure, having built up the largest back-log of patients waiting long times for both outpatients and inpatients/daycases. Therefore, it is these specialities that will provide the greatest challenge in recovering both the outpatient and inpatient/day case position.

5.4 The presentation at the last Board meeting focused upon the “see and treat” initiatives being planned in August to reduce the pressure on the outpatient queues. The impact of this activity, as well as additional internal clinics, on total list size in General Surgery and Urology is shown in Figure 5, with the General Surgery list falling by approximately 800 in the six weeks to mid-September.

5.5 The assessment of patient notes, carried out as part of the work to address the backlog, has also led to some patients – particularly from the General Surgery and Gastroenterology queues – to be sent directly for a diagnostic endoscopy. This redirection, accounting for approximately 200 patients, has impacted on diagnostic waiting times, which is covered in Section 7.
6 Timescales and Routes to Recovery of Inpatient and Outpatient Waits

6.1 In June’s Board paper, it was anticipated that 800 inpatients were at risk of being over 12 weeks at the end of September. At the time of writing 837 patients remain as likely to be in this position at Lothian Hospitals. The status of a further 338 patients due to be offered treatment at external providers over recent weeks is currently being confirmed. An updated position will be provided at the Board meeting.

6.2 The ultimate aim of the Clinical Management Teams is to reach a point where no patient is waiting beyond 12 weeks by the end of the calendar year. One challenge in working towards this aim is the case mix of these patients remaining.

6.3 Of those remaining in high risk specialties without a date, 84% have been identified as not being appropriate to be seen at an external provider. This places a particular pressure on internal capacity. In order to prioritise these patients and also quickly identify if there is a shortfall in capacity before the end of year, all of those remaining are now being booked, even where the dates offered go beyond the expected “booking window” of four to six weeks. This approach is expected to have two consequences. Firstly, the prioritisation of these “Lothian only” patients will limit the capacity available for other patients, which are likely to have to be accommodated through external providers or alternative additional capacity. Secondly, temporary changes to consultant job plans may also be required to increase the proportion of time spent operating so as to provide the necessary additional internal capacity.

6.4 The last report to the Board discussed the pressure on outpatient waits and outlined how “see and treat” initiatives across a range of specialties could be used. As
referred to earlier, Figure 5 above shows how the outpatient waiting lists in General Surgery and Urology have been impacted during this period.

6.5 The “see and treat” clinics and other local initiatives have had the expected impact of reducing the numbers of patients waiting over 12 weeks for an outpatient appointment. Management information suggests that numbers waiting over this timescale for an outpatient appointment will be below 4000 at the end of September. If this is achieved, this will be the lowest number of outpatients reported over 12 weeks during 2012.

6.6 Arrangements are currently underway for further “see and treat” clinics, and for the theatre sessions required to enable patients seen to be subsequently treated. This latter aspect is key. A high number of patients are being seen in clinic. A proportion will require surgery and it is necessary – in order to comply with the Treatment Time Guarantee - that these patients can be assured of treatment within 12 weeks of their agreement to it.

6.7 Board members will therefore be conscious that although significant improvements are being made in the inpatient and outpatient setting, challenges remain in continuing this reduction. Vigilance and sustained effort is therefore required.

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 August, 372 patients were waiting longer than six weeks for a diagnostic endoscopy; a rise from 28 the month before. The trend in endoscopy numbers over the 6 week standard is shown in Figure 6.

7.3 1 MRI patient waited longer than 4 weeks due to an equipment failure.

7.4 As indicated in paragraph 5.5 above, the position at the end of August was exacerbated by the identification of a number of people on the outpatient waiting list as requiring diagnostic endoscopies. This, coupled with difficulties maintaining additional capacity, led to a significantly worsened position in August.

7.5 Action to resolve this situation is discussed in section 9.
8 Current Position – Other Waits

8.1 Last month the Chief Executive asked that all services be examined to identify areas of excessive delay, so that appropriate action could be taken. This exercise is currently underway.

8.2 Long waits are routinely reported in a number of diagnostic tests not covered by the diagnostic standard of six weeks. Figure 7 shows the position at the end of August for these tests.

8.3 Delays are also affecting those awaiting a surveillance endoscopy. National guidelines recommend that those patients at moderate or high risk of colon cancer participate in a surveillance programme, usually involving a periodic colonoscopy, to detect an occurrence of the disease. The guidelines suggest that these examinations are undertaken at particular intervals—varying from a year to 5 yearly—determined by the patient’s clinical condition and risk.
8.4 Those patients in the surveillance programme are held on a “repeat waiting list” alongside other patients requiring a further attendance for the service, for example because an attempted procedure was not able to be completed. At the time of writing, 2389 patients were on the waiting list and overdue their colonoscopy appointment with a further 811 patients waiting for alternative procedure. A further 5812 patients have been identified for an appointment at some point in the future.

8.5 Of the overdue colonoscopy patients, 46 date back to 2008 and a further 283 relate to 2009. It has been agreed that these patients need to be seen as soon as possible and arrangements are being made to support this, displacing routine endoscopy capacity, as discussed in section 7, as it is a higher clinical priority.

8.6 There are a further 1138 colonoscopy patients relating to 2010 and 2011 (436 and 702 respectively). Those of highest clinical priority in these years are being identified by clinical staff, so that their examination can be expedited.

8.7 Validation of the waiting lists is currently underway and it is expected that a proportion of those recorded on the waiting list will not actually require an endoscopy due to changes in national guidance on when such examinations are appropriate and changes in patient circumstances in the interim. Checks undertaken to date suggests that this will be the case for 20-25% of patients, potentially reducing the capacity necessary to accommodate those waiting to under 1800.

8.8 Work is currently progressing, under the leadership of the Medical Director, on securing the necessary capacity to address both the number of overdue patients but also to ensure that there is sufficient ongoing capacity available for both routine and surveillance cases.
8.9 As Board members would require urgent action is being taken in this area and a project team has been formed to ensure that implementation of the plan is achieved as quickly as possible. As would be expected, this matter has been discussed with the Scottish Government colleagues, with whom work will continue closely.

8.10 As this paper was being prepared, Health Boards across Scotland received a press enquiry on the issue. Given the topic’s planned inclusion in this report, and following discussion with the Chairman, the journalist concerned was asked to await this paper’s release.

8.11 The pressure on endoscopy is unlikely to diminish. NHS Scotland’s Diagnostic Steering Group highlighted to Board Chief Executives last month the likely growth in colonoscopies and other diagnostic imaging of the colon. Over the next 15 years, based on demographic changes alone, demand is anticipated to increase by 15%. This is before consideration of changing clinical practice, screening programmes, the implementation of “Detect Cancer Early” and ensuring that those at highest clinical risk are kept within a surveillance programme.

8.12 The Performance Report received by the Board is to be updated to incorporate the monitoring of these patients. Historically this group has been not reported at either national or local level. As such, the increasing demand in this area has not been evident nor considered for investment alongside proposals to accommodate the increasing numbers of diagnostic patients to be seen within national standards, which also makes use of the same capacity.

9 Investment in Core Capacity

9.1 The last few Board papers have stressed the importance of putting in place sustainable capacity, given that 75% of the additional capacity being sought was necessary to bridge the gap between core capacity and demand.

9.2 Employing modelling undertaken by Clinical Management Teams in partnership with the Scottish Government’s Quality and Efficiency Support Team, consideration was made in August of three areas where the need for early investment is necessary to address these imbalances between capacity and demand. These are outlined in Table 1.

<table>
<thead>
<tr>
<th>Specialty/Service</th>
<th>Description</th>
<th>Grade/Band</th>
<th>WTE</th>
<th>FY Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
<td>Upper Limb Surgeon Consultant</td>
<td>1.00</td>
<td>£117,251</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Back Surgeon Consultant</td>
<td>1.00</td>
<td>£117,251</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admin Support Band 3</td>
<td>1.00</td>
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<td></td>
<td></td>
<td>3.00</td>
<td>£255,486</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>Urologist Consultant</td>
<td>1.00</td>
<td>£117,251</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admin Support Band 3</td>
<td>0.50</td>
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<td></td>
<td></td>
<td>1.50</td>
<td>£127,743</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>Plastic Surgeon Consultant</td>
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<td>£117,251</td>
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</tr>
<tr>
<td></td>
<td>Physiotherapist Band 6</td>
<td>1.00</td>
<td>£36,896</td>
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<tr>
<td></td>
<td>Admin Support Band 2</td>
<td>0.81</td>
<td>£14,650</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>2.81</td>
<td>£168,797</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>7.31</td>
<td>£552,026</td>
<td></td>
</tr>
</tbody>
</table>

Table 1 - Investment outlined by CMT-QuEST Analysis
In addition to Orthopaedics, Urology and Plastic Surgery, consideration was also given to deficiencies in routine endoscopy and theatre staffing. As Board Members will be aware, external staff have been used to supplement internal endoscopy provision over the last 18 months. The investment outlined in Table 2 below seeks to incorporate this capacity into core. It was originally envisaged that this expansion of internal resourcing would reduce the need for external support. In light of the issues discussed in section 8, the need for external support is expected to continue, alongside other measures.

Table 2 - Endoscopy Investment

<table>
<thead>
<tr>
<th>Specialty/Service</th>
<th>Description</th>
<th>Grade/-Band</th>
<th>WTE</th>
<th>FY Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy</td>
<td>Colorectal Surgeon</td>
<td>Consultant</td>
<td>1.00</td>
<td>£117,251</td>
</tr>
<tr>
<td></td>
<td>Colorectal Surgeon (skill mix)</td>
<td>Consultant</td>
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<td>£42,588</td>
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<tr>
<td></td>
<td>GastroEnterologist</td>
<td>Consultant</td>
<td>1.00</td>
<td>£117,251</td>
</tr>
<tr>
<td></td>
<td>GastroEnterologist (skill mix)</td>
<td>Specialty Doctor</td>
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<td>£44,166</td>
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<tr>
<td></td>
<td>Nursing</td>
<td>Band 5</td>
<td>10.90</td>
<td>£362,039</td>
</tr>
<tr>
<td></td>
<td>Nursing</td>
<td>Band 2</td>
<td>4.67</td>
<td>£95,500</td>
</tr>
<tr>
<td></td>
<td>Admin</td>
<td>Band 3</td>
<td>2.00</td>
<td>£49,000</td>
</tr>
<tr>
<td></td>
<td>Non Pays</td>
<td>Labs/Clinical Supplies</td>
<td>-</td>
<td>£460,565</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>19.57</td>
<td>£1,288,360</td>
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</table>

Table 3 – Anaesthetic and Theatre Investment

<table>
<thead>
<tr>
<th>Specialty/Service</th>
<th>Description</th>
<th>Grade/-Band</th>
<th>WTE</th>
<th>FY Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics &amp; Theatres</td>
<td>Anaesthetist</td>
<td>Consultant</td>
<td>6.00</td>
<td>£703,506</td>
</tr>
<tr>
<td>Theatre Nursing/ODP</td>
<td>Band 6</td>
<td>4.80</td>
<td>£213,892</td>
<td></td>
</tr>
<tr>
<td>Theatre Nursing/ODP</td>
<td>Band 5</td>
<td>29.85</td>
<td>£1,004,323</td>
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</tr>
<tr>
<td>Theatre Nursing/ODP</td>
<td>Band 2</td>
<td>11.34</td>
<td>£261,647</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>45.99</td>
<td>£1,479,863</td>
</tr>
</tbody>
</table>

9.5 The Joint Management Team has agreed that these investments should progress as quickly as possible to lessen reliance upon non-recurrent means and many of the posts are already out for advert.

9.6 Having offset the recurrent resources available within the waiting time budget, a balance of £2.34M remains, a commitment against the 2013/14 budget. Further investments, related to both the elective and unscheduled arenas, are to be considered in the coming weeks as part of the planning and financial cycle for 2013/4.

10 Recording and Management of Patient Waiting Times

10.1 The national guidance relating to the Treatment Time Guarantee, anticipated at the Board’s meeting in June, was released in early August. Work is continuing on preparation for the introduction of the guarantee from 1st October.

10.2 As indicated in 3.1, The Treatment Time Guarantee, outlined in the Patients’ Rights Act, requires that Boards begin treatment of inpatients or daycases, with a few
exclusions, within 12 weeks of treatment being agreed - taking account of any clock adjustments.

10.3 In line with the discussion at June’s Board meeting, and following release of the guidance, the practice of resetting the waiting time clock for those refusing offers of dates at agreed sites other than those in Lothian and Golden Jubilee National Hospital has now been introduced.

10.4 To support this, training has been provided for staff to ensure that they follow the guidance and are able to appropriately explain options and consequences to patients. The training has been extended to staff at Nuffield Hospital and Ross Hall in Glasgow as well as Spire Murrayfield and The Edinburgh Clinic in Lothian.

10.5 Changes have also been made to the recording of offers in Trak so it is possible to identify the number of resets which relate to offers at a particular external location.

10.6 These resets will be monitored as part of the monitoring of waiting time practice outlined in July’s Board paper and put in place to alert line managers to unusual activity, thus supporting appropriate administrative practice.

10.7 The national guidance accompanying the act indicates that Boards should produce a Local Access Policy which sets out which locations are deemed appropriate to offer for treatment. Lothian’s Local Access Policy is in draft and will be presented to the Board for consideration at its next meeting.

10.8 With the advent of the Treatment Time Guarantee, the national approach to measuring and reporting waiting times will alter slightly as will the kinds of procedures reported against national standards. For example, procedures undertaken within the exceptional anaesthetic pathway are not included within the inpatient standard currently while spinal procedures and those being treated by the national scoliosis services are. Under the Treatment Time Guarantee, the current status of these groups against the national standard reverses.

10.9 It is intended that local reporting will alter reflect these national changes and this will be reflected in the Board paper tables as the treatment time guarantee takes effect.

11 Key Risks

11.1 NHS Lothian is engaged in the largest recovery operation against waiting times ever undertaken by a Scottish NHS Board. The establishment of a co-ordinated recovery programme that is bringing forward potential and actual solutions in short-timescales is a credit to the NHS Lothian staff steering and delivering the recovery. However, the recovery of waiting times contains a significant number of assumptions and thus confers risk.

11.2 The logistical challenges that have to be met over a short period of time to offer large volumes of patients both outpatient and inpatient appointments; co-ordinate treatment with external providers; arrange transport; provide information to patients; liaise with significant numbers of clinical and administrative staff and ensure that the whole process ‘hangs together’ and is co-ordinated, should not be underestimated. The complexity and sheer scale of the recovery programme is a risk in itself, but it is clear that the staff in Lothian are progressively meeting the challenge of this risk.
11.3 Particular risks reside around the extent to which patients will be willing to travel outside Lothian for treatment. The establishment of the External Provider Office is an attempt to mitigate this risk. However, should this mitigation prove insufficient, recovery will be delayed.

11.4 It is possible that some specialist work will be unable to be accommodated elsewhere. Where possible, expertise will be concentrated on such cases and the capacity for this maximised by displacing routine work so that it can be undertaken by others.

11.5 Recovery could also be slowed by difficulties in co-ordinating the various elements required to increase internal activity, such as lack of availability of additional anaesthetic staff, or disruption to existing core capacity, such as bed pressures from emergency admissions. Both of these aspects have been mitigated through the introduction of a recommended lead time for the former and retention of seasonal bed capacity for the latter.

11.6 Sustained progress will also be dependent upon the willingness of staff to undertake additional hours above contractual levels for a prolonged period. To reduce the level of risk this presents it will be necessary to invest in core capacity and also to seek alternative capacity to see those patients potentially affected.

11.7 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 maximise the level of core capacity retained. This is also being factored into the Boards winter/resilience planning.

11.8 Seasonality will also affect patient availability as we are already seeing an unwillingness for patients to be treated for routine conditions during the holiday period. Future plans will take better account of this through phasing. Core capacity could also be affected by further industrial action in light of the ongoing discussions over public sector pensions.

11.9 If the risks above are not managed successfully, the Board could be in breach of the Patients Rights Act.

12 Resource Implications

12.1 Expenditure against actions associated with recovery and maintenance of Access standards is £9.638M for the 5 months to end August. A revised expenditure projection is currently being prepared for Mid Year Review. However, Table 4 below shows actual expenditure to date of £9.638M alongside a revised forecast of £21.375M in total..
### Table 4 - Forecast and Expenditure Position

<table>
<thead>
<tr>
<th>Internal (in house)</th>
<th>Restated Forecast (Jun-12) £000s</th>
<th>Actual Expend. Apr-Aug (5 Months) £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal (in house)</td>
<td>5,845</td>
<td>2,566</td>
</tr>
<tr>
<td>Medinet</td>
<td>1,719</td>
<td>1,618</td>
</tr>
<tr>
<td>GJNH</td>
<td>2,995</td>
<td>1,156</td>
</tr>
<tr>
<td>Edinburgh Clinic</td>
<td>1,031</td>
<td>250</td>
</tr>
<tr>
<td>BMI Ross Hall</td>
<td>5,283</td>
<td>631</td>
</tr>
<tr>
<td>Nuffield Health</td>
<td>1,090</td>
<td>24</td>
</tr>
<tr>
<td>Spire Murrayfield</td>
<td>3,412</td>
<td>3,393</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21,375</strong></td>
<td><strong>9,638</strong></td>
</tr>
</tbody>
</table>

12.2 The original forecast at June identified a requirement for net funds of £20.346M to support recovery against 12 week standards for both Inpatient/Day Case treatment and new outpatients (and associated conversion). It also included an estimate of requirements to maintain balance against shortfalls in core capacity on an ongoing basis.

12.3 This forecast has been restated for two reasons: firstly, to recognise £1.029M of baseline funded internal expenditure that aligns against delivery of imbalance. The previous forecast was reported net of these funds and the associated expenditure. Secondly, the revised figures now report separately on the projected and actual expenditure against use of Medinet; an independent contractor supporting short term increases to internal capacity. There are no resource implications associated with these adjustments; changes are made for reporting purposes only.

12.4 Actual expenditure shows an increase in use of both internal (NHS Lothian) and Medinet options. This reflects a lower than forecast use of other (non-NHS Lothian) hospital facilities. At June, the main use of Medinet was to support delivery of the 6 week standard for diagnostic scopes. However this has now been developed into a partnership to deliver increased outpatient and theatre capacity across a wider range of services.

12.5 The table also shows that, within the Independent Sector the majority of spend has been against Spire Murrayfield, reflecting continuation of low take up of patient offers outwith the region.

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Associate Director, Strategic Planning  
21 September 2012  
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### List of Appendices

Appendix 1 – Trend in Patients reported over 12 weeks since April 2011  
Appendix 2 - Time since added to the Inpatient List for those Currently Waiting.  
Appendix 3 - Time since added to the Outpatient List for those Currently Waiting.
APPENDIX 1

Trend in Patients reported over 12 weeks since April 2011

<table>
<thead>
<tr>
<th>BREACHES OF WAITING TIME STANDARDS REPORTED ON MONTHLY MMI RETURNS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatients/day cases &gt; 12 weeks</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>Maxillofacial/Oral</td>
</tr>
<tr>
<td>General Surgery</td>
</tr>
<tr>
<td>Scoliosis</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Gynaecology</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td>Total &gt; 12 weeks</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Outpatients &gt; 12 weeks</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>General Surgery</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Plastic Surgery</td>
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<tr>
<td>Rheumatology</td>
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<tr>
<td>Pain control</td>
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<tr>
<td>ENT</td>
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<tr>
<td>Oral &amp; Maxillofacial</td>
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<td>Med specialties</td>
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<tr>
<td>Neurosurgery</td>
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<tr>
<td>Scoliosis</td>
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<td>Gynaecology</td>
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<tr>
<td>Rehabilitation</td>
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<tr>
<td>Paediatrics</td>
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<tr>
<td>Other CTR</td>
</tr>
<tr>
<td>Gastro Medicine</td>
</tr>
<tr>
<td>Vascular</td>
</tr>
<tr>
<td>Respiratory - sleep</td>
</tr>
<tr>
<td>Dental specialties</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total &gt; 12 weeks</td>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Specialty Description</th>
<th>&gt;6m</th>
<th>&gt;9m</th>
<th>&gt;12m</th>
<th>&gt;15m</th>
<th>&gt;18m</th>
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</thead>
<tbody>
<tr>
<td>PLASTIC SURGERY</td>
<td>271</td>
<td>71</td>
<td>21</td>
<td>14</td>
<td>11</td>
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<tr>
<td>UROLOGY</td>
<td>201</td>
<td>103</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
<td>21</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
<td>25</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>ORAL AND MAXILLOFACIAL SURGERY</td>
<td>56</td>
<td>28</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<tr>
<td>GENERAL SURGERY (EXCL VASCULAR)</td>
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<td>2</td>
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<td>0</td>
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<td>OPHTHALMOLOGY</td>
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<td>0</td>
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<td>GYNAECOLOGY</td>
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<td>0</td>
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<td>GASTROENTEROLOGY</td>
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<td>0</td>
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<td>ORAL SURGERY</td>
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<td>0</td>
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<td>NEUROSURGERY</td>
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<td>0</td>
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<td>CLINICAL ONCOLOGY</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VASCULAR SURGERY</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>638</strong></td>
<td><strong>242</strong></td>
<td><strong>35</strong></td>
<td><strong>17</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

#### August 2012 Extract

- Takes no account of periods of unavailability nor clock resets
- Figures should not be added – eg 638 patients were waiting longer than 6 months, of whom 242 were waiting longer than 9 months

**Source:** Performance Review 20th September 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>
</tr>
</thead>
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<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
<td>15</td>
<td>12</td>
<td>6</td>
<td>2</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
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<td>6</td>
<td>4</td>
<td>4</td>
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<tr>
<td>NEUROSURGERY</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>9</td>
<td>6</td>
<td>3</td>
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<tr>
<td>GENERAL SURGERY (EXCL VASCULAR)</td>
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<td>130</td>
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<td>UROLOGY</td>
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<td>OPHTHALMOLOGY</td>
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<td>0</td>
</tr>
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<td>0</td>
</tr>
<tr>
<td>RESTORATIVE DENTISTRY</td>
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<td>4</td>
<td>1</td>
<td>0</td>
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</tr>
<tr>
<td>ORAL AND MAXILLOFACIAL SURGERY</td>
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<td>3</td>
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</tr>
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<td>REHABILITATION MEDICINE</td>
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</tr>
<tr>
<td>GP OTHER THAN OBSTETRICS</td>
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<td>1</td>
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<td>0</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GYNAECOLOGY</td>
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</tr>
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<td>0</td>
</tr>
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<td>GERIATRIC MEDICINE</td>
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<tr>
<td>DIABETES</td>
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<td>0</td>
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<tr>
<td>PAEDIATRICS</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RESPIRATORY MEDICINE</td>
<td>1</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>1117</td>
<td>322</td>
<td>36</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

August 2012 Extract
Takes no account of periods of unavailability nor clock resets
Figures should not be added – eg 1117 patients were waiting longer than 6 months, of whom 322 were waiting longer than 9 months

Source: Performance Review 20th September 2012
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 Leads in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Note the background and current position as described.

2.2 Recognise the variables and risks around unscheduled care.

2.3 Support the Improvement Plan and receive regular progress reports.

2.4 Agree the financial framework.

3 Discussion of Key Issues

3.1 Background

The 4 Hour Access Standard aims to ensure 98% of all people attending Accident and Emergency (A&E) departments are seen, treated and admitted or discharged within four hours of their arrival. The HEAT target was introduced across Scotland in 2007. The target is 98% rather than 100%, to recognise that some clinical exceptions will be required because of the patients’ clinical need. There is a corresponding standard in England but with a target of 95%.

3.1.1 Initial compliance with the 4 hour standard across Scotland was positive, but in recent years most health boards have struggled to achieve it. (See graphs below). NHS Lothian has failed to achieve sustained compliance with the target. The clinical risks as well as the additional distress, discomfort and inconvenience this can cause for patients and their families is well recognised.
3.1.2 Reasons for non compliance with the standard are often focused on the A&E departments, but the causes are system wide across acute and community health and social care.

3.1.3 To achieve compliance with the 4 hour access target, a flow of patients through a hospital is required in terms of admission and discharge. This applies to patients admitted for elective surgery, as well as for emergency care. A number of factors can influence our ability to manage this, such as ward closures for clinical
reasons, increased attendance in relation to specific public events, seasonal fluctuations, underlying lack of capacity and delayed discharges (patients waiting for packages of care or nursing/residential home placement).

3.1.4 When a shortage of beds in the hospital, or delays in A&E, occur patients may be “boarded”. Boarding of patients occurs when there is a mismatch between the number and needs of patients and the available specialty beds which may not fit the precise clinical condition of the patient. The average age of admitted patients has increased over time, along with the amount of co-morbidity and complexity of conditions. This makes the matching of a patient to the right clinical area more challenging. This change has resulted in a trend observed across the United Kingdom\(^1\) for increasing numbers of patients remaining as boarders under General Medicine. There is increasing evidence that boarding has adverse impacts for patients. This can be reflected in increased mortality, length of stay and readmission rates for patients who have been boarding. In particular, the Scottish Government has directed NHS Boards not to board directly from the front door (acute assessment) areas of the hospitals, as the level of clinical risk is greatest for these patients\(^2\).

3.2 Current context

3.2.1 The average A&E attendance per month across NHS Lothian is 20,410, based on the last 12 months. This gives a daily attendance rate across all sites of 671 but with approximately 46% of those people usually attending the Royal Infirmary (see graph below)

3.2.2 Performance this year to date shows compliance of 93.1% against the 98% target (See graph below).

3.3 Improvement Programme

3.3.1 A refreshed approach to deliver timely Unscheduled Care has been implemented (June 2012) under the leadership of the Chief Executive. The approach is focused on much more integrated working across primary, secondary and health and social community care.

3.3.2 As part of this approach an Unscheduled Care Group (UCG) has been established with multidisciplinary/multiagency membership, and has developed an initial Improvement Programme. 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.

3.3.3 The aims of the Unscheduled Care Improvement Programme (UCIP) is:

- 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.

3.3.4 The UCIP is aimed primarily, but not exclusively, at improving the experience and access of older people and those with long term conditions to appropriate care and support during emergencies and unscheduled events.

3.3.5 Membership of the UCG is inclusive of services and professions delivering care across the whole patient pathway, but management of the care pathway for
individual patients must always be seen in the context of their registration and relationship with their GP. There is a high level of trust, familiarity and expectation of GPs and General Practice that is universal. As part of the UCIP, considerable work is required to engage with GPs and develop more positive working relationships and arrangements which facilitate admission avoidance and early discharge.

3.3.6 The UCG recognises, and will seek to address, the correlation between deprivation and unscheduled care, and will consider this relationship in determining achievement of a sustainable plan.

3.3.7 It has been agreed by the CMT that the Winter Plan will be incorporated into the Unscheduled Care programme. At this time, these plans have not yet been finalised and a further update will be given at a future meeting.

3.4 Improvement Work in Progress

3.4.1 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

3.5 Organisational Culture

3.5.1 To support significant change in the management of Unscheduled Care, cultural change is required in NHS Lothian and its partner organisations to ensure effective person centred patient flow. Part of delivering this is ensuring a greater understanding and focus on the patient needs and actions required within appropriate timescales across different organisations, as well as within individual teams. The standard should never be described as “the A&E target” and should always be considered as a whole system target.

3.5.2 While recognising that changes within primary and community care will assist with demand, there are also changes that are required to the working culture of specialty hospital teams. The changing demographic of the patient population means that either the general medicine function and medicine of the elderly function must expand, with a corresponding reduction in the specialty functions,
or the specialty functions will need to become more flexible in their acceptance of patients.

3.5.3 Part of achieving this change is reliable application of escalation policies, along with greater understanding of the clinical impact on patients of researched evidence, on the mortality associated with A&E department overcrowding and delays, as well as the adverse impacts associated with boarding.

3.6 Financial Framework

3.6.1 The UCG has noted that Local Authority partners have already made significant investments in services in this financial year, to support increased demand. The City of Edinburgh Council (CEC), for example had, by summer 2012, increased the number of hours available for care at home services by over 3300 hours per week. CEC had also recruited an additional 26 staff for its intermediate care service. These investments are over and above costs being incurred across the system, most obviously within Edinburgh CHP, to provide additional downstream capacity. The initial funding for COMPASS in 2012/13 has been secured from within the Edinburgh Partnership Change fund.

3.6.2 A number of key investments have been considered by the UCB and endorsed by the Joint Management Team (JMT). These schemes are considered to be critical as immediate actions to ensure patient safety and support an improving performance against the 4 hour emergency care standard across Lothian. The following schemes are already in place:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Current Year £000’s</th>
<th>Full Year £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reopening of Ward 104, RIE (26 beds) (Non Recurring)</td>
<td>1,469</td>
<td>1,469</td>
</tr>
<tr>
<td>Re-opening of ward 25, WGH, 12 beds (Non Recurring)</td>
<td>634</td>
<td>634</td>
</tr>
<tr>
<td>Emergency Department Workforce Plan</td>
<td>151</td>
<td>855</td>
</tr>
<tr>
<td>COMPASS*</td>
<td>160</td>
<td>360</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,414</strong></td>
<td><strong>3,318</strong></td>
</tr>
</tbody>
</table>

*Compass = Edinburgh CHCP Model of Care to deliver comprehensive assessment of frail older people and joint working of hospital and community services

3.6.3 The following schemes have been agreed by the UCG and JMT and will commence immediate implementation with time scales for start up between 1 and 6 months.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Current Year £000’s</th>
<th>Full Year £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further roll out of COMPASS</td>
<td>200</td>
<td>1,447</td>
</tr>
<tr>
<td>EL and ML Frailty model</td>
<td>281</td>
<td>571</td>
</tr>
<tr>
<td>WL Older People Support</td>
<td>110</td>
<td>310</td>
</tr>
<tr>
<td>Front Door/48 Hours at RIE</td>
<td>214</td>
<td>855</td>
</tr>
<tr>
<td>Front Door/48 Hours at WGH</td>
<td>297</td>
<td>1,188</td>
</tr>
<tr>
<td>Front Door/48 Hours at St. John's</td>
<td>55</td>
<td>219</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,157</strong></td>
<td><strong>4,590</strong></td>
</tr>
</tbody>
</table>
3.6.4 It is proposed that, given the nature of the fixed term funding associated with the Change Fund (which is supporting the Compass, Frailty and WL Older People proposals), these proposals are reviewed within appropriate timeframes to allow evaluation against the predicted impact, to allow decisions for ongoing investment to be made.

3.6.5 An overall financial strategy is being developed which can be integrated into the NHS Lothian Financial Plan. This strategy recognises that the overall ambition of the NHS and its partners is to move care from an institutional setting into a community based setting but also recognises that there are a range of issues in the Acute Hospitals that require resolution as discussed above.

3.6.6 Each scheme will be evaluated to consider its impact in clinical, operational and financial terms. To allow a financial evaluation, the impact of each scheme will be expressed in bed days released, which has been agreed as a currency, and work is underway with colleagues to develop this. Clearly in the light of the current financial framework, these schemes will have to deliver meaningful financial benefits to support the continuing redesign of the Health and Social Care system within Lothian.

3.1.7 This approach aims to mirror the parallel process underway, reviewing priorities for recovery within elective care. However the potential impact on elective care, activity and performance, on unscheduled care and vice versa, is important to note and will be addressed through further integration of capacity and financial plans as well as performance management.

4 Key Risks

4.1 The risks associated with the proposals 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 and being able to implement the proposals, 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, and boarding into surgical specialties is required. This could result in elective cancellations.

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.
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 A rapid impact assessment on the Unscheduled Care Improvement Plan is scheduled for October.

7  **Involving People**

7.1 The plans are in line with the programmes of the Reshaping Care Groups in each locality, which have appropriate representation from service users, carers and the Third Sector.

8  **Resource Implications**

8.1 A full financial quantification of the costs of the additional investments proposed above, and the financial and other benefits arising from them, is currently underway. Additional financial resources have already been invested in 2012/13 as is discussed above and work is underway to agree funding sources for these, along with the impact of further investments which are also detailed. 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.

**Melanie Hornett**
Nurse Director

**Chris Stirling**
Associate Director of Operations

**David King**
Head of Finance

21 September 2012

**List of Appendices**

Appendix 1: Quick summary of proposals for reference
Summary of proposals (Detailed papers on schemes are available on request)

1  Edinburgh: COMPASS in the Community
The approach being taken in Edinburgh, initially piloted in SE Edinburgh, to improve the comprehensive assessment of frail elderly patients and joint working of hospital and community services. This is proposed for roll-out in the first instance to North-West Edinburgh.

2  East and Midlothian: The Frailty Model
The approach being taken in E&M CHCP to redesign health and social care for older people which will contribute to the management of unscheduled care and prevention of admission for the frail elderly.

3  West Lothian: Intensive Case Management
The approach being taken in WL CHCP to redesign health and social care for older people and those with long term conditions which will contribute to the management of unscheduled care.

4  Front Door/First 48 Hours – RIE, WGH and SJH
These proposals relate to a range of actions being applied to improve the model of assessment at the start of the patient acute presentation and to support the reduction in boarding. Matching medical staff capacity with demand, through extending working in evenings and at weekends to support more rapid assessment, reduced boarding and reduced length of stay in line with Capita recommendations. A trial of this approach is underway at RIE and showing reduced 4 hour breaches associated with waits for bed and reduced medical boarding.

5  Ward 104 and Ward 25
These wards were opened at RIE and WGH to support partially the closing underlying capacity deficit confirmed by analysis undertaken by Capita, and are now part of the General Medicine substantive ward capacity.

6  WGH Medicine of the Elderly Mobile team
Implement a new model of providing MoE input and skill-mix to traditionally non MoE ward areas, to reduce the numbers of older patients who are boarding and increase access to specialist MoE multi-disciplinary care.

7  Emergency Medicine Workforce Plan
The existing workforce plan for Emergency Medicine has been updated to reflect changes to the recruitment market and the need to ensure NHS Lothian sustains two adult Emergency Departments (RIE & SJH) and RHSC, while dealing with reductions of medical trainee posts due to MMC. The updated plan, already supported by JMT, is now in the process of implementation.
CONSULTATION ON INTEGRATION OF HEALTH & SOCIAL CARE

1 Purpose of the Report

1.1 The purpose of this paper is to recommend to the Board to acknowledge the context and approach taken to respond to the national consultation on the Integration of Health & Social Care, which were submitted to government on the 11 September 2012, and to homologate these responses.

1.2 Furthermore, the purpose of this paper is to recommend to the Board to endorse the next steps set out in this paper to ensure ongoing progress across Lothian.

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

2 Recommendations

The Board is recommended to:

2.1 Acknowledge the context and approach taken in NHS Lothian to respond to the national consultation on the Integration of Health & Social Care.

2.2 Homologate the four partnership responses.

2.3 Endorse the next steps as set out in this paper to ensure progress across partnerships is made.

3 Discussion of Key Issues

The Context

3.1 In December 2011 the Cabinet Secretary for Health, Wellbeing and Cities Strategies set out her ambition that there would be a consultation in the spring of 2012 on the integration between health and social care\(^1\). This had previously been a party political manifesto commitment in the run up to the 2011 election.

3.2 The commitment made at that time was that the integration agenda would focus on adult care, but particularly care of older people given the recent work through the Reshaping Care for Older People and the Change Fund which has a focus on better integration between health and social care for older people.

\(^1\) [http://www.scotland.gov.uk/Publications/2012/05/6469](http://www.scotland.gov.uk/Publications/2012/05/6469)
3.3 The focus of the integration agenda as set out in the consultation document is around achieving significant improvement on pathways of care, addressing quality of care, reduce delays in hospitals, developing services to keep people at home safely and reduce admissions where appropriate.

3.4 The consultation although starting out with adult and older people groups is not limited to these groups, as there are many elements of joint working across services for children that are a strong foundation for this client group as well. Similarly, as the consultation document focuses on health and social care services, there may be flexibility locally in taking a broader perspective within our partnerships associated with housing, leisure and other related services.

The Approach with NHS Lothian

3.5 Within NHS Lothian the Chief Executive took an early decision that three things needed to be established;

- a process locally through the CHCP Directors for leading the discussions
- engagement around developing joint responses with the four councils as a fundamental starting point for our partnerships
- a pan NHS Lothian senior officer group to start to look what health services would be in scope and which would not

3.6 In order to take this work forward the three CHCP Directors have led a process locally of engagement and have now reached a position where there has 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 Lothian partnership areas. Broadly, all partners have indicated that in principle, a whole system approach, across age groups and departments should initially, at least, be in scope for consideration.

3.7 As part of the process of developing the responses to the consultation discussions and engagement exercises have taken place across the four partnerships.

- Across East Lothian and Midlothian Iain Whyte and Eddie Egan have been involved, informing the responses, In addition Council Board members Donald Grant and Cath Johnston have also been engaged. David Small has led a wide variety of engagement sessions with multi agency, multi professional staff, including partnership/trade unions having their views heard. Key discussions have taken place with elected council members to inform the joint response.

- Within Edinburgh Shulah Allan and Ricky Henderson have been fully engaged. Integration has appeared on the Joint Board of Governance agenda on two occasions. Other Board members have had the opportunity to play in through this route as well. There have also been direct officer to officer discussions, as well as meetings with officers and elected members. In addition there has also been a lot of engagement with the integrated management team which includes the CHP Partnership lead. The scale of ambition to apply a more integrated approach is significant in Edinburgh, the success of which and will rely upon an ongoing involvement strategy to achieve the scale of radical change desired.
• In West Lothian a similar process has been taken and there has been full and meaningful engagement with elected members/members of the Board such as Frank Toner and Peter Johnstone. Additionally Jim Forrest has chaired a multiagency, multi professional group that has ensured key contributions have been made from partners across both health and council from trade union colleagues, managers, clinicians across acute and community settings, patient fora as well as wider discussions between officers of NHS Lothian and the Council.

3.8 Within NHS Lothian a Board seminar was held at the June Board to bring Board members up to speed on the emergent issues and opportunities and have an early opportunity for engagement. In addition an NHS Lothian briefing session was held on the 29th August to bring Board members, particularly new Board members up to speed on the draft responses and an opportunity to ask questions about how the process will move forward from the 11th September consultation submissions. The NHS Lothian Chief Executive covering letter and partner submissions can be found in Attachment 1. It is these responses that the Board is recommended to homologate.

The Next Steps

3.9 Through the pan Lothian NHS senior officer group indicated in 3.5 above, there will be a focus, as we move forward, to ensure that there is a clear and robust process for agreeing at a Lothian wide level, what services are in scope and which are not, with clear rationale for these considerations being transparent. This focussed work will aim to provide reassurance that inter-dependencies and system wide impacts have been considered, and worked through, to ensure no detriment to quality of service being delivered, with the clear benefits of services being in or out of scope being identified for moving into the new Health & Social Care Partnerships.

3.10 Additionally the process and framework across each of the four mutli-agency partnerships in Lothian will require to be agreed, and will be led by the three CHCP Directors and the Director of Strategic Planning. As part of that process, strong principles and values will be applied, including:

Principles:
• Being clear on the outcomes that we hope to achieve
• Being clear on the benefits for patients, particularly around quality and experience
• Ensuring there is continuity of care and pathways
• Understanding the productivity and efficiency gains
• Ensuring service sustainability, and understanding wider impacts across the whole system
• Staff contractual arrangements being minimally affected, with it being clear however, that staff will require to be supported to work better collectively, in different ways to improve outcomes
• Ensuring that the rationale for bringing together the services under the auspice of our acute care system, is not lost when we develop our integrated partnerships.

Values:
• Shared vision
• Patient centred focus, through improving outcomes
• Openness and honesty
• Pragmatism
• Effective leadership
• Commitment to change

3.11 In taking this approach we aim to ensure that the new health and social care partnerships being created through the changes in legislation:

- are firmly focussed around individuals, carers and families, with services provided to the highest quality
- are characterised by strong and consistent clinical and social care professional leadership
- have clear accountability arrangements in place
- will demonstrate effectiveness, with services being underpinned by flexible, sustainable financial mechanisms, that give priority to the needs of the populations they serve.

3.12 In developing this framework and process we will ensure that there is further scope for Board members and in particular the CHCP Chairs to be actively engaged in the process and decision making. An outline of this work and the work plan with time lines could be brought to the October Board, This would also include an outline of our strategic longer term ambitions.

3.13 In undertaking this work we obviously need to ensure that we maximise the public pound, therefore there are a range of budgetary processes and check points that we need to build into the above process and framework which include:

- national and local solutions will be required to find the most appropriate model to allow the integrated resource to be used efficiently across both organisations
- long-term financial planning arrangements and practical funding mechanisms will need to be established, which deliver the best outcomes for people within the reality of the budgetary constraints
- the agreed financial planning solutions will need to agree mechanisms for managing cost pressures, efficiency targets, demographic changes, the scheme of delegation and procurement issues etc across both partnership agencies
- Partnership Agreements will need to be agreed by both the NHS Board and individual Local Authorities which cover financial planning, reporting etc and will provide guidance if an impasse occurs
- reconciliation of priorities of both parent organisations associated with efficiencies and reinvestment plans should be clearly set out, with the shared vision and priorities influencing the joint commissioning plans
- recognition that there are a number of ways in which the NHS and local government differ. These include VAT Regulations and capital expenditure and income rules, and that these need to be progressed again, through national guidance

3.14 It is also important to note that NHS Lothian and its four council partners have a strong foundation form which to work, and have over many years managed to
achieve both a pan Lothian and individual partnership approach to the delivery of services without putting at risk equity of access or variance in relation to the quality of care. Strong examples of this over recent years have been the work done through service strategies for mental health, learning disability, drugs and alcohol services, older people.

3.15 More specifically for older people, in relation to the most recent experience through the Change Fund has shown the clear ability for the partnerships to work collaboratively to achieve agreed the shared visions with implementation of joint plans and strategies to improve outcomes through application of shared values and principles. Indeed, this experience across the local partnerships has demonstrated that we can work more widely than simply between health and social care, with each of the Change Fund Plans being developed, agreed, implemented in part, and overseen by the positive inclusion of the voluntary and private sectors. Many of the key innovation elements across the partnerships have been led by our voluntary sector partners, to test different ways of service delivery, whilst improving quality and outcomes. This will be further consolidated across our partnerships with the development of Joint Commissioning Plans for Older People, that are currently being developed for submission from 2013 and beyond.

3.16 There are also many positive examples that similarly apply to our work across children’s services and more recently the work on developing Early Years Change Fund proposals being a good example of partnership working that we can also build on as we look at what aspects of children’s services may be in scope.

3.17 Going forward, the work as outlined above will be actively led by our Directors. In doing so there is an ambition through progressing work thus far, and based on discussions that have taken place locally, and at a pan Lothian level, that we are not curtailed by the outcome of the consultation process and any final recommendations. There is a strong view that local determination should agree the scope of system wide improvements that can be achieved by applying principles of integrated working, to achieve the scope of ambition.

3.18 It is highly unlikely that there will be consensus across the thirty two partnerships in Scotland as to the ambition around integration and its scope. We are clear that we would wish to work from the basis that ‘everything’ is in scope until rationalised otherwise, and the process for this has been highlighted above. That said, we are also mindful that NHS Lothian is a large tertiary teaching hospital and we host a range of national and regional services which will also require careful consideration and negotiation to ensure the best outcomes are achieved for these populations as well, as we understand that it won’t simply be in ‘our gift’ to make unilateral decisions about these services. We know from work done to date that the timelines for integration may differ, however we are well placed to move forward positively particularly with the foundations already set in West Lothian and in Edinburgh, where the scale of ambition at this stage to progress services in a more integrated way, is significant.

4 Key Risks

4.1 There are many risks associated with the integration agenda and that is why a clear plan for agreeing which services will or will not be in scope with work done on looking at unintended consequences and systems wide impacts requires to be part
of the fundamental process and approach as described above. Risk assessment of all plans, as well as impact on tackling inequalities will also be addressed as part of the agreed processes and framework.

5 Risk Register

5.1 There are no specific items as yet that have been placed on the Risk Register, however once the process gets underway any issues will be flagged, recorded with mitigating actions taken as appropriate and duly flagged to the Board in turn.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been carried out as yet, but will be done at both partnership and Lothian level as more detailed work progresses. The Scottish Government in developing the consultation document have themselves undertaken an equality impact assessment in March 2012 in advance of the consultation document going out and we are well cited on these and will consider as part of our deliberations.

7 Involving People

7.1 This will continue to be a key aspect of the work that will be progressed, not only internally within NHS Lothian staff groups, and with our council partners but with the public, carers and family members as well as with the third sector and others as appropriate and required. This will feature as part of our planning going forward and more detail will be contained within each of the local planning arrangements.

8 Resource Implications

8.1 The resource implications are significant regardless of what is in scope. Issue around financial and budgetary process have been highlighted in section 3.13 above.

8.2 We will also ensure, that across Lothian, the work that has been developed as part of the integrated resource framework (IRF), will be fully utilised to enable targeted resources for populations. We now have three years worth of activity and financial data across health and social care. This should be seen as a source of valuable information for planning as we have the ability to track patient journeys across both health and social care, and therefore will be able to track the rebalancing of care across the whole health and social care systems. Partnerships are currently considering what analytical resource they require to sustain and support this system in an active way.

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Director of Strategic Planning & Primary Care
4 September 2012
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Jim Forrest
Director, Community Health and Care Partnership, West Lothian
List of Appendices

Appendix 1 - NHS Lothian Chief Executive covering Letter to Consultation
Appendix 2 – West Lothian Partnership Joint Response
Appendix 3 – Edinburgh Partnership Joint Response
Appendix 4 – East Lothian Partnership Joint Response
Appendix 5 – Midlothian Partnership Joint Response
Integration of Adult Health and Social Care in Scotland
Consultation on Proposals - May 2012

Thank you for the opportunity to respond to the above Consultation. Broadly, the proposals, including the future enabling legislation are welcomed by the NHS Lothian, particularly:

- the case for change, along with the ultimate aim of improving nationally agreed outcomes for people, by working more effectively and efficiently together
- the recognition of a strengthened role for locality community planning, with the view that the involvement of key clinical and professional staff will add value to meeting the needs of partnership populations
- that staff contractual arrangements being minimally affected, with it being clear however, that staff will require to be supported to work better collectively, in different ways to improve outcomes
- that partnerships across Lothian consider that the option of integrating budgets through the delegation to the Health and Social Care Partnership, established as a body corporate, will allow most benefit on utilisation of resources.
Key areas suggested, that we would propose for further consideration at national level include:

- flexibility around local determination associated with the scope of services to be included within the integration agenda, bearing in mind key co-dependencies across adult services, and the considered benefits for children and young people

- clarity around the governance arrangements, taking into account the local authority democratic process, and the current mandates of both health and social care, including the configuration of the Partnership Committees, and the ongoing role of NHS Partnership Forum members

- being clear on the mandate, and level of autonomy, of the joint accountable officer

- ensuring local determination around how services will be planned, commissioned, delivered, evaluated and reviewed

- recognition of the scope and scale of change across partnerships, and the requirement to have investment associated with organisational change and development, including leadership and staff development, as well as supporting the mechanisms of ‘commissioning’ described in the consultation, relating to the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and the partnerships working together to put these in place

- there is a keenness to ensure a consistent and coherent approach to integration across all ages and client groups, and this should be emphasised in the final guidance, along with the opportunities to expand the scope to housing and other connected service provisions.

It is recognised that although NHS Lothian has four partnership areas, which will undoubtedly bring with it challenges, it is considered that the integration agenda will also bring clear opportunities to have a whole system pathway approach to improving outcomes for our population.
Care will require to be taken to ensure that the rationale for bringing together the services under the auspice of our acute care system is not lost when we develop our integrated partnerships.

NHS Lothian will continue to strategically support the partnerships to undertake their role and responsibilities locally, with it being acknowledged that there is likely to be a variation in delivery mechanisms and organisational structures to ensure safe and effective prevention, health promotion, assessment, care, treatment and support is delivered to a consistently high quality, to benefit our population.

**Partnership Responses**

In discussion with Partnerships and within the Corporate Management Team of NHSL it was agreed that the CH(C)P Directors / General Managers would be instrumental in leading the health and social care integration discussions at a local level, reflecting differences in existing structures between CH(C)Ps, and take responsibility for developing the partnership responses to the national consultation.

Local discussions and negotiations have taken place to ensure a partnership response from each CH(C)P area, to reflect the positive foundation against which the partnerships will progress as the legislation and guidance is developed nationally, and these are attached, and commended to you.

Yours sincerely

Signature

TIM DAVISON
Chief Executive

**Attachments**

1a – West Lothian Partnership Joint Response
1b – Edinburgh Partnership Joint Response
1c – East Lothian Partnership Joint Response
1d – Midlothian Partnership Joint Response
Health & Social Care Integration

WEST LOTHIAN PARTNERSHIP RESPONSE

Consultation Questionnaire

The case for change

**Question 1:** Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes ☑ No ☐

The focus on older people is understandable given the scale of the demographic challenge. However West Lothian Community Health and Care Partnership (CHCP) currently includes community care, children and families, health improvement, criminal justice, mental health, primary care, allied health professionals, community nursing and hosted services (Lothian wide services managed by the CHCP on behalf of NHS Lothian, namely the Salaried Primary Care Dental Service and smoking cessation).

Many adult services are already integrated or delivered jointly e.g. mental health, learning disability and addictions and it would be essential that any proposals include these. It would be anticipated therefore that in order to further develop the CHCP under the new arrangements locally these would constitute the minimum level of service areas in West Lothian.

Also when considering older people it may not be helpful to focus on age bands as this can create artificial differences. It may be more helpful to focus on biological age and individual need rather than only chronological age.

West Lothian CHCP asks for assurances that local flexibility will be given in determining the scope of the partnerships beyond the statutory minimum.

Prior to the formation of the CHCP in 2005, secondary and primary care services were integrated in West Lothian. Since the establishment of the CHCP, primary care and social care services have been integrated. We would now seek to develop a complete integrated care pathway for local people.

Outline of proposed reforms

**Question 2:** Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes ☑ No ☐

Yes the framework appears to be comprehensive with sufficient flexibility to allow for local requirements.
Integration will only succeed nationally if the correct legal framework is put in place through statutory amendments, and if the lines of accountability are clearly drawn.

However very little mention is made of the role of health improvement to advance wellbeing and reduce health inequalities. Also other than a brief reference in Annex B no mention is made of addiction services in the consultation document.

The status of the partnership under one model is described as “a body corporate”, this requires to be clarified as to whether this means a separate legal entity, or some new form of hybrid body. There are models available to use, or else the body could be part of the decision-making structures of both partners as a form of committee or joint committee (see Question 7).

The complications of establishing a separate corporate entity are unnecessary, when a committee model is achievable with minor statutory amendments. That arrangement fits with traditional decision making in both councils and health boards.

### National outcomes for adult health and social care

**Question 3:** This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes □ No □

West Lothian CHCP has developed an integrated approach to performance management over the last year and close partnership working between Council and NHS staff has led to considerable progress in the development of a more comprehensive range of performance indicators across the CHCP. Work is ongoing to extend the range of performance indicators to include measures related to GP practices and community nursing.

Some of the national outcomes are very high level and clarity is required regarding the detail. A single unified set of outcomes(targets is required to replace the current separate sets to avoid duplication and make best use of resources. Also there needs to be a clear connection between these and the parent body’s set. An outcome–based focus is more useful but not if it results in being pulled in different directions by the target.

Responsibility for delivery of services and outcomes should lie with the partner bodies and not directly with the JAO, which is the traditional and familiar arrangement. The JAO will in turn be responsible for delivery to the partner bodies through their Chief Executives. Separate audit and scrutiny arrangements are required to ensure councils and health boards comply and perform.

**Question 4:** Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?
It will be essential to have strong and effective linkages to the community planning agenda in order to provide an opportunity to give expression to the broader contribution of the partners to the SOA.

West Lothian Community Planning Partnership is currently completing a CPP wide strategic assessment that will help determine local priorities and focus for the new combined West Lothian Community Plan and SOA from April 2013. Analysed data and information from across all the SOA themes will provide a clearer focus of local priorities. CHCP services are very involved in that process and are members of the core project team. It is expected that nationally agreed but locally focused outcomes for adult health and social care will feature in our new SOA.

**Governance and joint accountability**

**Question 5:** Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

West Lothian CHCP is well placed to respond to the new arrangements, already having a single joint director, integrated management arrangements and a number of fully integrated operational teams and in many ways already represents the integrated model of health and social care proposed by the Scottish Government. Our governance arrangements also reflect the equal involvement of both partners, with equal representation from each on the CHCP Board. The NHS element of the Board consists of two Non-Executive Directors, one Partnership representative (nominated by Lothian Partnership Forum) and one GP (nominated by the West Lothian GP Practice forum). The Board provides governance oversight to the activities of the CHCP to ensure the remit of the CHCP is being effectively discharged. The CHCP has found that this approach allows an equitable relationship between partners and satisfactory assurance regarding governance and accountability.

Delivery/decision-making and oversight/scrutiny are two separate functions, and should be separated clearly. The proposal for accountability adds an unnecessary layer to current arrangements for scrutiny and accountability which apply to councils and health boards.

The JAO will be responsible by means of contractual arrangements to the partners through their Chief Executives for performance and delivery, and the partners will retain responsibility for meeting agreed outcomes, and will be subject to audit and scrutiny through existing mechanisms. Ultimate accountability for strategic service development decisions will remain with each partner (NHS Lothian/West Lothian Council). This needs to be clear in how we structure any future models. It would be helpful therefore if the Bill recognised the potential risk of a partner following a course of action which might be at odds with the direction of the partnership.

The position of Council Leader is not a legal requirement, and no single councillor, whether Council Leader or not, carries the legal and management powers and
responsibility the proposed arrangement envisages.

**Question 6**: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes [ ] No [√]

West Lothian CHCP benefits from being coterminous across health and local authority boundaries. This coterminosity has proved advantageous for West Lothian and facilitated joint working/planning, generally reducing bureaucratic obstacles that may otherwise have resulted from straddling boundaries.

**Question 7**: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes [ ] No [ ]

See response to Q.5.

The proposals do not address existing statutory limitations on councils’ powers in relation to their decision making structures. Councils can only establish a joint committee with other councils, not health boards, and there are rules which prevent appointment of an equal number of non-councillors to decision-making committees. Relatively simple amendments can be made to remove those obstacles and ensure there are options available in determining the decision-making structure to apply.

Those amendments will also help with audit and scrutiny arrangements, since a similar committee can be established to perform that role and oversee the way the partnership board operates.

**Question 8**: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes [√] No [ ]

More detail is required to ensure arrangements are sufficiently robust without being inhibiting.

**Question 9**: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes [√] No [ ]

West Lothian has operated a community health and care partnership which has included a substantial range of council and health services spanning all age ranges including community care, health improvement, primary care, community nursing, mental health, children and families, allied health professionals, criminal justice and Lothian wide services. In order to further develop the partnership it will be essential to continue and
build upon these services to meet the twin challenges of shifting the balance of care and advancing wellbeing. The opportunity to include elements from the acute sector is welcomed. As stated in Q.1 this will be necessary to enhance the development of care pathways and to provide seamless services for people encompassing primary, secondary and social care.

**Integrated budgets and resourcing**

**Question 10:** Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

Yes ☑️ No ☐

It is likely that Option A – Delegation to the Health and Social Care Partnership, established as a body corporate will be the preferred model for West Lothian. The definition of body corporate is to be advised. It is not envisaged that conditions of service of staff in either Health or Social Care will be altered. Consequently the overall responsible manager having full executive autonomy of decision making is crucial to its efficacy.

The West Lothian Model currently envisages both partners agreeing an annual financial contribution to the Health and Social Care Partnership. Each contribution would still be accounted for through respective bodies financial systems and accounts but would be delegated to the Partnership under the management of the Jointly Accountable Officer.

Given the demographic demands in this area over coming years it is important that the provision of health and social care services is operated as one and decisions are made jointly within overall resources available.

Therefore the principles made in the case for change are strongly supported. It is important to acknowledge however that significant work will be required in order for the budgetary and financial aspects of this to work effectively. It will be important that council and health finance work closely over the coming months to agree approaches required for annual and medium term budgeting, in year monitoring and financial reporting including final accounts. This will need to take account of separate current financial frameworks and systems in place. However harmonisation of planning/budget cycles within health and council should be considered.

A key aspect of successful integrated budgets will be both public sector bodies at all levels embracing the integrated budget principle and accepting that each of their resources need to be seen as a total resource to be prioritised towards shifting the balance of care and achieving key outcomes. This will mean resources being vired across public sector bodies from and to areas that previously would have been seen as a council or health responsibility. Every effort will be made to ensure joint budgets are utilised to improve the outcome for the West Lothian population and enhance existing public sector workforce within West Lothian.

**Question 11:** Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?
West Lothian’s excellent performance in relation to managing hospital discharge (since the census in July 2009, only one patient in West Lothian has been recorded as being delayed for longer than six weeks in hospital) illustrates the benefits of collaborative working and flexible use of resources across health and social care services.

Also the establishment of the Health and Social Care Change Fund has given an indication of how integrated budget can be operated. Through this mechanism an overall pot of money has been allocated to West Lothian and council and health have jointly agreed (with community planning partners) on priorities for how this money has been utilised.

This has worked effectively and has been very helpful in improving joint working between both bodies. It has also helped to understand issues and perspectives of both bodies which has aided understanding of resource issues each have.

From a finance perspective, it has led to a much closer working relationship between finance professionals in both bodies. During the year this has resulted in money being vired from Health-led project to Council-led project which underlines a joint working approach and a genuine acceptance that the Change Fund is a West Lothian resource rather than belonging to an individual organisation.

This working relationship, and joint reporting stemming from this, has established a solid footing for further integration.

West Lothian also has a strong and effective CHCP with existing areas of joint resourcing operating in Mental Health, Community Rehabilitation and Brain Injury Service (CRABIS), Joint Equipment Store and through partnership centres at Strathbrock and Fauldhouse.

**Question 12:** If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes √ No □

Given the strong track record of joint working in West Lothian between the council and health it is felt that clear guidance on this would be sufficient to achieve the integrated budgets and resourcing objectives set out.

West Lothian CHCP supports the position that the method of integration should not be imposed on councils and health but rather that local agreement on what is most suited for an area will provide the best means of effective integration.

**Jointly Accountable Officer**

**Question 13:** Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes √ No □
The position of JAO requires clarification. Responsibility for delivering agreed outcomes should rest in statutory terms with the partners. The partners should be required to appoint a JAO who would be accountable to them in a contractual sense in the same way as any other employee or officer.

The partners should then be required by the legislation to delegate certain powers to the JAO as a minimum, with the power to delegate more depending on local agreement. That will ensure maximum flexibility whilst requiring partners to take the basic steps necessary for the success of the JAO position.

Strong and effective oversight will be needed of the JAO, especially where major investment decisions are involved. There should also be appropriate involvement of relevant finance professionals such as the Section 95 officer in local authorities and Health equivalent.

However it is essential that the JAO has the required delegated authority to vire resources as appropriate without having to refer back to the parent bodies.

**Question 14**: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes √ No ☐

A joint Director post, similar to the proposed Jointly Accountable Officer post, has been in place in West Lothian since 2005. The Director post manages the Senior Management Team who in turn manages all CHCP health and social care staff. This level of seniority is crucial to the effective management of resources and avoids ambiguity regarding accountability and reinforces equity as ultimately all staff are accountable to the joint post who in turn is equally accountable to both partner bodies.

However concerns have been expressed in the past in relation to legal/contractual responsibilities of the Director post which resulted in a formal Partnership Agreement failing to be signed off. The legal position of the single accountable officer in relation to resource and staff management would therefore need to be clarified and redefined in legislation if required to enable the post to have sufficient autonomy to discharge his/her duties effectively.

Given the significance of the role, it may be appropriate to designate the JAO as a statutory officer of the council, in the same manner as the head of Paid Service and Head of Social Policy.

**Professionally led locality planning and commissioning of services**

**Question 15**: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes ☐ No ☑

It would be inappropriate for locality planning to be directed by the government. By its very nature locality planning needs to be informed by local needs and priorities. Current
strategic arrangements in West Lothian reflect this approach. Local priorities need to be identified locally otherwise there would be no local autonomy.

Also see response to Q4.

**Question 16:** It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes ☐ No ☐

Further clarification is needed regarding how the active and meaningful involvement of key players will be encouraged and supported otherwise there is a danger of tokenism. Local input and influence will be important to meet local requirements. From NHS and Council a system comprising of local professionals, manager and staff representatives will be developed.

Also see response to Q4.

**Question 17:** What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

West Lothian is currently completing a Community Planning Partnership wide strategic assessment that will help determine local priorities and focus for the new combined West Lothian Community Plan and SOA from April 2013. The analysed data and information will provide a clearer focus of priorities for West Lothian and local practitioners/professionals.

The development of a local interface group in West Lothian has contributed to more effective involvement between clinicians and social care professionals. The group meets bimonthly with membership from acute, primary care and social care, clinicians and managers. This has improved communication, tackled service and patient safety issues and facilitated implementation of integrated care pathways.

**Question 18:** Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Yes ☐ No ☐

This should be agreed locally according to local needs and circumstances. See response to Q. 17 regarding West Lothian Interface Group. Also West Lothian has a Primary Care Forum which involves all GP practices.

**Question 19:** How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

This should be agreed locally according to local needs and circumstances.
Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes ☐ No ☐

Again this should be agreed locally according to local needs and circumstances.

Do you have any further comments regarding the consultation proposals?

Other than a brief reference in Annex B no mention is made of addiction services in the consultation document. Addiction services are included in the services provided by West Lothian CHCP and we would intend to continue this arrangement given the links between addictions and health and wellbeing.

Also very little mention is made of the role of health improvement to advance wellbeing and reduce health inequalities.

Do you have any comments regarding the partial EQIA? (see Annex D)

In Annex D reference is made to health care being ‘free at the point of need’. This is not the case. NHS community dental services, as provided by the Salaried Primary Care Dental Service, are chargeable (Lothian SPCDS is a Lothian wide service within West Lothian CHCP).

Do you have any comments regarding the partial BRIA? (see Annex E)

No.
### Health & Social Care Integration

#### EDINBURGH PARTNERSHIP RESPONSE

Consultation Questionnaire

Integration of Health and Social Care in Scotland
Scottish Government consultation on proposals
City of Edinburgh Council and NHS Lothian
Joint Response

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This response is submitted on behalf of the City of Edinburgh Council and NHS Lothian.

A number of joint discussions have taken place between May and August. The deadline for submission to the Scottish Government is 11 September 2012. It is proposed that the response be:
- submitted as a draft to the Joint Board of Governance for comment on 27 August;
- submitted for approval to Policy and Strategy Committee on 4 September;
- submitted for approval to NHS Lothian Board
- submitted to the Scottish Government between 4 and 11 September; and
- forwarded for information to Health, Social Care and Housing Committee on 11 September.

The case for change

**Question 1:** Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

The initial focus on outcomes for older people provides a practical baseline, which leaves sufficient scope for local determination. Given that the arguments in favour of integration are sound, serious consideration will be given in Edinburgh to extending the scope to all service user groups, particularly as many of our services provide simultaneously for older people and adults.

This will have the benefit of ensuring that management arrangements are not complicated by the creation of new barriers between groups.

As the consultation document states, conditions associated with old age often present much earlier than 65, and people with disabilities and mental health issues have needs irrespective of their age. A focus on older people alone creates ‘an artificial divide within adult services’. It would be helpful to consider specifically the management and treatment of long term conditions for adults, such as diabetes, heart failure, dementia and COPD.

There is a commitment to explore the development of an integrated children's service for Edinburgh.

A number of services that are currently provided by East, Mid and West Lothian CHPs on behalf of the City of Edinburgh Council are being reviewed.

The consultation document is explicit about the need to integrate some
acute services. This is welcome. NHS Lothian is keen in principle to integrate acute services within the Health and Social Care Partnership in order to improve pathway management, resource utilisation and most importantly, patient experience.

In re-designing and reconfiguring health and social care services, it will be essential to ensure that the integration of primary and secondary care services is enhanced, such that positive outcomes for people are maximised and that those services not included in the partnership are clear about their relationship to it.

The integration process will also need to take account of other local authority strategies, which have a significant effect on older people. For example, community engagement, fuel poverty, leisure and housing.

Appendix A outlines the services that may be considered for inclusion between NHS Lothian and City of Edinburgh Council. This is not an exhaustive list and continued discussions across the Council and NHS may identify additional services which, if integrated could improve pathways of care and outcomes for people.

Outline of proposed reforms

**Question 2**: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

The proposed framework is reasonably comprehensive. It is helpful to see acknowledgement of the good examples of integrated working, which already exist, and the stated intention that proposals will not dictate local delivery mechanisms or organisational structures so that these can be developed to suit local needs.

The joint responsibility arrangement is helpful in ensuring equity between organisations in the integration process. It avoids the distractions of structural change and allows a focus on matters which deliver best outcomes for people.

It would be helpful if the Scottish Government would consider a more holistic approach to an individual’s needs and include guidance on the connections with other critical support services, which are not referenced in the national proposals. This will include areas such as community engagement, fuel poverty, leisure and housing services.

As the consultation document states, additional ‘improvement work’ will still be necessary at a local level to complement the proposed ‘systems changes’ outlined in the framework.
Additional guidance would be helpful on how shared capital assets should be managed as part of the integration agenda and into the future or whether this would be left to local determination.

National outcomes for adult health and social care

**Question 3:** This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

It is important for effective operation and delivery of services that we have a joint set of performance measures and outcomes, jointly agreed and owned, which continue to improve on current national indicators. Joint reporting is an important component of this shared responsibility.

The approach will be sufficiently strong to effect the changes required, subject to joint agreement being achieved.

An outcomes-led approach with jointly agreed and reported outcomes between Health Boards and local authorities will ensure the partners are focused on the same priorities. This will make them easier to deliver. However, the necessary cultural shift within both organisations will be significant and should not be underestimated.

The required changes to reporting arrangements and developing mechanisms to support joint accountability will need to be managed as part of the change programme.

The Edinburgh Health and Social Care Partnership intends to:
- focus on a small number of outcomes, which are critical to effective service delivery for service users and to engage with service user representatives to ensure their relevance;
- strip out any organisation-specific indicators, which do not contribute to the agreed outcomes, in order to make the reporting arrangements more manageable and focused; and
- review whether there any existing perverse incentives or conflicts in performance targets, which may be within the existing separate performance management arrangements to ensure overall care is at the forefront of the newly integrated approach
- ensure that governance structures and decision making processes are clear in order to avoid slowing down integration and service delivery
- develop structures, which ensure that other partners in a holistic approach can be included in the planning process.

We intend to ensure strong and effective linkages to the Community Planning agenda, as this develops, to ensure the proposals support the
broader goals of Single Outcome Agreements, such as tackling health inequalities.

It would be helpful for any future legislation to support these approaches.

**Question 4:** Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Depending on the scale and nature of the national outcomes, inclusion in the SOA may be helpful. However, this should be left to local determination.

Partner agencies should have the ability to determine locally the content of the SOA, in line with their joint priorities. It has been agreed in Edinburgh that the partners will determine a small number of key priority outcomes, based around key issues for the locality. The SOA may not simply be a reflection of the local position on national outcomes for any specific service/agency. It might therefore be unhelpful to include all national Health and Social Care outcomes in the SOA. This is particularly the case when considering that the SOA is a focus of joint work across a multiplicity of agencies.

**Governance and joint accountability**

**Question 5:** Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

**Further work will be required to mandate the roles required.**

This is one of the most complex areas of the proposals. For the arrangements to be truly effective in terms of ensuring accountability of the key players, there will need to be discussions on current local government legislative powers.

Under current local government legislation, only a council committee, sub-committee or a delegated officer can be authorised to commit resources/take decisions on behalf of the council. In view of this collective responsibility, the council leader cannot currently undertake this role.
Further work will need to be undertaken at a national level to connect the governance role of the Leader and the Health Board Chair back to the full Council and Health Board.

It would also be helpful to reflect on the ability of the arrangements to truly hold the chair and vice chair of the new Health and Social Care Partnership to account under current local government legislation, when the collective responsibility applies.

It is proposed that the Chief Executives of NHS Lothian and the City of Edinburgh Council be accountable for performance to the Council Leader, Health Board Chair and Cabinet Secretary. However, constitutionally, the Council Chief Executive is formally accountable to the full Council, not to the Council Leader. This therefore needs to be addressed properly in the proposals.

The Edinburgh Health and Social Care Partnership will specify clearly the leadership and accountability roles and responsibilities held by the Partnership itself and those delegated to the Jointly Accountable Officer, particularly with respect to budgets, investment and the obligations associated with these. Guidance from Scottish Government on this would be welcome.

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Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

It may be sensible to allow for partnerships to cover more than one local authority area, but this must be subject to local determination.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes in principle, but they require alignment with current local government legislation.

The proposals to have voting members of the Health and Social Care Partnership Committee made up of an equal number of Health Board Non-Executive Directors and local elected members are sensible and balanced in principle. A minimum of three representatives from each statutory partner may be insufficient to reflect the political mandate of the local population. However it is important to ensure that local authority representation on the Partnership reflects the democratic make up of the council.

There are a number of issues, which need to be addressed to facilitate this
Currently, any committee of the City of Edinburgh Council is required, in law, to have two thirds membership of elected members. Further work will be required to marry this legal requirement with the proposal for the Partnership Committee to be both a committee of the Council and of the Health Board, and have an equal split between elected members and non-executive Health Board members.

In NHS Lothian there is an issue of insufficient Health Board Non-Executive Director resource to service partnerships across the NHS Lothian region. NHS Lothian is currently considering how it can support the governance arrangements for the Health and Social Care Partnership.

There are concerns regarding the number and role of non-voting members on the partnership committee, and a balance needs to be struck between the need for these roles and the size of the partnership committee. However, the importance of professional, patient and third sector advisers is strongly supported.

Patients, service users, the third sector, neighbourhood partnerships and carer organisations have all made a significant contribution to the development of CHPs. Consideration will need to be given to the best way to enhance and improve these contributions in the partnership arrangements, learning from both good practice and lessons of the past.

It would be helpful if the Medical/Clinical Director role could be chosen from a variety of the clinical leads/professions and have a clearly specified role on the committee to represent the range of clinical perspectives (not simply that of their own profession). Alternatively the partnership may consider the establishment of a clinical advisory support structure with the chair of this structure responsible for representing a range of clinical views. The key point is that relevant clinical/functional perspectives are clearly represented when these need to influence decision making.

The NHS has a strong history of partnership working with Trade Unions. This will need to be reflected in the final governance arrangements for the Health and Social Care Partnership.

**Question 8**: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

**More detail required.**

The introduction of a new set of nationally agreed outcome measures, which are jointly agreed and which apply across all adult health and social care will improve the alignment and balance of performance measures for older people/adult services. The coverage must expand beyond measures...
such as delayed discharge to be truly meaningful. This has potential to improve the robustness of performance management arrangements in a way that is meaningful for those in receipt of services.

However, joint performance management will take time to bed in across the two organisations because of practical issues related to data, systems, etc., and these issues should not be underestimated.

NHS Lothian and the City of Edinburgh Council each has its own distinct performance management arrangements and systems to manage failing services and these provide sufficient public confidence. It is less clear how performance will be managed at the level of the new Health and Social Care Partnership. Clarity is needed on the nature of support arrangements for managing ‘failure’.

The shift to personalisation must also be recognised as an influencing factor on outcomes for people. The monitoring and measurement of this will be an important part of overall outcomes monitoring.

It would be helpful for the collaborative working across external scrutiny partners to provide for a consistent approach to measuring performance, establishing evaluation criteria and supporting quality development in adult health and social care. It is essential that this is aligned to the Local Government Strategic Group, which identifies and agrees the key risks in each council and develops an appropriate programme of scrutiny activity.

**Question 9:** Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Local determination on this matter is very welcome, particularly for the Edinburgh CHP where it is hoped a broad view of integration will be taken.

**Integrated budgets and resourcing**

**Question 10:** Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

The models proposed do offer a real mechanism to improve the effective use of the resources available. However, demographic forecasts are such that the efficiencies achieved through these changes are unlikely to be sufficient to offset the need for increased resources in future.

Key issues to be addressed will include:
- finding the most appropriate model to allow the integrated resource to be used efficiently across both organisations;
- establishing long-term financial planning arrangements and practical funding mechanisms, which deliver the best outcomes for people within
the reality of the budgetary constraints; and
- agreeing the mechanisms for managing inflation, the ordering and
authorising processes, procurement, etc.

There are a number of ways in which the NHS and local government differ. These include charging, VAT and capital rules. It would be helpful if detailed guidance were made available to progress these issues.

A national work programme has been established to consider the implications of these proposals on staffing. While it is believed that changes to terms and conditions are an unnecessary distraction and will not form part of changes in Edinburgh, it is important for these matters to be fully scoped, and any issues addressed at an early stage at a national level.

**Question 11**: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

In Edinburgh, there are examples of flexible use of resources across both organisations, including:
- Intermediate Care;
- Geriatric Orthopaedic services; and
- Stroke Pathways.

Edinburgh has some experience of resource transfer between organisations and with the development of joint approaches through the Change Fund.

It would be particularly helpful to learn of examples from other bodies where flexible use of resources has led to demonstrable improvements in patient care and/or efficiencies, which can be redirected to front line services.

**Question 12**: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Edinburgh is one of the few CHPs in Scotland with a jointly appointed Director of Health and Social Care with responsibility for services in both the NHS and the local authority.

A joint management team meets regularly to work towards joint outcomes.

A number of joint services have been established with both NHS and Council staff, for example Intermediate Care.

Edinburgh is keen to retain its position as a leader of integration across health and social care, and therefore the Council and NHS Lothian will seek to integrate beyond the scope outlined in the consultation document.

Local determination is important. Therefore minimum, rather than maximum, categories of spend are welcomed.
Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

The financial authority to manage budgets would be established either through a service level agreement/partnership agreement between organisations or through accountability to the chief executive of the host organisation.

With the requisite commitment from both partners and clarity within the agreement, these mechanisms would deliver sufficient financial authority to the Jointly Accountable Officer to facilitate shifts in investment and deploy resources across the partnership to ensure efficient pathways of care.

Strategic financial decisions, for example over major investment, will remain the responsibility of the Health and Social Care Partnership.

The proposals can be interpreted as going beyond what would normally be allowed within a local authority context, where only a delegated officer of the council or committees can allocate resources or make decisions on behalf of the Council. However, the scale of these changes is necessary if current barriers to quality of care are to be removed and the reshaping care agenda is to be progressed to deal with future service demand.

It would be helpful to specify clearly the governance and leadership responsibilities for budgets, as noted in the response to Question 5 and 7.

We note that the National Group on Commissioning is considering the issue of Joint Accountable Officer in relation to joint procurement. The views of this group will be important in ensuring adequate authority.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Generally, the proposals will allow sufficient autonomy to facilitate integration and management of resources, without moving to centrally directed structural change.

The collective responsibility in the council’s decision-making role, highlighted in the response to question 7 above, must be addressed to facilitate these proposals.
Professionally led locality planning and commissioning of services

**Question 15**: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Local determination is a key factor in local planning. Central direction may not be sufficiently flexible to cater for the range of local circumstances across the whole of Scotland. However, it would be helpful to develop an overall national framework to reduce the risk of ‘postcode’ variations in services.

Community Planning arrangements in Scotland are currently under review. Any locality planning arrangement proposed through the Integration Bill should take full cognisance of the outcomes of this review.

**Question 16**: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

The duty to consult local professionals is very strong. During the process of developing the new arrangements, it will be essential to ensure effective engagement of a range of professionals, including acute clinicians, social care professionals and all primary care practitioners.

Public Partnership Forums, patients, service users, Neighbourhood Partnerships, the third sector and carers organisations have all made a significant contribution to the work of Community Health Partnerships. In addition, Health and Social Care Services in Edinburgh have a range of consultation mechanisms, which also make an important contribution.

Consideration will need to be given to how these contributions can be maintained and enhanced within the Health and Social Care Partnerships. Both the City of Edinburgh Council and NHS Lothian would welcome the opportunity to rethink these mechanisms in the light of integration.

**Question 17**: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

A key incentive, which will encourage clinicians and social care professionals to become involved in local planning, is linked to the positive influence they will have in the new Health and Social Care Partnerships, and in the creation of new and more effective pathways of care, which increase the benefits to their patients/service users.

It will be important to consider new ways to encourage professional groups to participate fully in locality planning forums and groups.
**Question 18:** Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Clusters of GPs are one option to facilitate locality planning. The rationale for local planning should be left to local determination so that local circumstances influence the design.

It may be helpful for Scottish Government to develop a range of options for local areas to choose from and apply as most appropriate to their circumstances. Alternative configurations could be linked to actual geographical communities or to other administrative boundaries, such as wards, neighbourhood delivery areas or school catchments.

Whatever the arrangements, the reference to the direct involvement of elected members is to be welcomed.

**Question 19:** How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

A key aim of the proposals is to facilitate integration across organisational boundaries to deliver improvements across a whole system of care for older people and adults.

It is critical that the responsibilities and decision making within locality planning arrangements fit firmly within this whole system concept and facilitate local delivery of whole system improvements for care.

The benefits of locality planning should not outweigh the possibilities for economies of scale and strategic oversight, which are achievable at a partnership level, nor should they lead to ‘postcode variations’ in outcomes for people.

**Question 20:** Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

This matter should be left to local determination, in line with local circumstances and should not be based on national, arbitrary statistical populations.

**Do you have any further comments regarding the consultation proposals?**

The principles of the proposals are strongly supported in Edinburgh by all partner agencies. Central direction is welcome on matters of principle and in delivering the enabling legislation.

Local determination should be a key factor in deciding delivery mechanisms and organisational structures for the improvement of outcomes for
individuals.

There are a number of links to other initiatives, which will need to be understood and managed carefully. These include:
- Self Directed Support/personalisation;
- Change Fund;
- Commissioning strategies;
- Integrated Resource Framework – where experience could be used to inform integration; and
- Sustainable Procurement Bill – and the need to ensure a common approach to implementation of its provisions by councils and NHS Boards.
- Management of health inequalities

Do you have any comments regarding the partial EQIA? (see Annex D)

Do you have any comments regarding the partial BRIA? (see Annex E)
Services to be considered for Integration in the Health and Social Care Partnership

Adult Services
The overlap and interdependencies of health care and social care are complex. The proposals for integration offer a positive opportunity to consider the whole care system for adult service users and to resource care in a way which is responsive to need rather than being restricted by organisational budget and management boundaries.

With this in mind the services being considered for inclusion are:
- Learning Disability Services;
- Mental Health Services
- Addiction Services;
- Older People’s Services; and
- Elements of Acute Services

Hosted Services
There are currently a number of ‘hosted’ arrangements where services are hosted by a CHP, but are provided across the whole of NHS Lothian. Discussions have begun to reconsider the existing arrangements for hosted services.

NHS Lothian and the City of Edinburgh Council will consider the integration of hosted services, except where the disadvantages outweigh the benefits, for example where they are:
- highly specialist
- small in scale and patient numbers
- currently configured and operating in a way which would be too complex and not in the interests of patients/clients to change

Council Services
There are a small number of services not currently within the remit of the health and social care where the merits of further integration need to be considered.

There may also be some small and specialist services currently within health and social care which may need to be integrated with other Council services.

Children’s Services
There is a commitment to explore the development of an integrated children’s service for Edinburgh.
The case for change

**Question 1:** Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Focus is crucial to ensure tangible progress, and demographic pressures provide a strong case for focusing on older people. However this should be viewed as the first stage of a programme of change across adult care. Whilst the proposed focus on outcomes for older people is understandable given the investment and costs associated with this grouping, and the opportunities recognised already through Change Fund have allowed early exemplar work to be embedded, we believe it would be disruptive to people who use services, and to services and organisations, if a false age defined focus was applied. We also believe that this requires, as much as practicable, a whole system approach and not an incremental approach.

The significant change programme required to drive and implement integration needs to be recognised at all levels. The benefits should be evidenced across all adult care groups, and we believe that only in this way can we enable a more flexible and efficient approach to the deployment of staff and services in delivering the improved outcomes required and expected of us. We will establish a Shadow Integration Board to drive the detailed planning required to deliver a Health and Social Care Partnership by 2014.

There is, in addition, a view in some quarters that any improvements in commissioning care arising through the integration of adult health and social care services, should also be extended to children’s services. Transition between children’s and adult services is an integral part of the continuum of care and the arguments in favour of integration are similar. However overall, whilst this argument is well rehearsed and understood, we believe that within the current limited capacity to manage the change programme across all sectors locally, we should learn the lessons from adult health and social care integration and harness this to effectively plan for the integration of children’s services in the medium to longer term.

Within NHS Lothian there are currently a number of “hosted” services provided on a pan Lothian basis but hosted by one CHP. Examples include learning disability, substance misuse, Lothian unscheduled care service, prison healthcare and health promotion. Existing arrangements are currently under review and will need to be considered within the wider scope of the integration agenda. However, as a point of principle and where practicable, the East Lothian partnership would look to provide local integrated services in line with our current structures and care systems as much as possible.

Finally, the development of more effective services for older people in particular without additional government funding is highly dependent on the participation and appetite for service redesign in the acute sector. This needs to be very clearly stated to ensure successful management of change.
Outline of proposed reforms

**Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?**

The proposals are reasonably comprehensive and reflect the necessary change in focus to outcomes as well as the development of strategic commissioning as an approach to the planning and delivery of services. This term – strategic commissioning – is, however, subject to significant differences in interpretation across the Public, Third and Independent sectors and it will be vital that organisations working together on this agenda agree their understanding and clarify language and expectations at the outset.

The focus on health and social care is understandable but runs the risk of implying a lesser importance of the wider community planning approach. Housing, financial inclusion and transport and the contribution of the full range of NHS acute services are critical to the wellbeing of our population and new structures should enhance rather than diminish their contribution.

The value of involving patients, carers and the public in the development and planning of services has not been included in the proposals and this is a major omission given the legislative and policy requirements placed on both the NHS and council. NHS services, whether integrated or not, cannot work without the partnership of the people who use the services. Given the current Scottish Government consultations on the proposals for the Community Empowerment and Renewal Bill as well as Self Directed Support and new duties under Community Planning, it is a further omission.

Good long-term strategic commissioning strategies allow providers to plan services better to build more preventative services into their business plans. From the consultation document we note that each H&SCP will be expected to produce joint commissioning strategies and delivery plans over the medium and long-term. It is also noted that partnerships will be required to produce integrated strategic commissioning plans for use of the integrated budget over the medium and long-term. Whilst working in this way is new for many, particularly in the NHS, the early learning from Change Fund work will facilitate this although anxieties around financial pressures across sectors are early indicators of where robust and effective planning (and associated transparency) will be required for partnerships. This should be an early focus for development.

We particularly welcome the references to engagement of the Third and Independent sectors in the consultation document. However this sector will require ongoing support within and across partnerships to ensure they can fully contribute and be involved in a meaningful way for all.
National outcomes for adult health and social care

**Question 3:** This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

It is helpful to unify the accountability and reporting mechanisms for the new health and social care partnerships, and important to align reporting between local authorities and the NHS to fulfil statutory duties for public performance reporting.

It will be important to consider the value of partnership reporting being routed through community planning partnerships and Single Outcome Agreements. This could maximise opportunities for other agencies and services involved in the community planning partnership, but not in the health and social care partnership, to contribute to better outcomes for users of health and social care services.

We view the approach set out in the consultation paper as welcome, timely and a necessary enabler in supporting the principles of integration. However it will be successful only if there are jointly agreed, jointly owned and jointly reported outcomes routed through community planning partnerships which lead to tangible improvements rather than partners working to these and their own individual agenda(s). Previous experience of developing joint local improvement targets whilst also working to, for example, HEAT targets diluted the full commitment of all partners. The development of joint outcomes will also need to be reflected in national inspection regimes.

Full recognition at all levels of the significant investment which will be required in staff engagement and development and effective management systems across all sectors (as well as across sectors locally, regionally and nationally) to ensure a consistency of approach and understanding will be required.

**Question 4:** Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

This is a welcome approach to supporting and developing an integrated partnership, which builds naturally upon the thinking, values and aims of Single Outcome Agreements. This approach will ensure that account is taken of local pressures and demographic factors. There will be, however, a need to achieve consistency with the level of detail agreed for SOAs as a whole. It may be necessary to revisit the concept of indicators being below the “waterline” to avoid SOAs becoming too unwieldy.
The importance of building in a robust governance structure and removing duplication of reporting to enable scrutiny at the appropriate levels will be an early priority for partnerships, and should be built into the comprehensive detail of Partnership Agreements.

**Governance and joint accountability**

**Question 5:** Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

The principle of joint accountability is important. The role of the Council Leader however is to lead the administration of the Council: it is not a statutory role and that individual requires the agreement of Council in order to progress policy and strategic issues. At present it is the Council which is responsible and accountable rather than one individual. Further consideration is required on this issue before a satisfactory solution can be agreed.

The Partnership agrees that local accountability is key if integration is to be successful and effective – and in doing so ensures meaningful involvement of front line staff (including independent contractors and secondary care), managers, service users, carers, third and independent sector and the local population.

However, further work is necessary to understand the complexities and detail of the roles and functions required to deliver this.

Early discussion, with sufficient strategic support to “tease out” whole systems accountability to partnerships, particularly in those Health Board areas spanning multiple Health and Social Care Partnerships, will be required and could be viewed as a significant gap in arrangements. The need, therefore, to ensure engagement of all relevant partners in developing the exact detail of the Partnership Agreement, will be a crucial element of the governance and accountability structure.

Nonetheless, it is recognised that the current accountability arrangements for CHPs, and the expectations of others of CHPs, has often presented challenges and clear guidance on enhanced local, democratic processes is welcomed.

**Question 6:** Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

We support the proposal that will enable partnerships to operate across more than one local authority boundary. Whilst the benefits of co-terminosity are well rehearsed and understood, there is concern that small and sometimes specialist health services’ viability may be at risk in small separate partnerships. This could have detrimental effects on outcomes. In addition the economies of scale possible across more than one Local Authority in partnership with health may not be achievable.

Equally, the value in developing shared partnership approaches where it can be demonstrated that this will lead to improved, productive and efficient service delivery in local communities should be recognised and the decision subject to local determination.
We have positive experience of shared partnership approaches through our work in Public Protection, Calls Response Service, Drugs and Alcohol and across numerous other services. Any such decisions, if taken, will require some flexibility to establish governance mechanisms that satisfy the needs of more than one local authority at the same time.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

The balance of democratic scrutiny and accountability within the proposals needs to be strengthened. Having a minimum of three elected members and three non executives making decisions on potentially very significant budgets is not adequate. This process should involve a larger group of members and non executive directors to mirror the scale and importance of health and social care partnerships and the scale of resources involved.

Terms of reference for committees setting out their powers, budget setting processes and disputes resolution procedures are required.

Further clarity is required on the relationship between these processes and councils’ and NHS budget setting and accountability processes, and the Community Planning Partnership’s role in scrutiny and governance

Involvement of communities, voluntary and independent sectors in the formal governance processes should be determined as appropriate by partnerships. Any lessons learnt from the Directly Elected Health Boards pilots that are appropriate to community engagement should be considered.

The proposed membership of the Health and Social Care Partnership committee only partly addresses perceived problems with current CHP guidance which resulted in heavily populated, but unproductive committees within a complex governance structure. This does not reflect on, nor diminish in any way the significant contribution of patients, service users, third sector and carers’ organisation to the work of CHPs; serious consideration on the best way to continue, if not enhance, this contribution will be a cornerstone of emerging partnerships.

Similarly, the NHS has a requirement for strong and effective working with Trade Unions, and Partnership Fora have formal representation within CHP structures. We believe this should be reflected in H&SCP governance arrangements. We recognise that there are, however, different structural approaches to staff engagement across sectors and we will actively work towards a shared solution to this, recognising the importance and value of the partnership role.

The East Lothian partnership also believes there is a need to include appropriate representation of secondary care, with appropriate devolved responsibility, given their key role across the health and social care continuum and the influence of the acute sector on budgets.

Finally, there is a risk with the proposed structure that services currently in CHPs but not within scope in partnerships are marginalised in some fashion and the importance of these services and integration with them is lost.
**Question 8**: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Further clarification is required in terms of how the performance management systems and requirements of each organisation will play into such arrangements, both jointly and severally. Equally, this is dependent upon what is fully within the control of the local Partnerships. The status of independent contractors would imply limited local control by Partnerships and the Acute Sector often covers more than one H&SC Partnership area. This could challenge the ability in the Partnership’s capacity to take effective action in relation to acute/hospital services.

Close working with and support from agencies such as Audit Scotland, the Care Inspectorate and Healthcare Improvement Scotland will be necessary and valuable.

As outlined in the consultation, and most crucially of all, performance management must focus on outcomes and not structures or delivery.

**Question 9**: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Partnerships already vary significantly in terms of demography, need and influencing factors, and in terms of maturity and vision / ambition and capacity. Local planning, scoping, commissioning and decision making should be carried out in the context of these parameters and permissive legislation put in place to enable such local ambitions within the agreed outcomes framework. These should be determined at the local level.

**Integrated budgets and resourcing**

**Question 10**: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

The question implies an over reliance on the benefits of structural change. The models may help but will not on their own deliver without accompanying cultural change towards outcomes, support and care at home and coproduction. Importantly, the reference to resource identity and the recommendation to eliminate the need to track this is welcome and does acknowledge that an outcome based approach will lead to significant change in the way that we deliver care. In making this change in resource identity, the role of the Jointly Accountable Officer and the supporting structures put in place for accountability, governance and planning will be crucial.

However, further evidence is required to allow our understanding of which model allows the most effective and productive use of an integrated resource locally.
**Question 11:** Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

In our wide ranging consultation exercise we heard many examples of highly successful teams working across sectors in an integrated fashion for the benefit of our populations. These include Child and Adult Protection, Integrated Mental Health Team, Response and Rehabilitation Teams, Drug and Alcohol Teams and through the overall delivery of our Older Peoples Strategy. There was a strong recognition in teams of the myriad positive benefits of integrated working and of minimising duplication across sectors and an enthusiasm at service delivery level to embrace this proposal.

Commitment from strategic, middle management and from clinical/frontline staff is a prerequisite for success but the lack of a shared IT system reduces the effectiveness of joint working. Employment terms and conditions is a potential obstacle whereby staff employed in different organisations are perceived to be carrying out very similar roles but with varying T&Cs. There was little success in addressing this issue through the Joint Future agenda and it will be important not to repeat the largely unsuccessful but very time consuming efforts to harmonise terms and conditions across large organisations.

**Question 12:** If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

It is fully recognised that there must be a sufficient critical mass in an integrated budget and its constituent parts to enable flexibility and efficiency and to support local planning and response for the partnership population; this should include elements of acute sector spend. The early work we have done via the Integrated Resource Framework will give us a helpful starting point, but it will be important for the credibility of partnerships to reach an early agreement on how much of the acute pot is to be included within the scope of the partnership and how much flexibility can realistically be attached to the financial resource this represents. For example, given that the majority of acute resources consumed by East Lothian residents are located in Edinburgh, what is the latitude available to our local partnership to make decisions about how this resource is used?

Conversely, if the Ministerial direction is too limited the desired outcomes may not be achieved for that local population. A “one-size-fits-all” approach to integration as a concept should be avoided. The type and degree of integration should reflect programme goals and local circumstances. Approaches to integration require some flexibility, adapting to stakeholder views including those of front-line staff, users, carers and managers and this should be reflected in guidance. However, the emphasis should be on what we need in order to deliver our outcomes safely and effectively – and what functions are needed to deliver these outcomes and not dedicated categories or services as such.

Equally importantly, evidence suggests that there should not be significant expectations, at least in the short term that the integration agenda will reduce costs. Within this, the need
for transparency across the statutory sectors in identifying and agreeing allocated funding will be a crucial enabler to the success of the new partnerships. We recognise that this identification of agreed allocations could be challenging for NHS Boards with multiple partnerships within their boundaries, and therefore unambiguous guidance and supporting information in order to help make informed financial decisions would be welcomed.

Local determination of budgets should be the norm, therefore minimum, not maximum, categories of spend should be determined.

Jointly Accountable Officer

**Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?**

We believe that proposals for financial authority of the JAO require further clarification and unambiguous direction. It is important that the arrangements for the authority of the Jointly Accountable Officer ensure that local democratic accountability is retained, if not strengthened.

Under proposals, the JAO will remain separately accountable, through the partnership, to the Chief Executives of the Local Authority and the NHS Board, (which, in turn, have separate governance and accountability arrangements and may have different priorities for service delivery). Delegation of minimal powers of authority from statutory organisations to the JAO should be permitted by legislation, recognising the need for effective governance of the JAO.

In determining the role of the JAO, it will be important to acknowledge the role of the Chief Social Work Officer in managing the risks associated with the creation of H&SCPs and for the ongoing delivery of social work services within H&SCPs.

**Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?**

The seniority of the Jointly Accountable Officer should not be nationally prescribed. It will by necessity vary according to the size and scope of the Partnership.

However, we recognise that such posts should be at a very senior level, with sufficient autonomy and able to operate at director level within a significant public sector body. They should evidence appropriate demonstrable experience within the public sector in order to engender the confidence required to lead this significant policy change.

Integrated budgets should include appropriate funding for the post and for supporting infrastructure.
**Professionally led locality planning and commissioning of services**

**Question 15:** *Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?*

We recognise that integrated care must be delivered quickly and at large scale. This requires work across whole council area populations and at community level, as well as with a range of stakeholders. To achieve integrated care, and the expected outcomes, those involved with planning and providing services must include the user's and carer’s perspective as an organising principle of service delivery (Lloyd and Wait 2005; Shaw et al 2011). This has been reinforced in national policy through Changing Lives, Self Directed Support and most recently Co-production.

It should be left up to partnerships to determine how locality planning is taken forward to ensure a good fit can be established with local community planning if required. Too much government direction may restrict innovation and the development of effective community involvement. There should, therefore, be flexibility to take forward different approaches in different areas with an ongoing requirement to continuously evaluate the impact. Within this, the East Lothian partnership recognises the ongoing review of community planning across Scotland, and the outcomes of this review should inform any proposals.

**Question 16:** *It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?*

No single ‘best practice’ model of integrated care exists. What matters most is service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations. It follows, therefore, that these professionals should be pivotal in planning and reviewing service arrangements.

The East Lothian partnership recognises that we should invest in approaches that capture the voices and experiences of patients, service users and carers in relation to integrated care planning and whether services are being delivered that meet their needs. The proposal should therefore set out how service users, carers and local communities are to be involved in line with national standards for community engagement.

In harnessing all this knowledge and input for local planning, strong clinical and professional leadership will be required to deliver the level of organisational intelligence needed. The duty placed on Health and Social Care Partnerships to involve and consult on service provision should therefore be clear, unambiguous, measurable and evaluated.
**Question 17:** What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

All health and social care professionals involved will need to be supported to ensure that the local approach is central to how they do their jobs, not something they do on top of their jobs. It will be important for local partnerships to define the role of locality planning so that all participants understand what is expected of them and support them to maximise their contributions.

Integrated care is unlikely to happen at scale unless those implementing it are given support. Whilst for professionals, users and carers, financial support to ensure involvement is important, other organisational supports also need to be considered. These could include:

- building leadership skills
- building commissioning skills and public health skills for prioritising investments
- supporting networks within partnerships to share learning and ideas

While much of this might be sought and delivered locally within partnerships, there is a need for the Scottish Government to equally invest resources and support the development of skills and competencies for integrated care, to promote learning and share ideas to support the adoption and successful application of integrated care.

**Question 18:** Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Locality planning should fundamentally be organised around natural communities such as Council Wards. Economies of scale may prove a challenge to local commissioning on this basis but we have local experience to draw upon including “neighbourhood planning” designed to support community planning.

Each partnership will look quite different in terms of urban / rural make up, or GP population sizes; nor do GP practice lists always fit neatly with local authority boundaries, so for many areas GP clustering would be challenging. In line with the response to Question 15, there should be flexibility to take forward different approaches to planning in different areas with a requirement to continuously evaluate the impact.
**Question 19:** How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

At the population level suggested (15,000 – 20,000) it is difficult to see what direct strategic role locality planning groups could play other than to feed their local knowledge of needs and resources up to the Council-wide strategic level. Perhaps the focus for locality planning should therefore be on improving day to day operational activity across statutory, voluntary, independent and community sectors to find ways to improve local service delivery.

Whilst we agree with the principle of devolving decision making as close to the point of delivery as possible, this cannot always be defined as there are a number of factors such as geography, level of need and deprivation and demography that will influence this. The level of responsibility should therefore be determined locally once it has been agreed what the role and geographic focus is to be. Local decision making would be restricted to any devolution of resources that had been made by the partnership to the locality planning level, and accountability would need to remain at the Health and Social Care Partnership level.

There is a danger of raising unrealistically the amount of responsibility which locality planning groups could undertake and sustain without additional infrastructure to support their activities. The key shift is to ensure that locality groups have a real say in the design, implementation and review of new services/service redesign at a local level.

There is, however, also a need to fully recognise the value of existing structures such as Public Partnership Forums, and their history of delivering for local communities, and not simply “re-invent” new ways of working.

It is only at partnership level that the critical mass to achieve integration will be delivered.

**Question 20:** Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

There are too many parameters to consider in a country of the size and diversity of Scotland. *No one size fits all* is a good mantra when dealing with the complex landscape that faces us; this should be a matter for local determination.
Do you have any further comments regarding the consultation proposals?

The broad principles of health and social care integration are welcomed by the East Lothian partnership and we are eager to start planning our joint work programme to deliver improved outcomes for our population.

The consultation is being carried out at a time of great change for the public sector, and it is important the legislation reflects this. Strong links with the report of the Christie Commission, the review of community planning, welfare reform and the Community Empowerment and Renewal Bill are required. However, the consultation document underplays the importance of strengthening an effective community planning system, focusing as it does on the health and social care dimension alone. There is also a danger that the focus on the creation of Health and Social Care Partnerships becomes the dominating issue in the next few years rather than the continuing implementation of an outcomes approach alongside the transformation required to deliver Self Directed Support.

It is regrettable, however, that the consultation of necessity concentrates on the proposed new organisational arrangements. Structures may help but will certainly not deliver the step change required in the drive towards truly community based care and the shift in resources required to deliver this. Research and experience tells us that leadership and culture are critical.
Health & Social Care Integration

MIDLOTHIAN PARTNERSHIP RESPONSE

Consultation Questionnaire

Midlothian CHP and Midlothian Council (The Midlothian Partnership)
Joint Response to the Scottish Government Consultation on Proposals

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<td>David Small General Manager, East and Midlothian CHPs</td>
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<td>Eibhlin McHugh, Director of Communities and Wellbeing</td>
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The case for change

**Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?**

Focus is crucial to ensure tangible progress, and demographic pressures provide a strong case for focussing on older people. However this should be viewed as the first stage of a programme of change across adult care. Whilst the proposed focus on outcomes for older people is understandable given the investment and costs associated with this grouping, and the opportunities recognised already through Change Fund have allowed early exemplar work to be embedded, we believe it would be disruptive to people who use services, and to services and organisations, if a false age defined focus was applied. We also believe that this requires, as much as practicable, a whole system approach and not an incremental approach.

The significant change programme required to drive and implement integration needs to be recognised at all levels. The benefits should be evidenced across all adult care groups, and we believe that only in this way can we enable a more flexible and efficient approach to the deployment of staff and services in delivering the improved outcomes required and expected of us. The Midlothian Partnership therefore have a shared ambition to implement a “shadow” health and social care partnership in the very short term in order to deliver our desired outcomes for older people as soon as possible, with the explicit aim of adult health and social care integration by 2014.

There is, in addition, a view in some quarters that any improvements in commissioning care arising through the integration of adult health and social care services, should also be extended to children’s services. Transition between children’s and adult services is an integral part of the continuum of care and the arguments in favour of integration are similar. However overall, whilst this argument is well rehearsed and understood, we believe that within the current limited capacity to manage the change programme across all sectors locally, we should learn the lessons from adult health and social care integration and harness this to effectively plan for the integration of children’s services in the medium to longer term.

Within NHS Lothian there are currently a number of “hosted” services whereby services are provided on a pan Lothian basis but hosted by one CHP. Examples include learning disability, substance misuse, Lothian unscheduled care service, prison healthcare and health promotion. Existing arrangements are currently under review and will need to be considered within the wider scope of the integration agenda. However, as a point of principle and where practicable, Midlothian partnership would look to provide local integrated services in line with our current structures and care systems as much as possible.

Finally, the development of more effective services for older people in particular without additional government funding is highly dependent on the participation and appetite for service redesign in the acute sector. This needs to be very clearly stated to ensure successful management of change.
Outline of proposed reforms

**Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?**

The proposals are reasonably comprehensive and reflect the necessary change in focus to outcomes as well as the development of strategic commissioning as an approach to the planning and delivery of services. This term – strategic commissioning – is, however, subject to significant differences in interpretation across the Public, Third and Independent sectors and it will be vital that organisations working together on this agenda agree their understanding and clarify language and expectations at the outset.

The focus on health and social care is understandable but runs the risk of implying a lesser importance of the wider community planning approach. Housing, financial inclusion and transport are critical to the wellbeing of our population and new structures should enhance rather than diminish their contribution.

The value of involving patients, carers and the public in the development and planning of services has not been included in the proposals and this is a major omission given the legislative and policy requirements placed on both the NHS and council. NHS services, whether integrated or not, cannot work without the partnership of the people who use the services. Given the current Scottish Government consultations on the proposals for the Community Empowerment and Renewal Bill as well as Self Directed Support it is a further omission.

Good long-term strategic commissioning strategies allow providers to plan services better to build more preventative services into their business plans. From the consultation document we note that each H&SCP will be expected to produce joint commissioning strategies and delivery plans over the medium and long-term. It is also noted that partnerships will be required to produce integrated strategic commissioning plans for use of the integrated budget over the medium and long-term. Whilst working in this way is new for many, particularly in the NHS, the early learning from Change Fund work will facilitate this although anxieties around financial pressures across sectors are early indicators of where robust and effective planning (and associated transparency) will be required for partnerships. This should be an early focus for development.

We particularly welcome the references to engagement of the Third and Independent sectors in the consultation document. However this sector will require ongoing support within and across partnerships to ensure they can fully contribute and be involved in a meaningful way for all.

**National outcomes for adult health and social care**

**Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?**
We view this approach as welcome, timely and a necessary enabler in supporting the principles of integration. However it will be successful only if there are jointly agreed, jointly owned and jointly reported outcomes which lead to tangible improvements rather than partners working to these and their own individual agenda(s). Previous experience of developing joint local improvement targets whilst also working to, for example, HEAT targets diluted the full commitment of all partners. The development of joint outcomes will also need to be reflected in national inspection regimes.

Full recognition at all levels of the significant investment which will be required in staff engagement and development and effective management systems across all sectors (as well as across sectors locally, regionally and nationally) to ensure a consistency of approach and understanding will be required.

**Question 4:** Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

This is a welcome approach to supporting and developing an integrated partnership, which builds naturally upon the thinking, values and aims of Single Outcome Agreements. This approach will ensure that account is taken of local pressures and demographic factors. There will be, however, a need to achieve consistency with the level of detail agreed for SOAs as a whole. It may be necessary to revisit the concept of indicators being below the “waterline” to avoid SOAs becoming too unwieldy.

The importance of building in a robust governance structure and removing duplication of reporting to enable scrutiny at the appropriate levels will be an early and required work for partnerships, and should be built into the comprehensive detail of Partnership Agreements.

**Governance and joint accountability**

**Question 5:** Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

The Midlothian Partnership understand and agree that local democratic accountability is key if integration is to be successful and effective – and in doing so ensures meaningful involvement of front line staff (including independent contractors and secondary care), managers, service users, carers, third and independent sector and the local population.

However, further work is necessary to understand the complexities and detail of the roles and functions required to deliver this. Accountability to Council Leaders, for example, does not ensure sufficient local democratic accountability which can only be fully achieved via the Council itself. In a similar vein, the accountability proposals for the chair and vice chair of the H&SCP as currently understood within local government legislation require greater clarity.
Early discussion, with sufficient strategic support to “tease out” whole systems accountability to partnerships, particularly in those Health Board areas spanning multiple Health and Social Care Partnerships, will be required and could be viewed as a significant gap in arrangements. The need, therefore, to ensure engagement of all relevant partners in developing the exact detail of the Partnership Agreement, will be a crucial element of the governance and accountability structure. Nonetheless, it is recognised that the current accountability arrangements for CHPs, and the expectations of others of CHPs, has often presented challenges and clear guidance on enhanced local, democratic processes is welcomed.

**Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?**

We support the proposal. Whilst the benefits of co-terminosity are well rehearsed and understood, there is concern that small and sometimes specialist health services’ viability may be at risk in small separate partnerships. This could have detrimental effects on outcomes. In addition the economies of scale possible across more than one Local Authority in partnership with health may not be achievable.

Equally, the value in developing shared partnership approaches where it can be demonstrated that this will lead to improved, productive and efficient service delivery in local communities should be recognised and the decision subject to local determination. We have positive experience of shared partnership approaches through our work in Public Protection, Calls Response Service and across numerous other services. Any such decisions, if taken, will require some flexibility to establish governance mechanisms that satisfy the needs of more than one local authority at the same time.

**Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?**

The proposals are not fully aligned with current statutory limitations on local authorities decision making structures. There is a lack of clarity about the respective responsibilities of the Joint Accountable Officer and the Partnership body. Genuine democratic oversight would indicate that the JAO would account to the Partnership committee.

The proposed membership of the Health and Social Care Partnership committee is however helpful in that it partly addresses perceived problems with current CHP guidance which resulted in heavily populated, but unproductive committees within a complex governance structure. This does not reflect on, nor diminish in any way the significant contribution of patients, service users, third sector and carer’s organisation to the work of CHPs; serious consideration on the best way to continue, if not enhance, this contribution will be a cornerstone of emerging partnerships.

Similarly, the NHS has a requirement for strong and effective working with Trade Unions, and Partnership Fora have formal representation within CHP structures. We believe this should be reflected in H&SCP governance arrangements. We recognise that there are, however, different structural approaches to staff engagement across sectors and we will actively work towards a shared solution to this, recognising the importance and value of the partnership role.
The Midlothian partnership also believe there is a need to include appropriate representation of secondary care, with appropriate devolved responsibility, given their key role across the health and social care continuum and the influence of the acute sector on budgets.

Finally, there is a risk with the proposed structure that services currently in CHPs but not within scope in partnerships are marginalised in some fashion and the importance of these services and integration with them is lost.

**Question 8**: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Further clarification is required in terms of how the performance management systems and requirements of each organisation will play into such arrangements, both jointly and severally. Equally, this is dependent upon what is fully within the control of the local Partnerships. The status of independent contractors would imply limited local control by Partnerships and the Acute Sector often covers more than one H&SC Partnership area. This could challenge the ability in the Partnership’s capacity to take effective action in relation to acute/hospital services.

Close working with and support from agencies such as Audit Scotland, the Care Inspectorate and Healthcare Improvement Scotland will be necessary and valuable.

As outlined in the consultation, and most crucially of all, performance management must focus on outcomes and not structures or delivery.

**Question 9**: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Partnerships already vary significantly in terms of demography, need and influencing factors, and in terms of maturity and vision / ambition and capacity. Local planning, scoping, commissioning and decision making should be carried out in the context of these parameters and permissive legislation put in place to enable such local ambitions within the agreed outcomes framework.

**Integrated budgets and resourcing**

**Question 10**: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?
The question implies an over reliance on the benefits of structural change. The models may help but will not on their own deliver without accompanying cultural change towards outcomes, support and care at home and coproduction. Importantly, the reference to resource identity and the recommendation to eliminate the need to track this is welcome and does acknowledge that an outcome based approach will lead to significant change in the way that we deliver care. In making this change in resource identity, the role of the Jointly Accountable Officer and the supporting structures put in place for accountability, governance and planning will be crucial.

However, further evidence is required to allow our understanding of which model allows the most effective and productive use of an integrated resource locally.

**Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?**

In our wide ranging consultation exercise we heard many examples of highly successful teams working across sectors in an integrated fashion for the benefit of our populations. These include Child and Adult Protection, Integrated Mental Health Team, Rapid Response Teams and Drug and Alcohol Teams. There was a strong recognition in teams of the myriad of positive benefits of integrated working and of minimising duplication across sectors – indeed, an enthusiasm at service delivery level to embrace this proposal.

Commitment from strategic, middle management and from clinical/frontline staff is a prerequisite for success but the lack of a shared IT system reduces the effectiveness of joint working. Employment terms and conditions is a potential obstacle whereby staff employed in different organisations are perceived to be carrying out very similar roles but with varying T&Cs. There was little success in addressing this issue through the Joint Future agenda and it will be important not to repeat the largely unsuccessful but very time consuming efforts to harmonise terms and conditions across large organisations.

**Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?**

Within our discussions in Midlothian there were a number of conflicting responses to this question. It was fully recognised that there must be a sufficient critical mass of budget in an integrated budget and its constituent parts to enable flexibility and efficiency and to support local planning and response for the partnership population; this should include elements of acute sector spend. Conversely, if the Ministerial direction is too limited the desired outcomes may not be achieved for that local population. A “one-size-fits-all” approach to integration as a concept should be avoided. The type and degree of integration should reflect programme goals and local circumstances. Approaches to integration require some flexibility, adapting to stakeholder views including those of frontline staff, users and managers and this should be reflected in guidance.
However, the emphasis should be on what we need in order to deliver our outcomes safely and effectively – and what functions are needed to deliver these outcomes and not dedicated categories or services as such.

Equally importantly, evidence suggests that there should not be significant expectations, at least in the short term that the integration agenda will reduce costs. Within this, the need for transparency across the statutory sectors in identifying and agreeing allocated funding will be a crucial enabler to the success of the new partnerships. We recognise that this identification of agreed allocations could be challenging for NHS Boards with multiple partnerships within their boundaries, and therefore unambiguous guidance and supporting information in order to help make informed financial decisions would be welcomed.

Local determination of budgets should be the norm, therefore minimum, not maximum, categories of spend should be determined.

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**Question 14:** Have we described an appropriate level of seniority for the Jointly Accountable Officer?

The seniority of the Jointly Accountable Officer should not be nationally prescribed. It will by necessity vary according to the size and scope of the Partnership and there may be a case for more than one such position depending on what is within scope.

However, we recognise that such posts should be at a very senior level, with sufficient autonomy and able to operate as a Director of a significant public sector body. They should evidence appropriate demonstrable experience within the public sector in order to engender the confidence required to lead this significant policy change. Partners should ensure that appropriate funding is in place for the post and for supporting infrastructure.
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Too much government direction may restrict innovation and the development of effective community involvement. There should, therefore, be flexibility to take forward different approaches in different areas with an ongoing requirement to continuously evaluate the impact. Within this, the Midlothian partnership recognise the ongoing review of community planning across Scotland, and the outcomes of this review should inform any proposals.

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No single ‘best practice’ model of integrated care exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations. It follows, therefore, that these professionals should be pivotal in planning and reviewing service arrangements.

The Midlothian partnership equally recognise that we should also invest in approaches that capture the voices and experiences of patients, service users and carers in relation to integrated care planning and whether services are being delivered that meet their needs.

In harnessing all this knowledge and input for local planning, strong clinical and professional leadership will be required to deliver the level of organisational intelligence needed. The duty placed on Health and Social Care Partnerships to involve and consult on service provision should therefore be clear, unambiguous, measurable and evaluated.

**Question 17:** What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

Two key changes are required. One is for practitioners to believe, and have evidence that their views are being heard and actively acted upon; this will only be achieved through positive experience and the development of effective pathways of care. The other is for the “task” of contributing to locality planning to be more clearly reflected in job descriptions and job contracts as constituting a legitimate part of a role.
Additionally, integrated care is unlikely to happen at scale unless those implementing it are given support. Whilst, particularly for GPs – but also, importantly for other professionals, users and carers – financial support to ensure involvement is important, other organisational supports also need to be considered. These could include:

- building leadership skills
- building commissioning skills and public health skills for prioritising investments
- supporting networks within partnerships to share learning and ideas

While much of this might be sought and delivered locally within partnerships, there is a need for the Scottish Government to equally invest resources and support the development of skills and competencies for integrated care, to promote learning and share ideas to support the adoption and successful application of integrated care.

**Question 18:** Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Whilst for GPs and Community Nurses this approach would make sense, locality planning should fundamentally be organised around natural communities. Economies of scale may prove a challenge to local commissioning on this basis but we have local experience to draw upon including “neighbourhood planning” designed to support community planning.

We know from evidence that approaches to integrated care are likely to be more successful when they cover larger populations and a range of groups - older people, people with particular diseases or conditions, and people requiring access to specialist services. For example, the evidence for case management and care co-ordination shows that it is less likely to succeed unless it is part of a ‘programme approach’ to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation, re-ablement and independent living – this supports the wider philosophy of good community planning. The evidence shows that it is the cumulative impact of multiple strategies for care integration that are more likely to be successful in meeting the demands and improving the experiences of patients, service users and carers.

To this end, each partnership will look quite different in terms of urban / rural make up, or GP population sizes; nor do GP practice lists always fit neatly with local authority boundaries, so for many areas GP clustering would be challenging. So, in line with the response to Question 15, there should be flexibility to take forward different approaches to planning in different areas with a requirement to continuously evaluate the impact.

However, the Midlothian partnership recognise that general practice can act as the hub of a wider system of care that takes a role in co-ordinating and signposting individuals to services within the NHS as well as beyond health care on a 24/7 basis; this is a pivotal role in an integrated care system and the value of general practice in delivering this cannot be underestimated. Ongoing discussions on the future of the GMS contract in Scotland may afford opportunities for more effective “cluster working” across practices, of sharing services and enhancing local provision, and Health and Social Care Partnerships should be ensuring ongoing discussions and planning with GPs to maximise this potential as and when it affords it.
**Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?**

Whilst we agree with the principle of devolving decision making as close to the point of delivery as possible, this cannot always be defined as there are a number of factors such as geography, level of need and deprivation and demography that will influence this. There is a danger of raising unrealistically the amount of responsibility which locality planning groups could undertake and sustain without additional infrastructure to support planning and commissioning. The key shift is to ensure that locality groups have a real say in the design, implementation and review of new services/service redesign at a local level. 

There is, however, also a need to fully recognise the value of existing structures and their history of delivering for local communities, and not simply “re-invent” new ways of working. The Midlothian Partnership have benefited from active involvement from our Public Partnership Forum and from Third Sector participation and the need to continue to harness this intelligence and give it credence is paramount. 

As indicated above it is only at partnership level that the critical mass to achieve integration will be delivered.

**Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?**

There are too many parameters to consider in a country of the size and diversity of Scotland. *No one size fits all* is a good mantra when dealing with the complex landscape that faces us; this should be a matter for local determination

**Do you have any further comments regarding the consultation proposals?**

The broad principles of health and social care integration are warmly welcomed by the Midlothian partnership and we are eager to start planning our joint work programme to deliver improved outcomes for our population.

It is regrettable, however, that the consultation of necessity concentrates on the proposed new organisational arrangements. Structures may help but will certainly not deliver the step change required in the drive towards truly community based care and the shift in resources required to deliver this. Research and experience tells us that leadership and culture are critical.

The consultation document underplays the importance of strengthening an effective community planning system, focussing as it does on the health and social care dimension.

There is also a danger that the focus on the creation of Health and Social Care Partnerships becomes the dominating issue in the next few years rather than the continuing implementation of an Outcomes approach alongside the transformation required to deliver Self-Directed Support.
1 Purpose of the Report

1.1 The purpose of this paper is to present the above strategy for consideration and approval by the Board. Any member wishing additional information should contact the Medical Director in advance of the meeting.

2 Recommendations

Board members are recommended to:

2.1 Endorse the strategy and the outline proposals for delivery, to be shared between NHS Lothian and the Edinburgh and Lothians Health Foundation.

2.2 Endorse the position that the collection of artworks belongs to the Foundation, and that the arrangements for future oversight and management of it should be agreed by the Trustees.

2.3 Recognise the need for sustainable coordination to support the implementation of the strategy, and support the submission of a proposal for funding to the Foundation.

3 Discussion of Key Issues

3.1 It has been recognised that NHS Lothian and the Health Foundation would benefit from a clearly articulated vision for the contribution of art and creativity to the wellbeing and health improvement of patients and staff, and a strategy for maximising the benefits from allocated resources and the management and use of the extensive art collection. The proposed strategy has been developed and is attached at Appendix 1. This brings together the evidence base for the positive impact of arts and creativity on health and well-being, priorities for action, and options for sustainable financial and managerial solutions. It has tapped into considerable enthusiasm from staff, voluntary organisations and local authority partners, along with Creative Scotland, who have commended NHS Lothian in the creation of this strategy.

3.1.1 In 2010 Creative Scotland, NHS Lothian and Art in Hospitals created a collaborative supported by £20,000 grant from Creative Scotland, to create a strategy for Arts in Health & Wellbeing Strategy for NHS Lothian and the Health Foundation.

Blake Stevenson was successfully engaged following advert and recruitment, and started work on the strategy in earnest in January 2011.
The strategy builds upon:

- The Finance Director’s confirmation that the collection belongs to the previous ‘Endowments’
- Endowments supporting an agreement with Art in Hospitals for three years (2011-2014) to manage the collection and take forward some of the recommendations in the Art Collection Audit (2009), previously funded by Endowments.

3.1.2 The strategy has been developed following interviews with key staff, partners, stakeholders and former members of staff and two consultative events (18th July 2011 and 1st December 2011). Staff-side, Public Partnership Forums and Patient Networks, and Local Authority representatives were all present.

3.2 This strategy is unique in the NHS in Scotland, given the comprehensive nature of its scope, the size of the collection and the heritable and civic opportunities which are possible. Charity to charity giving is a very exciting possibility to progress areas of the action plan. An Arts Co-ordinator post in Greater Glasgow and Clyde has been very successful in fund raising. Creating a sustainable funding base is critical to the ongoing success and delivery of the plan.

3.2.1 The emerging evidence base on the impact of creativity and arts on health in appendix 1 of the strategy was used to build priorities and rationale. Staff and patient wellbeing/experience is enhanced by design, environment, colour etc. The four main site liaison committees have all been visited to ensure local ownership of paintings and art works etc. and this has been well received. It is not intended to re-establish local Arts Committees (there are no functioning committees left), but to ensure local ownership via the site operational groups with strategic coordination in a pan Lothian group. It is hoped this group will be chaired by a Board non-executive director/Foundation Trustee.

3.2.2 Key themes from the strategy are:
- Mapping what currently exists and the evidence base
  A focus on four pillars for action:
  Prevention and promotion; performance and artistic input; managing the collection and heritage to maximise the benefits from these; art and design in the environment
- Priority areas: mental wellbeing, older people and early intervention within a context of reducing inequality
- A pan Lothian structure for delivery of an outline action plan
- Alignment to the Health Foundation of a coordinator role

3.3 The strategy sets out how the shared responsibilities will be achieved between NHS Lothian and the Foundation and proposes that a pan Lothian steering group is established. This will report to both NHS Lothian through the Medical Director as executive lead, and the Foundation, but as progress is made, funding routes explored (e.g. potential creation of a separate charity or alignment with the Foundation) and new partnerships created, these accountabilities may change.
3.3.1 The strategy proposes a coordinator role for all aspects of the strategy implementation, to undertake external fundraising and to raise awareness of strategy and the benefits of arts and creativity for health. It is proposed to seek funding for this role on a sustainable basis from the Health Foundation.

3.3.2 In addition it is proposed that there will be a lead person within NHS Lothian for each of the four pillars as follows:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and promotion</td>
<td>Dr Margaret Douglas (part of existing work)</td>
</tr>
<tr>
<td>Participation, performance and artistic input</td>
<td>Libby Tait</td>
</tr>
<tr>
<td>The collection and heritage</td>
<td>Tim Montgomery</td>
</tr>
<tr>
<td>Design linked to new buildings and refurbishments</td>
<td>Iain Graham – through project management arrangements</td>
</tr>
</tbody>
</table>

4 Key Risks

4.1 The key risks are loss of assets, updating and ownership of the catalogues of Art works, lack of an acquisition and dispersal policy, damage/loss of high value art works, or those with historic ‘value’.

4.2 As owners of the collection, the Foundation also has a number of ‘free loans’ from artists e.g. a very large artwork in the main foyer at RIE. As there is currently no acquisition and dispersal policy decision making about display of artworks and image presented by NHS Lothian is not managed.

4.3 If the strategy is not approved the recognised benefits of arts and creativity on health and wellbeing will not be fully delivered by NHS Lothian.

5 Risk Register

5.1 As above, there is no risks relating to loss, civic responsibility or reputation management separately listed on the risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 Appendix 1 of the strategy gives an overview of the evidence base supporting the use of arts and creativity in reducing inequalities and improving wellbeing.

An impact assessment was carried out on 16th November 2011 and changes were made following the review These particularly strengthened the processes to evaluate equality monitoring and involvement.

7 Involving People

7.1 Paragraph 3.1.2 above describes the range of bodies involved in this work.
8 Resource Implications

8.1 The resource implications will be addressed by application to the Foundation for support of the coordinator role. The Foundation already funds current activities through grants. The strategy also sets out those areas where capital grants, design costs etc are met via other funding routes, and the action plans includes the development of a sustainable funding plan.

<table>
<thead>
<tr>
<th>Libby Tait</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Director Modernisation</td>
</tr>
<tr>
<td>31 August 2012</td>
</tr>
<tr>
<td><a href="mailto:Libby.Tait@nhslothian.scot.nhs.uk">Libby.Tait@nhslothian.scot.nhs.uk</a></td>
</tr>
</tbody>
</table>

List of Appendices

Appendix 1: NHS Lothian’s Strategy for Creativity, Arts, Health & Wellbeing 2012
Creativity, Arts, Health and Wellbeing for NHS Lothian

2012-2017

FINAL DRAFT
FOR APPROVAL
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Foreword

NHS Lothian has a long history of using creativity, arts and design to support health in a variety of different settings. This is an imaginative programme that is set out in the strategy which will build on the work that has already being done in Lothian. It uses all types of art to support the most vulnerable in our communities, and expedite rehabilitation for those using healthcare services.

The outcome of the strategy is aligned with Scottish Government key policies, focusing on health inequalities and ensuring that care is more person centred, and provided as close to the patients home as possible.

Key to this strategy is strong partnership working using the skills and expertise of others to achieve the aims of the strategy.

Building on the collaborative approach which was demonstrated at the consultation event in December, and commitment of individuals, and communities, I anticipate patients and staff in Lothian will see the real benefits of this innovative work.

David Farquharson,
Executive Medical Director & Lead for Arts in NHS Lothian
NHS Lothian
“Wanting to look at the paintings has given me a purpose to walk through the ward every day, helping build up my strength after the operation”
– Patient, Royal Victoria Hospital

**Executive Summary**

NHS Lothian has developed a strategy to bring together and build more coherently on the various creative and arts activities that take place within healthcare establishments and more widely to support positive health and wellbeing across Lothian.

The vision for this strategy is as follows:

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<tr>
<td>• we achieve all this through close collaboration with a range of partner organisations, including the four local authorities and a wide range of artists.</td>
</tr>
</tbody>
</table>
The outcomes we want to achieve are:

- through providing opportunities for creativity, a diverse arts programme and supporting more participation and enablement, those who are most vulnerable in our communities have greater wellbeing and because of this, in the long term, have better health
- those who use health care services have faster and more lasting rehabilitation
- those who use, work or volunteer in health care services have improved wellbeing through an enhanced therapeutic environment and access to a diverse range of arts and creative opportunities
- staff and volunteer morale is raised and because of this there is improved experience for both staff and patients
- NHS Lothian is recognised for its contribution to local and national creativity and design linked to improved health and wellbeing
- the strategy has a sustainable future and there is evidence to demonstrate the benefits it brings

The strategy covers all aspects of the relationship between creativity, arts, health and wellbeing and ranges from prevention of ill health and promotion of wellbeing within our communities across Lothian to building in creativity and design to new and refurbished healthcare establishments.

There are four key pillars to the strategy:

- Prevention and promotion, particularly within the community setting;
- Performance and artistic input, particularly within the healthcare setting;
- The collection and heritage, maximising what benefits these bring to the people of Lothian;
- Art and design in the environment, both the built environment and the spaces around healthcare settings.

These all have connections and overlaps between them and in turn are underpinned by communication, involvement and participation, sustainable funding and partnership.

The strategic priorities for 2012-2017 are:

- Mental wellbeing
- Older people
- Early intervention (both in terms of early years and also early detection)

Reducing health inequalities and promoting wellbeing is integral to the whole strategy.
There is a suggested Action Plan contained within this strategy document and these actions will be agreed through the proposed structures for implementation: a pan-Lothian Steering Group linked to sub-groups/existing groups for each of the four pillars. There is a proposed Co-ordinator role to bring this all together and to undertake ongoing fundraising, communication and partnership building work.
Chapter 1

1.1 Introduction

There is a growing evidence base to demonstrate the positive impact of creativity and arts on wellbeing and health (see Appendix 1).

In Lothian there has been activity to bring creativity and arts to support health at various levels over the past thirty years: from individual staff in hospitals giving their own time, and sometimes their own money, to bring art and colour into clinical spaces; to arts organisations such as Artlink dedicated to working creatively with patients and staff; to individual artists who have contributed their work and time. This strategy wishes to build on all this work, add value to it in terms of coherence and support, and take it further with new and innovative ideas for example through the use of new technology for greater participation and creativity.

NHS Lothian

NHS Lothian is committed to being the best health board in Scotland and to rank among the best in the world. It recognises that creativity and arts can help it achieve better health and wellbeing for its population. It also recognises its role in supporting citizenship and participation.

NHS Lothian covers the four local authority areas of City of Edinburgh, Midlothian, East Lothian and West Lothian and the total population served is 837,000. It has a workforce of around 27,000.

It is an area generally rich in cultural heritage and the arts being the home of the National Galleries, the Edinburgh Festivals, the Museum of Scotland and many arts organisations and national companies. It is a centre for the arts and cultural activity and as such has the potential for fertile partnerships through NHS Lothian’s creativity, arts, health and wellbeing strategy in the future.

Partnership is central to this strategy. In difficult economic times it is more than ever pressing to work in imaginative and collaborative ways with a range of partners who share aspects of the vision and goals this strategy sets out.

Creative Scotland

Creative Scotland has been involved in supporting this strategy development because it recognises the important role that artists and artistic activity can play in contributing to the nation’s health and wellbeing. Creative Scotland’s vision is of a ‘Scotland … recognised as a leading creative nation… a nation where the arts and creativity play a central part in the lives, education and well-being of our population’. The Creative Scotland Corporate Plan 2011-2014, Investing in Scotland’s Creative Future, states:
“Creative Scotland believes strongly that the arts contribute to health and wellbeing. We will therefore continue to advocate for innovative work, embedding art in healthcare provision.”

Creative Scotland’s corporate objectives include a commitment to generational change in cultural opportunity, international partnership and equalities in all areas. Over the next three years it will invest in quality artistic production, audiences’ access and participation, the cultural economy and places and their contribution to a creative Scotland.

Link to Scottish Government and NHS Lothian’s Policies

The strategy links in to the Scottish Government’s key policies around health and wellbeing. These include:

- a focus on prevention and tackling the huge health inequalities that exist in Scotland
- a move to provide more services within the community rather than in a hospital setting
- greater attention on person-centred care and on greater choice for the patient.

It also links to other NHS Lothian strategies and policies including:

- **A Sense of Belonging: A joint strategy for improving the mental health and wellbeing of Lothian’s population, 2011-2016:**
  “There is good evidence that the creative arts have a role in promoting the mental health and wellbeing of participants and challenging stigma against people with mental health problems to promote social inclusion. There is evidence on the impact of the arts on increasing self-esteem and self-worth and in reducing symptoms of common mental health problems. Arts and creativity have also been shown as a resource for promoting social inclusion.”

- **NHS Lothian: Volunteering Framework and Action Plan:**
  Key priorities include: “contributing to building Community Capacity, Social Capital and Health Improvement and identifying opportunities for volunteers”

- **NHS Lothian Design Quality Framework for Capital Projects:**
  “NHS Lothian is committed to improving the quality of life for people who use its premises as patients, staff, visitors and the local communities by enhancing and creating buildings and spaces that are healthy for present and future generations and environmentally sustainable.”
More generally the strategy recognises that creativity and arts can help build social capital (the links between individuals, groups and communities) and this in turn is seen to support wellbeing.

In Scotland there are already examples of linking arts and health, embedded within the NHS, from the well-established Grampian Hospitals Art Trust (GHAT), to the new Charitable Arts and Health Co-ordinator for Forth Valley, to the work of the Strategic Arts and Health Co-ordinator now mainstreamed in NHS Greater Glasgow and Clyde (see chapter 2 for more details).

This document sets out NHS Lothian’s strategy for creativity, arts, wellbeing and health for the next five years and provides an Action Plan for the next two years. It proposes how the strategy will be implemented and includes appendices to provide further detailed evidence and information.

Definitions

By creativity and arts we mean all kinds of art activity including visual art, dance, music, drama, poetry and story writing, story telling, performance and film. It also includes art and design in the healthcare environment. The strategy is particularly concerned to encourage work with vulnerable communities to support wellbeing and prevent ill health.

1.2 Mapping what currently exists

This section provides a summary of the main creative and artistic inputs that currently exist in Lothian to support health and wellbeing. The aim of this strategy is to build on these existing initiatives and bring some coherence to the overall impact they can have on NHS Lothian’s priorities. We are aware that there are many more organisations that contribute towards this end goal throughout Lothian. The second part of this section provides a summary of what is happening in other areas in Scotland.

Current Activity in Lothian

The current activity is described under the following headings but it is recognised that there are clear links and crossovers between these:

- prevention and promotion, particularly within community settings;
- performance and artistic input, particularly within healthcare settings;
- the collection and heritage, and how the benefits these bring can be maximised including for the wider community;
- art and design in the environment, including built and open spaces within new and existing settings.
Prevention and Promotion

Current health policy is concerned with how more effort can be made to prevent ill health, reduce inequalities and focus on how to build positive wellbeing and health. In the longer term it is seen that this will bring about the greatest level of impact for individuals as well as a reduction on the demands made on NHS resources.

In relation to the current public health approach in Lothian the focus is more on an asset-based approach to health, focusing on what people can do rather than on what they can’t do, with community development as a central part of this. It is about promoting the positive (wellbeing) rather than always focusing on the negative (ill health) with potential inputs for example around working with the community to identify issues they want to address such as campaigning for more green space in their area.

Building social capital is key to this approach. This means helping people develop all the personal and community connections in their lives that promote their sense of wellbeing and resilience. A “sense of belonging” is critical to this process.

In Lothian the new five year mental health and wellbeing joint strategy emphasises this focus on building social capital linked to wellbeing. It refers to a number of projects and initiatives underway that will continue and a few examples of these are given here: the Bridgend Community Garden, Cyrenians Gardens Project and Artlink’s “Growing Plots” to further increase community participation in developing and using green spaces and green gyms; “Branching Out”, a partnership with the Forestry Commission to promote wellbeing for people with mental health problems; community (geographic and interest-based) projects such as the LGBT healthy living centre and projects in geographic areas such as Wester Hailes, Gorgie/Dalry and East Lothian.

NHS Lothian has invested core funding this year for deprived areas to support community health projects (seven projects supported). In addition there are a number of other community-based projects totalling around 20, mainly in Edinburgh. There is a Community Health Projects’ Forum and a co-ordinator for these.

Fairer Scotland Fund has funded two creative projects one around healthy weight and children (Muirhouse) and one around food and physical activity (Moredun).

Another example of creativity and design linked to promoting health is in the field of early detection of mouth, neck and throat cancer. Dr Victor Lopes leads a Knowledge Transfer Partnership (KTP) with the Edinburgh College of Art. The aim of this project is to get earlier detection of such cancers as this improves survival rate considerably. The process aims to use creativity/design to produce installation art/environmental art to get the message about looking in your mouth for early signs to the whole of the Lothian population but aiming to reach some high risk minority ethnic groups in particular. The project is keen to evidence what impact it has.
Performance and Artistic Input

This section focuses on the current activities provided by Artlink, Hearts and Minds and Music in Hospitals as key organisations in current delivery. In addition it describes some other activities being funded by the Royal Hospital for Sick Children’s Friends Foundation. There are other ad hoc inputs and activities throughout the year, often organised through direct contacts between hospitals and artists, for example artists performing at the Edinburgh Festival offering to perform within hospitals.

Artlink

Artlink is a leading arts organisation encouraging innovative artistic practice in communities. It works with artists, arts organisations and arts venues – locally, nationally and internationally - looking at imaginative ways to support disabled and disadvantaged individuals to get into the arts. Artlink manages ‘Functionsuite’, a hospital arts programme which creates opportunities for artists to work in collaboration with patients and staff in NHS Lothian hospitals. Artlink exhibits work, arranges music and arts events, commissions artists and works with patients in arts workshops such as the Glasshouses at REH. Artlink manages gallery spaces in four of NHS Lothian’s hospitals: the Pelican Gallery in the Edinburgh Royal Infirmary, The Gallery in the Western General, the Link Gallery in the Royal Edinburgh Hospital and the St John’s Gallery in the St John’s Hospital.

Artlink is also involved in development of public art for the new Midlothian Community Hospital.

Artlink’s work is funded mainly by NHS Lothian Endowments, Royal Edinburgh Hospital Endowments, Creative Scotland and the NHS Lothian Capital Projects.

Hearts and Minds

Hearts and Minds employs professional actors trained to work in healthcare settings as Clown Doctors (with children) and Elderflowers (with older people with dementia). They provide participative personalised sessions in six children’s hospitals/hospices/projects in Lothian and three older people’s providers (Royal Edinburgh Hospital, Royal Victoria and Findlay House). Their children’s work is currently supported by the Royal Hospital for Sick Children and NHS Lothian and West Lothian Council among others but their work with older people receives no funding from either NHS Lothian or the local authorities but comes from commercial sponsorship and charitable trusts.

Hearts and Minds ran a pilot entitled Clown Doctors on Call working with children (with cancer and complex needs) in the community. They have international links with Clown Doctors and those working with older people with dementia throughout the world. As yet they do not have research/evidence to demonstrate the impact of their work with older people with dementia but have this identified within their forward strategy.
Music in Hospitals

Music in Hospitals employs freelance musicians in hospitals, care homes and day centres to provide musical performances from classical to ceilidh. The musicians are paid a modest fee and the hospital/care home contributes a small amount. The organisation subsidizes its work through charitable trusts and business contributions. NHS Lothian provides a core amount each year, to cover the individual hospital fees (although West Lothian has never been included within this budget). Music in Hospitals subsidised this amount with their own fundraising to provide a total of 182 concerts in Edinburgh, Mid and East Lothian.

MiH is hoping to be involved in some clinical psychology research starting in the autumn to show the effects of live music on dementia patients.

The Collection/Heritage

NHS Lothian holds a collection of just over 2000 artworks distributed over 32 sites. The collection consists of fine and decorative art (historic and contemporary), archival material relating to the history of NHS Lothian hospitals and just over 300 reproductions. The collection has been made up of historic acquisitions relating to the foundation of individual hospitals, ongoing donations from staff and patients, art commissions and site specific art installations. Some hospitals have, or have had voluntary arts committees to guide or manage this area of work. (The most recent active arts committee was at Royal Infirmary Edinburgh but this has been in abeyance awaiting the outcome of this strategy development process.)

NHS Lothian commissioned an audit of the collection which was carried out in 2009 resulting in a number of recommendations, some of which are currently being carried out by Art in Healthcare which has a three year agreement (2011-2014) with NHS Lothian Endowments to manage the collection. NHS Lothian Endowments is now Edinburgh and Lothian Health Foundation which is the new name for the Lothian Health Board Endowment Fund. Art works are also cared for by interested members of staff in a voluntary capacity and more formally through the site liaison groups on major sites.

Lothian Health Services Archive (LHSA) which is housed at the University of Edinburgh holds historically important local records of NHS hospitals and other health-related material. Conservation and collection development advice is available from LHSA. LHSA has been involved in arts projects in conjunction with Ginkgo Projects.

NHS Lothian and the area it serves has a rich heritage in terms of medical and health-related history. Individual hospitals, such as the Royal Edinburgh Hospital, have a rich heritage some of which is linked to the heritage of medical advancements in Edinburgh.
Art and design in the Environment

NHS Lothian is currently undergoing a very active period of development of new healthcare facilities. An NHS Lothian Design Quality Framework for Capital Projects was produced in 2010 which sets out the principles and procedures for ensuring excellence in design. This framework document acknowledges that ‘good quality health buildings can help patients recover their spirits and their health; they also have a positive impact on staff performance and retention.’

NHS Lothian policy is also influenced by the standards promoted by Architecture + Design Scotland, Greenspace Scotland and Scottish Natural Heritage.

The refurbishment of existing buildings and the open spaces surrounding them are equally important in this respect.

Art consultancies such as Ginkgo Projects, Art in Healthcare, Artlink and Grit & Pearl are employed to commission the integration of art into new build and refurbishment projects and to foster public participation in what are public spaces.

1.3 Other art and health approaches in NHS Scotland

Grampian Hospitals Art Trust

GHAT has existed for 25 years and has over 4,500 pieces in its collection across the health facilities throughout Grampian. There is an Arts Co-ordinator, employed within NHS Grampian, who runs two gallery spaces in the Aberdeen Royal Infirmary, as well as commissioning artists’ residencies, art workshops and environmental art linked to new build and design. There is also a part-time collections manager. As well as the Trustees for GHAT there is a Board of Management and a group of Arts Advisers who advise on the acquisition of art.

They have a volunteer fundraiser as well as volunteers (art students) who help with exhibitions and fundraising events. Grampian does not currently have a formal written arts and health strategy.

NHS Forth Valley

NHS Forth Valley has recently produced an Arts Strategy for 2011-2014 and has appointed a Charitable Arts and Wellbeing Co-ordinator, partly funded by Creative Scotland for a period of two years. The strategy highlights the importance of working in partnership and has three main strands:

- temporary programmes of exhibitions and events
- integrated public art that enhances chosen spaces
community learning and development that helps to improve arts, health and wellbeing (in collaboration with the three local authorities in the area).

NHS Glasgow and Greater Clyde

NHS Glasgow and Greater Clyde has had an Arts and Health Co-ordinator post since 2005. The role involves overseeing the integration of arts into new builds, networking to keep abreast of everything happening across the area, fundraising, and educating and raising awareness. The first two years’ of the post were funded by the then Scottish Arts Council and the post is now mainstreamed, funded by NHS GGC and situated within Health Improvement and Inequalities.

Glasgow does not have a formal written arts and health strategy (although there is a design strategy for capital projects Working Well: People and Spaces – a therapeutic design and art strategy for new South Glasgow hospitals). There is no separate advisory or steering group for the work of the Co-ordinator and she is line-managed internally within the health improvement team.
Chapter 2

The Strategy

NHS Lothian’s strategy for 2012-17 is set out as follows:

- the vision
- the outcomes
- the principles on which the strategy is based
- the overall strategic framework
- the Action Plan for 2012-14
- implementation and structures.

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</tr>
</tbody>
</table>
2.1 What outcomes are we seeking?

We want to achieve the following outcomes in collaboration with our partners, artists, staff, volunteers and health care users:

- through providing opportunities for creativity, a diverse arts programme and supporting more participation and enablement those who are most vulnerable in our communities have greater wellbeing and because of this, in the long term, have better health
- those who use health care services have faster and more lasting rehabilitation
- those who use, work or volunteer in health care services have improved wellbeing through an enhanced therapeutic environment and access to a diverse range of arts opportunities
- staff and volunteer morale is raised and because of this there is improved experience for both staff and patients
- NHS Lothian is recognised for its contribution to local and national creativity and design linked to improved health and wellbeing
- the strategy has a sustainable future and there is evidence to demonstrate the benefits it brings

2.2 The Principles

The strategy has the following core principles:

- creativity and art should be integrated into NHS Lothian’s overall approach as a core element: this core element is about health and wellbeing, prevention, humanising spaces and paying attention to health inequalities;
- it will recognise and build on what already exists in terms of, art, creativity, heritage, and social capital within our communities and add new and exciting elements to this;
- it will make use of all our resources (staff, volunteers partners, service users, artists, spaces, venues and environments) not just funding;
- participation and involvement will be central to all levels of implementation of the strategy
- collaboration and partnership will be key to the strategy as will a sustainable future funding model;
- in line with national policies on shifting the balance of care, early intervention and prevention, there will be a strong emphasis on health and wellbeing in the
community, the development of social capital and the use of arts and creativity to support health promotion;

- the strategy will allow for central coherence, support and co-ordination while at the same time supporting local emphases, involvement and delivery;
- in particular those who work in or use a given space (ward/health centre etc) will have a say in what happens there both in terms of visual art and any other aspect of creativity;
- the strategy will make use of the existing evidence base and add to this to demonstrate the impact of arts and creativity on health and wellbeing.

2.3 The Strategic Framework

The framework for the strategy encompasses prevention, building social capital and working to tackle health inequalities while at the same time allowing for creativity and arts to support those who use, work or volunteer in health settings both at community and hospital levels.

There are four pillars to the strategy:

- prevention and promotion, particularly within community settings;
- performance and artistic input, particularly within healthcare settings;
- the collection and heritage, maximising the benefits of these to Lothian’s population;
- art and design to enhance the therapeutic nature of the built and surrounding environment.

The way in which these will be used in the different health settings is described below. Communication, participation and involvement, funding and partnership working will underpin this strategic approach.

Community Health Projects

- focus on deprived areas, community development and engagement, self-help groups, self-support and co-production to support wellbeing and prevent ill health;
- participative work with priority groups;
- use of visual arts/collection/heritage to support participation;
- use of creativity and design for health promotion and early detection of disease
Community Health Centres/Hubs

- exhibition space/spaces for art
- collection/visual arts (and using it for participation)
- heritage (and using it for participation)
- art and design built in to any new builds or refurbishments to enhance the therapeutic nature and attractiveness of the environment
- participative work (for staff and patients)

Hospitals

- exhibition space/spaces for art (where appropriate)
- collection/visual arts (and its use for participation)
- heritage (and how it is used, including participative uses)
- art and design built in to any new builds/refurbishments to enhance the therapeutic nature and attractiveness of the environment
- participative work (for staff and patients)
- performance/other artistic inputs

The strategic priorities for this work for 2012-2017 are:

- mental wellbeing
- older people
- early intervention (both in terms of early years and also in terms of early detection)

Reducing health inequalities and promoting wellbeing is integral to the whole strategy.

All aspects of the strategy will only be successful if we work in collaboration with local authority, arts and heritage organisations as well as individual artists and individual staff and patients within NHS Lothian.

One aspect of any funding will be to build in awareness and understanding of equality issues and Lothian’s strategic priorities with all groups that receive funding. Guidance will be developed, to be incorporated into funding agreements, to ensure that the various projects and activities understand and address the needs of these four priorities. In addition the Guidance will set out the monitoring arrangements in relation to receiving funding/creating partnerships.

This Framework will last for five years and will then be reviewed. An action plan for the first two years has been informed by the framework. The Action Plan will be reviewed and amended appropriately on an annual basis.

The section following the Action Plan sets out proposals for how the strategy will be implemented, including the structures, co-ordination and local engagement and participation in the process.
Chapter 3

3.1 Action Plan: 2012-2014

The proposed Action Plan for the next two years is set out below. There will be a lead person within NHS Lothian for each of the four pillars and a sub-group/existing group to oversee it and take final decisions about aspects within it reporting to an overall pan-Lothian Steering Group.

The suggestions for action set out below are a starting point for discussion and agreement between those involved in the sub-groups and the pan-Lothian steering group.

The proposed new post of Co-ordinator will be asked to fundraise for other innovative and exciting projects, for example exploring how new technology can be used to enhance creativity and communication such as digital technology to make the collection more widely accessible and used.

Prevention and Promotion (focus on community settings)

1. Community development/building social capital through support for community health projects
2. Further support for community based inputs in partnership with the local authorities
3. Health promotion: support for innovative and technology-based creativity/design within health promotion and early detection
4. Build further collaboration with third sector and local authority partners as appropriate

Performance and Artistic Input (focus on healthcare settings)

1. Develop a strategic programme of artists in residence (eg in Royal Hospital for Sick Children/Royal Edinburgh Hospital) building on what already exists;
2. Music in Hospitals: seek involvement of West Lothian in core budgeting. (It has been absent in MiH funding from endowments to date);
3. Hearts and Minds: explore possibility of funding for Clown Doctors on Call taking the service to children in the community with cancer and complex needs; explore the development of a research project (in collaboration with Edinburgh University/ Dundee University) on the impact of the Elderflowers programme on those with dementia; provide funding to support the Elderflowers work for those with dementia (currently not funded through endowments);
4. Key settings for Artlink’s inputs in hospitals are currently Royal Edinburgh Hospital, Western General, St Johns, Royal Infirmary. Review where Artlink’s resource is best used in relation to this strategy and key priority groups.
The collection/heritage

1. Develop an acquisitions and disposal policy
2. Art in Healthcare addressing recommendations of the 2009 collection audit
3. Develop participative uses for the collection (e.g. art-in-cart; exploring potential from partnership working with museums and local authorities; taking the collection out to people within communities through use of digital technology)
4. Develop strategic partnerships to make more effective use of collection internally and externally, e.g. Lothian Health Services Archive (separation of archival material), East of Scotland Museums Partnership (community engagement, curatorial expertise), Royal Scottish Academy (advice on disposal procedures)

Art and design in the built and surrounding environment

1. Integration of arts and creativity in all new build and refurbishment designs to enhance the therapeutic nature of the environment
2. Ensure that within the designs there is scope for creative spaces
3. Commissioning art for public spaces as appropriate, with the involvement of those who will use the space
4. Develop a coherent approach for patients, staff, community to access or use the gardens/external areas of NHS grounds

Communication, Involvement and Participation

The above action areas will not be achieved without raising awareness of what we are trying to achieve and without collaboration, involvement and participation at many different levels. Over the next two years we need to:

1. Embed the strategy within NHS Lothian, at all levels;
2. Develop a general communication plan to keep everyone informed, including the development of an arts and health network;
3. Work to maintain high levels of involvement in all aspects of the strategy

Sustainable funding and partnership building

It is essential that the strategy finds ways to support its own sustainability and this in turn will be linked to the ability to demonstrate the evidence of the impact it is having. Part of the action for this next period has to be to develop a clear funding plan with a range of funding sources accessed.

1. Draw up and agree a funding plan with the Pan Lothian Steering Group
2. Draw up Guidance for funding criteria
3. Agree how the outcomes for the strategy will be monitored, evaluated and evidenced.
4. Put the funding plan into action
5. Build specific collaborations and partnerships around some of the actions identified, liaising with partners and keeping everyone involved

The envisaged action for each and more detail is given below.

**Prevention and Promotion**

The aim is to build social capital and increase wellbeing for those most vulnerable through support for community health projects. Having discussed this idea with the Community Health Projects Co-ordinator we propose an annual allocation of grants, between £3-5K to ask the projects to undertake work targeted at our priority groups (older isolated people and those at risk of mental ill health). It is estimated around £25-30K for this grant funding each year with projects invited to bid for it and their use of the funding to be reviewed each year.

Creative health promotion and the existing project between Dr V Lopes and Edinburgh College of Art to support work in early detection of mouth cancer is one example for potential funding.

**Performance and Artistic Input**

Participation is central to the Lothian approach and covers all locations from community to hospital. There can be many different levels of participation and these offer opportunities for professional artists to be involved in new ways with their work as well as for patients and staff to have opportunities to participate.

The Royal Hospital for Sick Children (RHSC) Friends Foundation already has plans for a writer in residence for the RHSC. Similarly the Royal Edinburgh Hospital (REH) has plans for writers-in-residence to celebrate its bi-centenary. It will be important to manage these residencies carefully to support the artists involved and assess the impact of their involvement.

Music in Hospitals provided nearly 200 concerts in health settings last year in Lothian. These are examples of other work which could be supported to an agreed level each year.

The work undertaken by Artlink in the four main hospitals and within the community is highly valuable and valued. Among other things this includes the use of dedicated workshop space and facilitation by artists (for example at REH) that is similar to the Art Room model used in Glasgow and Grampian. Likewise Hearts and Minds provides participative work within children’s and older people’s settings and Music in Hospitals provides musical inputs by professional musicians across hospitals and care homes.

Our sense is that one of the first actions for this sub-group/pan-Lothian committee (see next section) will be to review where the performance/artistic inputs are currently taking place and decide whether there needs to be some re-adjustment to align more closely with the priorities set for the next five years in terms of the main
priority groups and the balance of settings (shifting the balance away from hospitals to community health settings and communities).

3.2 The Collection/Heritage

It is clear that there is a pressing need for stronger management of the collection. Priority areas are:

- Ownership of collection: we suggest that ownership of the collection should be transferred to the Lothian Health Foundation. This will offer protection to the collection and increase opportunities for charitable funding to care for and develop it.
- Development of an acquisitions and disposal policy: while this is a sensitive subject it needs to be addressed. An advisory board will be created with input from the Royal Scottish Academy which has leading expertise in this area, Bill Hare at Edinburgh College of Art, Ruth Honeybone at Lothian Health Services Archive, NHS Lothian, to establish policy and procedures based on best practice from museum, gallery and archive sector
- Creation of a documentation system that will enable accountability for and ongoing administration of the collection
- Separation of archival material from art collection and transfer to LHSA for long term preservation
- Suitable insurance of the collection and insurance for temporary loans or displays of student work
- Assessment of the art historical significance of the collection
- Consider digitalisation of the collection or at least some of it to allow for greater access
- Development of volunteer opportunities
- Potential for loans in of artworks from other institutions
- Create learning opportunities for students at Edinburgh College of Art to curate exhibitions of their work and to engage with health buildings to gain an understanding of particular needs of this setting.

Art in Healthcare has been charged with delivering some of the curatorial recommendations of the 2009 audit. This contract could be extended to cover recommendations on documentation and insurance of the collection.

Further possibilities for using the collection and heritage in a participative way should be explored including the Swedish idea of art-in-a-cart (making prints of some of the collection which patients can chose to have in their ward/beside their bed in a Perspex frame) and development of a programme of activities to engage staff and patients with the collection.

Opportunity to develop partnerships with local authority museums and galleries to curate an exhibition on the history and development of the NHS Lothian art collection, with associated programme of activities, to promote the collection and raise awareness of the arts strategy.
Art and design in the Environment

There will be new builds and refurbishments at hospital and community level over the next few years and it is important that arts and creativity are built into these. Any new build or refurbishment should be in line with the requirements of BREEAM (Building Research Establishment Environmental Assessment Method) and specific policy linked to them will be developed and integrated into the NHS Lothian Design Quality Framework for Capital Projects.

An audit of spaces, and the various types of environments across all NHS Lothian sites, will be carried out with a view to identifying suitable spaces for arts activity/use of open spaces for the benefit of patients and staff.

A partnership with Telford College will be developed, initially through a pilot project, to explore opportunities for students in creative industries to contribute to the enhancement of the environment in health facilities across the Lothians.

Communication, involvement, participation and collaboration

Communication, involvement, participation and collaboration will be essential to the success of this strategy.

In terms of communication there will be awareness raising tasks including presentations to a wide variety of groups about the strategy plus use of appropriate communication tools to keep as wide a group of people as possible informed about latest developments.

Involvement and participation is the single thread that will run throughout all aspects of this action plan: from prevention through to new builds people should be involved in decisions and participate in all aspects of activity.

Collaboration opens up exciting opportunities. The City of Edinburgh Council (Culture and Sport Corporate Services) has already indicated that it would be interested in developing a partnership at senior and operational level with NHS Lothian and steps have begun at senior level to start this process. At operational level the starting point could be on participating in ASC (Access to Sports and Culture) by signing up to the ASC Pledge which is a commitment to partnership working.

Another immediate opportunity for collaboration lies with the East Scotland Museums Partnership to develop collections- related projects and to access curatorial expertise. Contacts have also been made with the City of Edinburgh Council links.

There are potential collaborations with education establishments including Edinburgh College of Art and Telford College among others.
In the medium term it would be useful to develop collaboration with the three other local authorities’ cultural services.

**Funding and partnership building**

One of the ways to unlock funding is to be able to prove the benefits and impact that creativity and arts inputs have on wellbeing and health. It will be useful to have an overall monitoring and evaluation plan for the strategy but within this to focus on one or two aspects to provide more rigorous evidence (depending on what is funded in the first few years). For example this might involve in-depth research to evidence the impact of the Elderflowers on older people with dementia or it might involve in-depth research on the impact of participation in creativity and arts within a community setting.

The proposed Co-ordinator will develop a funding plan in the first three months which will include a range of sources including income generation (through use of exhibition spaces for artists with a commission charged), charitable trusts and commercial sponsorship. Appendix 2 contains examples of funders and ideas for potential fundraising.

The strategy’s implementation assumes that in the first three years there will be core involvement from Lothian Health Foundation.

**3.3 Implementation**

To be fully implemented this strategy and action plan requires central co-ordination. This role might be fulfilled by one or two people (given the range of skills required) and by an employee or by an external source.

There are options as to how the role should be managed and where it should be located including being within NHS Lothian and managed there; being completely separate from NHS Lothian and reporting through a contractual agreement to NHS Lothian; being managed by NHS Lothian but being located elsewhere.

Our sense is that it would be ideal if Lothian Health Foundation played a key role in supporting the implementation of this strategy and for this reason, if the Foundation agrees to this, we think the co-ordination role should sit within the Foundation but be managed by a senior person within NHS Lothian. This gives the benefit of keeping the role closely tied in to NHS Lothian but at the same time providing it with enough space to develop new ideas, bring in new sources of funding without being constrained by being directly part of a large organisation.

It would also emphasize its charitable nature which in difficult economic times will be particularly important.
3.4 Delivery Structures

**Pan-Lothian Steering Group**

A Pan-Lothian Steering Group comprising the key partners and individuals will have responsibility for the overall implementation of the strategy to ensure its successful delivery. This Steering Group will include NHS Lothian (both Board and staff representation from senior levels) Lothian Health Foundation and RHSC Friends Foundation along with local authority and museum representation.

The pan –Lothian Steering Group will have three sub-groups each led by a senior staff member of NHS Lothian. The sub-groups and leads are proposed as follows:

- **Prevention and promotion:** Dr Margaret Douglas (this sub-group will be incorporated within existing work)
- **Participation, performance and artistic input:** Pat Dawson
- **The Collection/heritage:** Tim Montgomery
- **Design linked to new builds/refurbishments:** Ian Graham (within existing channels)

At local level there will be key local groups with responsibility and involvement in aspects of the Action Plan. The diagram below sets out what these structures would look like.
Role of Co-ordinator

We have outlined the role of the co-ordinator in the diagram below. The main remit of this role is to provide support and co-ordination to all aspects of the strategy implementation, to undertake fundraising (with external funders such as other charitable trusts for specific aspects of the Plan) and to raise awareness of the strategy and the benefits of arts and health inputs as well as continuing to find and develop opportunities to gather and review the evidence of impact.

It is hoped that the Co-ordinator and structures will be in place for the start of the new financial year in April 2012.

Conclusion

This strategy seeks to bring coherence and add value to a variety of activities and inputs that have already been taking place in Lothian. It is hoped that through improved communication, collaboration and partnership it will be possible to do more in the area of creativity and arts in the coming years bringing about greater benefits to the Lothian population’s wellbeing and health.

Building on the commitment of individuals who have championed the importance of this aspect of health care and prevention for many years it is hoped that Lothian will become renowned for its contribution to this field.
Appendix 1

Evidence of the impact of creativity and arts on health

Arts in health is defined as creative activities that aim to improve individual and community health and healthcare delivery using arts-based approaches, and which enhance the healthcare environment by providing artworks or performances (Smith, 2003). It incorporates all art forms including dance, theatre/drama, visual arts, performance arts, crafts, literature and music.

We have reviewed the literature and evidence on the benefits of creativity and arts in health and we list examples of the benefits/evidence under the headings of:

- patients
- staff
- patient-staff relationships
- hospitals
- mental health services
- general population
- partnership.

All references are listed at the end of this appendix.

Patients

Creativity and arts can have various benefits for patients:

Reduced length of stay in hospital

- A study by the University of Sheffield found that “patient treatment time reductions of between 14 and 21% are attributable to the design characteristics of new buildings” (Arts Council England, 2007b)

- the length of stay of patients on a trauma and orthopaedic ward at Chelsea and Westminster Hospital was one day shorter when they experienced visual arts and live music (Staricoff et al, 2004)

- music can improve clinical and behavioural states in neonatal intensive care, and significantly reduce the length of stay in hospital (Staricoff, 2004)
Reduced stress, anxiety and depression

- arts can improve the mental, emotional and spiritual state of health service users (Arts Council England, 2007a)
- live music was very effective in reducing levels of anxiety and depression; visual arts and live music reduced levels of depression by a third in patients undergoing chemotherapy (Staricoff et al, 2004)
- in cancer care, visual arts and music can address anxiety, depression and side-effects associated with chemotherapy (Staricoff, 2004)
- arts interventions can increase comfort and reduce stress associated with medical procedures used for screening or diagnosis (Staricoff, 2004)
- music and the visual arts can reduce stress and anxiety associated with surgery (Staricoff, 2004)
- Ulrich and Zimring (2004) talk about the importance of ‘evidence-based design’ in making hospitals “less risky and stressful for patients, their families and for staff”
- Visual artworks featuring scenes of nature have a more positive effect on patients than abstract paintings (Staricoff, 2004). “Even fairly brief encounters with real or simulated nature settings can elicit significant recovery from stress within three minutes to five minutes at most” (Ulrich and Zimring, 2004). (For example, New Victoria Hospital and Southern General Hospital in Glasgow)
- A study found that participating in a creative arts exercise (clay modelling) lowered depression, obsessive–compulsive symptoms, and phobic anxiety among patients with Parkinson’s disease (Goldblatt et al, 2010)

Improved patient experience

- The King’s Fund has found that the arts can help to humanise the hospital environment and improve levels of privacy and dignity (Arts Council England, 2007b)
- a study of the impact of a new hospital in Middlesbrough, with high quality art and design, found that patients had an increased sense of ‘feeling at home’ – “the artworks made the hospital seem ‘less like a hospital’”(Arts Council England, 2007b)

Improved clinical outcomes

- There is “clear and reliable evidence that clinical outcomes have been achieved through the intervention of the arts” (Staricoff, 2004).
• More than 30 rigorous scientific studies show how exposure to nature quickly decreases stress and reduces pain, slowing respiration and lowering blood pressure (Arts Council England, 2007b)

• handling museum objects can have a positive impact on patient wellbeing, self-reported measures of life satisfaction and health status (Chatterjee et al, 2009)

• in cardiovascular care, music can have a positive effect on anxiety, blood pressure, heart rates and demand for myocardial oxygen (Staricoff, 2004)

• Live music helped to increase the number of accelerations of foetal heartbeat, a sign of wellbeing, in an antenatal clinic, and lowered blood pressure of patients waiting for appointments in an antenatal high risk clinic (Staricoff et al, 2004).

Reduced need for medication

• need for pain relief among patients who experienced visual arts and live music was significantly less than those in the control group (Staricoff et al, 2004)

• music is particularly effective in reducing the need for sedatives when recovering from surgery (Staricoff, 2004)

Improved wellbeing

• Singing has been found to improve quality of life for people with dementia (Clair, 2000)

• Showcasing patients’ work can enhance self-esteem (Big Difference Partnership et al, 2011)

Positive impact on job satisfaction and staff recruitment and retention

• “the introduction of works of art and nature features have been recognised as having an impact on staff satisfaction and possibly contributing to reduced staff turnover” (Staricoff, 2004)

• “A study of the impact of an active arts programme integrated into the healthcare environment showed that it is a major consideration for staff when applying for a job or remaining in their current positions” (Staricoff, 2004)

• 66% of respondents to a survey said that “the environment – architecture, light, colour, visual art and live music - of Chelsea and Westminster Hospital
• The King’s Fund has found evidence of a positive relationship between improved healthcare environment and improved staff recruitment and retention (Arts Council England, 2007b).

Reduced absenteeism

• A study by the University of Sheffield found that improvements to the architecture of hospitals can reduce staff absenteeism (Arts Council England, 2007b).

Improved approaches to healthcare (Arts Council England, 2007a):

• improve the lives of healthcare staff by humanising the treatment and giving more respect to individuals;
• use creativity in, and creative approaches to, continuing professional development for healthcare staff; and
• help staff to provide better, more tailored care to service users through, for example, increased awareness of their personalities, interests and skills (South Staffordshire and Shropshire Healthcare Foundation NHS Trust, 2009).

Improved education and training

• “Teaching strategies involving the use of art have been incorporated to develop a personal philosophy of nursing which gives students an opportunity to be creative and assertive” (Staricoff, 2004)
• An initiative that introduced students to works of art in a gallery and asked them to assess the mental and physical health of the characters in the paintings developed skills of observation and increased trainees’ awareness of dealing with health problems across cultures (Staricoff, 2004)
• The study of literature in medical and nursing undergraduate courses promotes clarity of observation, expression and fluency in ordinary language (Staricoff, 2004).

Patient-staff relationships
Improved communication

- Arts in health projects help medical staff, carers, patients and families to communicate more effectively with one another by offering opportunities for involvement and empowerment (Arts Council England, 2007a)

- the arts can help to improve communication, empathy and understanding of patients’ needs (Staricoff, 2004)

Reduced aggressive behaviour

- The King’s Fund has found that improved environments can reduce aggressive behaviour (Arts Council England, 2007b)

- A study by the University of Sheffield which looked at two cohorts of patients, one before and one after the building of new accommodation, found that ‘good’ architectural environments “dramatically reduced patient aggression levels” (Arts Council England, 2007b)

- A study of the benefits of introducing music in hospital waiting rooms found that it reduces stress levels among visitors, leading to reduced aggression against staff (Staricoff, 2004).

Hospitals

Cost savings

- Reduced length of stays, reduced need for medication, improved staff recruitment and retention lead to reduced costs

- “The research team found more than 600 rigorous studies linking a range of aspects of the built environment of hospitals to staff stress and effectiveness, patient safety, patient and family stress and healing, and improved overall healthcare quality and cost” (Ulrich and Zimring, 2004)

Improved design

- Artworks can act as landmarks and wayfinders in hospitals (Arts Council England, 2007b). (For example, Southern Genertal Neonatal Unit in Glasgow)

- A new hospital in Middlesbrough found that artworks helped to provide colour, distraction and a sense of calm within public areas (Arts Council England, 2007b)
Improved public relations

- An NHS Trust in Middlesbrough found that establishing a structure for selecting and funding commissioned artworks improved links with the community and helped to maintain positive public relations (Arts Council England, 2007b).

Mental health services

“There is a growing body of evidence to suggest that the arts can have a positive effect with respect to the care, treatment and support available to those experiencing mental health problems” (Scottish Arts Council, 2008b). Staricoff’s literature review (2004) found that the use of arts in mental healthcare can help to:

- increase the communication skills of mental healthcare users;
- improve mental healthcare users’ relationships with family and mental healthcare providers;
- provide people experiencing mental health problems with new ways of expressing themselves; and
- stimulate creative skills and enhance the self-esteem of people experiencing mental health problems.

The Scottish Arts Council’s evaluation of the pilot Strategic Arts and Healthcare Co-ordinator post in Glasgow recognised the potential of arts activities to contribute to faster or more lasting rehabilitation from mental health problems (Scottish Arts Council, 2008a).

A study undertaken by the Department for Culture, Media and Sport, and the Department of Health found that participation in the arts provided relaxation and distraction, resulting in improved mental wellbeing and decreased mental distress, and provided a means for connecting with other people, thereby reducing social isolation (Arts Council England, 2007b).

General population

Health promotion

- “The arts play a hugely valuable role in engaging excluded or hard-to-reach groups or communities who may not respond to traditional methods of health promotion… Evidence shows that participation in the arts can provide a non-threatening and alternative way to engage in a healthier lifestyle” (Arts Council England, 2007a).
Wellbeing

- Participation in the arts promotes positive physical and mental wellbeing, especially for children and young people (Arts Council England, 2007a).
- Taking part in creative activities resulted in reduced anxiety levels reported by college students (Aaron et al, 2011).
- The British Medical Journal argued for greater spending on the arts to improve public health. Even if it does not prevent disease in itself, it has an important role in improving wellbeing (Smith, 2002).

Partnership

A partnership approach is important:

- Partnerships have been created with local authorities, museums, universities and voluntary groups such as Age Concern (South Staffordshire and Shropshire Healthcare NHS Foundation Trust, 2009).
- “It is essential for Arts and Health champions, supporters and practitioners to work in a multi-agency, cross-disciplinary way, establishing a supportive environment” (Big Difference Company et al, 2011).
- It is important to create clear pathways for third sector bodies to engage with statutory services (Big Difference Company et al, 2011).
- The Artfull initiative included an example of partners from a local authority, the voluntary sector and the NHS working together to deliver a project of a scale that would not otherwise have been possible in their rural area (Scottish Arts Council, 2008b).
- Successful partnerships result from development over a period of time, ensuring regular contact and updates, and clearly defining each partner’s roles and responsibilities (Scottish Arts Council, 2008b).
Appendix 2

List of references


- Big Development Company, Derbyshire Community Health Services, Leicester City Primary Care NHS Trust and Lincolnshire Partnership NHS Foundation Trust (2011), Reflecting Upon the Value of Arts and Health and a New Approach for the East Midlands 2011-2013

- Bristol City Council (2005), Neighbourhood Arts Strategy, Bristol

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NHS Wirral (not dated), *Arts and Health Strategy for St Catherine’s Health Centre*

NHS Wirral (not dated), *Arts and Health Strategy for the West Wirral Group Practice Centre, The Warvens, Wirral*

Royal Aberdeen Children’s Hospital Arts Project (2011): http://www.rach-art.org.uk/ (accessed 8 July 2011)

Scottish Arts Council (2008a), *Catalysing Arts and Health: Evaluation of Strategic Arts and Health Co-ordinator Post*, Scottish Arts Council, Edinburgh

Scottish Arts Council (2008b), *Evaluation of the Artfull Initiative*, Scottish Arts Council, Edinburgh


Smith, T (2003), *An Evaluation of Sorts: Learning from Common Knowledge*, CAHMM, University of Durham

NHS Lothian Art Audit 2009

South Staffordshire and Shropshire Healthcare NHS Foundation Trust (2009), *Arts for Health Programme Strategy*


- Yorkshire Futures (2010), *What Works in the Arts: Good Practice in Yorkshire and Humber*, Yorkshire Futures
Ideas for additional funding for the strategy

Assuming that the strategy is able to attract core funding there will always be a need to find other sources of funding and finance to allow for additional pieces of work/commissions to happen.

There are three main ways outlined below:

- enterprising activity, with proceeds going to support the strategy’s implementation
- private sector support, from individual giving to corporate sponsorship
- applications to various charitable organisations and foundations.

We provide further information about each of these below.

Enterprising activity

This encompasses activities which generate money through direct activity. For example one of the ways that has been used in the past is to use exhibition space within a hospital for a private art exhibition where selected artists can sell their work and a commission is payable to the strategy fund on anything they sell. The money made is then re-invested to the ongoing work.

Another take on this is to ask artists to donate a CD-sized picture and these are displayed and then an auction is held with bidders not knowing whether they will buy a picture by a famous artist or someone less well known.

Private sector support

Individual donations can be encouraged through an awareness-raising campaign and/or direct approach to wealthy individuals for specific items/commissions.

Similarly corporate sponsorship can be sought for targeted areas/commissions and can be an attractive proposition if careful matching of what is required to an appropriate sponsor is undertaken.

Charitable funders and foundations

There is a plethora of potential charitable funders. We list some of the key ones below.

PURPOSE: To make a positive difference for the benefit of people living in Scotland (with a preference for Perth & Kinross) by supporting a wide variety of projects, ranging from major national flagship projects to smaller community projects. One of the four themes of the Trust is ‘Improving the Quality of Life of
the Disadvantaged and Vulnerable’ (including therapeutic drama and music for the disabled and educationally and socially disadvantaged.)
AMOUNT: Not specified.
APPLICATION PROCESS: Form of three sides of A4, giving details of project, plus accompanying documents. No deadline specified.

**Esmee Fairbairn Foundation** [http://www.esmeefairbairn.org.uk/about-us.html](http://www.esmeefairbairn.org.uk/about-us.html)
PURPOSE: This large, independent grant-making foundation aims to improve the quality of life for people and communities in the UK both now and in the future by funding charitable activities of organisations that have the ideas and ability to achieve change for the better.
Will not fund Healthcare or related work, or work that is primarily the responsibility of central or local government, health trusts or health authorities.
AMOUNT: In 2010 average grant size was £79,000
APPLICATION PROCESS: First stage application form online, by e-mail or hard copy by post. Successful proposals will be invited to send in a second stage application for further consideration. No deadline.

The London-based PF Charitable Trust has been using the Scottish Community Foundation to distribute funds in Scotland.
PURPOSE: Grants are made to voluntary organisations and charities working in the areas of disability, health, youth work, elderly, children and families and homelessness.
AMOUNT: Express grants <£2000
APPLICATION PROCESS: Apply to Community Grants Programme Express Grant using the online application form. No deadline.

**Nancie Massey Charitable Trust**
[http://www.culturalprofiles.net/scotland/Units/828.html](http://www.culturalprofiles.net/scotland/Units/828.html)
PURPOSE: Makes grants to charitable bodies carrying out projects in the Edinburgh area for the benefit of the young, the elderly, medical research, education and the arts.
AMOUNT: unspecified
APPLICATION PROCESS: Contact the administrator for an application form. J G Morton, Solicitors, 61 Dublin Street, Edinburgh EH3 6NL, Scotland, United Kingdom 44 (0) 131 558 5800. No deadline given.

**The Robertson Trust** [http://www.therobertsontrust.org.uk/](http://www.therobertsontrust.org.uk/)
PURPOSE: Exists to provide financial support to charities where the work takes place in, or has an impact on, Scotland. The four main priorities areas are care, health, education and training, and community art and sport.

AMOUNT: Small and main donations form the bulk of the donations made by the Trust and are assessed on a rolling programme with recommendations made to the Trustees six times a year. Major capital donations which are likely to be for
capital developments where the total value is in excess of £1M will be considered three times a year in January, May and September.

APPLICATION PROCESS: By application form or letter.

The Volant Trust [http://www.volanttrust.com/](http://www.volanttrust.com/)
PURPOSE: Founded by JK Rowling to support charitable causes. One of its two main areas of interest is charities and projects, whether national or community-based, at home or abroad, that alleviate social deprivation, with a particular emphasis on women’s and children’s issues.
AMOUNT: varies
APPLICATION PROCESS: Form on website to be used for all applications except for Scottish applications that are for £10,000 and under per annum. For the latter apply via the Scottish Community Foundation [http://www.scottishcf.org/resources/funds/view/66/volant-charitable-trust/?from=V/1](http://www.scottishcf.org/resources/funds/view/66/volant-charitable-trust/?from=V/1). Trustees meet in March and September. See website for deadlines

MacRobert Trust [http://www.themacroberttrust.org.uk/grant-making/](http://www.themacroberttrust.org.uk/grant-making/)
PURPOSE: Support will be given to charities dealing with the health, welfare and well-being of young people, particularly where those charities work with issues surrounding addiction to alcohol and substance misuse, crime, homelessness and disadvantage and disability of any sort. UK wide, with a preference for Scotland
AMOUNT: Varies. Usually £5,000 to £10,000.
APPLICATION PROCESS: Application form, submitted before 31st Oct or 31st May of any year.

PURPOSE: to enrich and connect the experiences of individuals, families and communities, with a special interest in supporting those who are most disadvantaged. Funding is available to support a small number of truly exceptional ideas and/or projects that contribute to meeting the identified objectives under the three main strategic aims: Cultural Understanding, Fulfilling Potential, Environment
AMOUNT: Usually between £10,000 and £25,000
APPLICATION PROCESS: Online form with more information requested at next stage. No deadline.

The Tudor Trust [http://tudortrust.org.uk/](http://tudortrust.org.uk/)
PURPOSE: Supports organisations working in any part of the UK, funding a wide range of people and organisations working to build stronger communities. Has a wide remit, with emphasis on encouraging progress, development and fresh ideas. More likely to fund groups with an annual turnover of less than £1 million.
AMOUNT: Variable
APPLICATION PROCESS: First stage applications comprise an introductory letter, answers to three questions, organisation details and accounts, sent by
post. At the second stage the Trust will make contact and ask for more information.

PURPOSE: Support is provided in either the performing or visual arts. Aims to help sustain the arts and to support projects that particularly help to deliver artistic vision.
AMOUNT: Usually between £10,000 and £50,000. Maximum total of £500,000. Also Small Grants fund.
APPLICATION PROCESS: Application form and supporting information. No deadlines except for Capital Projects of over £50,000, which are considered in spring and autumn.

**Clore Duffield Foundation** [http://www.cloreduffield.org.uk/](http://www.cloreduffield.org.uk/)
PURPOSE: To support both large and small projects generally in the cultural sector, but occasionally in health and social care
AMOUNT: <£5,000 - £1 million
APPLICATION PROCESS: Letter of application, followed by a full proposal. No deadlines.

**Earnest Cook Foundation**
PURPOSE: Gives grants to registered charities, schools and not-for-profit organisations wishing to encourage young people’s interest either in the countryside and the environment or the arts (in the broadest sense). Work which encourages or ensures the continuation of rural skills and crafts is of particular interest to the Trustees. All applications are expected to link in with either the National Curriculum or with recognised qualifications.
AMOUNT: A large grants programme for awards of over £4,000 (most awards are between £4,00 and £10,000) and a small grants programme for awards of under £4,000 (most awards are between £1000 and £1,500.)
APPLICATION PROCESS: Covering letter with organisation description, project budget, accounts and list of other funding applications. No deadline but Board meets in April and September.

**Craignish Trust**
PURPOSE: Aims include the advancement of arts, heritage, culture or science through the support of charities and community groups.
AMOUNT: Small grants - the Trust gives approximately £20,000 a year.
APPLICATION PROCESS: The Trust is managed by Geoghegan and Co Chartered Accountants
6 St Colme Street
Edinburgh
EH3 6AD
Cruden Foundation
http://www.grantsnet.co.uk/grantdetail.asp?grantID=1353&searchterm=operating&searchtype=normal
PURPOSE: Offers grants to charities that manage activities that can bring benefit to communities in Scotland.
AMOUNT: Variable
APPLICATION PROCESS: There are no set guidelines or application form.

Applications should be submitted to the Secretary at:
Baberton House
Juniper Green
Edinburgh
EH14 3HN

Lloyds TSB Foundation for Scotland – Henry Duncan Award
PURPOSE: Supports grassroots charities operating in Scotland (with an income of less than £500,000) which are clearly focused on improving the quality of life for people who are disadvantaged or at risk of becoming disadvantaged.
AMOUNT: No maximum but average Henry Duncan Award is £6,000-£8,000. Small grants of less than £2,500 also available.
APPLICATION PROCESS: Request hard copy or electronic application form by e-mail or telephone. Six closing dates for submission given in guidance notes.

Creative Scotland – Cultural Economy: Sustainable development
http://opportunities.creativescotland.com/view.aspx?id=68017104-cf09-4000-88a2-824821b8ceaf
PURPOSE: To develop the cultural economy by building the long-term organisational resilience and financial sustainability of the cultural and creative sector in Scotland through supporting projects that encourage clear mission-led strategic projects, collaborations and initiatives that enable organisations to improve their long-term organisational resilience and financial sustainability.
AMOUNT: A total of £700,000 is being invested in 2011/12 but likely individual amounts are not specified.
APPLICATION PROCESS: Application form on website to be submitted by e-mail. Deadline 31st March 2012.

Creative Scotland – Youth Music Initiative
http://www.creativescotland.com/investment/investment-programmes/youth-music-initiative
PURPOSE: To support and create access to high quality music making programmes particularly for young people that would not normally engage in music activities. The Informal Sector Large and Small Investments aims to support organisations working within the Informal Sector who wish to programme music making activities for young people (0-25 years) outwith mainstream education settings or for children under 5 either in or out of nursery settings.
AMOUNT: Small investments will be made between £1,000 and £5,000. Large investments will be made between £5,001 and £30,000. In any application for support we expect at least 10% cash partnership funding.
APPLICATION PROCESS: Application form to be submitted by e-mail. Deadlines for small investments is 13th Feb 2012 and for large is 1st Feb 2012.

Creative Scotland – Access, Audience Development, Participation http://opportunities.creativescotland.com/view.aspx?id=54a76ac0-a120-4090-9441-b3d9b4aae32c
PURPOSE: to invest in original and new models that develop new and existing audiences, that encourage participation and that improve and increase access to the arts, screen and creative industries across Scotland.
AMOUNT: Awards are likely to be in the range £10,000– £50,000
APPLICATION PROCESS: Application form on website to be submitted by e-mail. Deadline 31st March 2012.

PURPOSE: Bringing real improvements to Scottish communities, tackling need and addressing health inequalities. Funds a wide variety of organisations, including community and voluntary organisations, local authorities and community councils, social enterprises and private companies. Investing in three areas: growing community assets; life transitions; and supporting 21st century life.
AMOUNT: £10,000 - £1million.
APPLICATION PROCESS: Stage one application form on website, then proceed to a stage two application. Applications are ongoing with a deadline of 30th June 2015.

Awards for All – Scotland http://www.awardsforall.org.uk/scotland/index.html
PURPOSE: Provides grants for people to take part in art, sport and community activities, and projects that promote education, the environment and health in the local community. Considers applications from not-for-profit/voluntary and community sector groups, community councils, schools or health bodies but prioritises smaller voluntary and community groups with an annual income of less than £20,000.
AMOUNT: £500 - £10,000
APPLICATION PROCESS: Application form on website to be submitted by post or e-mail. No deadline.

NHS Lothian 2012
QUALITY REPORT

1 Purpose of the Report

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

2 Recommendations

The Board is asked to:

2.1 Review the quality measures.

2.2 Identify changes/amendments to the dashboard required to meet quality governance requirements.

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. 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. The October report will focus on diabetes clinical effectiveness measures.

3.3 The Quality Report is intended to link with NHS Lothian’s Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities.

3.4 The dashboard consists of a front sheet with “at a glance” trend arrows and a series of supporting charts. The front sheet shows for each measure whether there has been an increase, decrease or no change in comparison to the preceding month/quarter. As many of the measures included are intended for improvement, it is important that the background trend charts are also scrutinised, as focusing on one data point may be misleading.

3.4.1 Underpinning the dashboard is the recognition that staff have expressed the desire that data should only be collected once for use for all three levels. As part of the Clinical
Governance & Risk Department’s strategic direction, a Quality Improvement Database (QIDS) and Ward Scorecard have been developed with staff. These collect data in a user-friendly manner at the front line and provide data at a local level which can be used for a range of reporting requirements both locally and nationally.

3.4.2 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.

3.4.3 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.

3.4.4 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.

3.5 At present the dashboard is skewed toward acute care. Discussions are scheduled with the Primary Care Measures Group to identify primary care measures to be reported in the dashboard on a routine basis.

3.6 It is envisaged that this Dashboard will be accompanied by a paper providing a summary of key quality governance issues which would include risk management, clinical standards and public protection, and progress against the Board on Board Action Plan.

3.7 Patient Experience – Better Together Patient Experience Programme Adult Inpatient Survey, August 2012. This is the third national survey in the Better Together Experience Programme. Out of 3,596 people who stayed overnight in an NHS Lothian hospital between the period of October 2010 and September 2011, 1,822 people responded to the survey (a 51% response rate) from 8 NHS hospitals. This included 2 teaching hospitals, 1 large general hospital, 4 long stay hospitals and 1 other location.

3.7.1 The initial assessment of the results suggests that NHS Lothian continued to score positively on the summary indicators regarding patients being treated with respect (94%) and care (94%). NHS Lothian also scored in the 90’s for summary statistics regarding trusting the people looking after me, understanding what was happening to me and physical comfort.

3.7.2 When comparing to the 2011 results NHS Lothian patient experience has improved and were more likely to report a positive experience in the following areas:-

- I was not bothered by noise at night (55%; +5%)
- I understood what my medicines were for (96%; +2%)

3.7.3 Areas where patient experience has reduced are in the following:-

- My religious and spiritual needs were respected (53%; -5%)
• I was confidence that any help I needed had been arranged for when I left hospital (73%; -4%)

3.7.4 A more detailed paper including response to the results will be going to the HCGRM Committee in October.

3.8 Better Together National Patient Experience Survey – GP Practices

3.8.1 The outcome of the Better Together GP Patient Experience Survey was published by the Scottish Government in May 2012 and contained 37 individual patient survey questions.

3.8.2 Since the 2009/10 survey there has been a small decrease in overall care provided by NHS Lothian GP surgeries as good or excellent (-1%) and patients being treated with dignity and respect (-4%). This trend is noted across almost all NHS Boards. As seen in the 2009/10 survey nursing staff in Lothian continue to score highly, scoring equal or higher than national averages.

3.8.3 The five areas where NHS Lothian scored highest in accordance with national figures are:-

99% - The surgery is clean
98% - Patients know enough about their medication and when to take them
98% - Patients’ take their prescription as they were supposed to
97% - Patients know enough about what their medicines are for
96% - The nurse listens to the patient

3.8.4 The five areas where NHS Lothian scored the lowest in accordance with national figures are all connected to access:-

80% - Able to book a Doctors appointment 3 or more working days in advance
83% - Can usually see preferred Doctor
84% - Can see or speak to a Doctor or nurse within 2 working days
85% - Easy to get through on the phone
85% - Time waiting to be seen at the surgery

3.8.5 Consistent questions which focused on aspects of person-centeredness relating to the patients’ experience of doctors were selected from the survey and results were compared for 2009 and 2011. Practice-specific results are presented in graphs 3.8.7 to 3.8.9 for all Lothian practices. Each point on the curves corresponds to a practice.

3.8.6 For two of the three questions, the proportion of patients responding positively increased between the two survey periods, suggesting that there has been an overall improvement in person-centeredness in Lothian general practice, albeit starting at a very high level.

3.8.7 Patients feel that the doctor has all the information they need to treat them

In 2009/10, 50% of practices had 87% or more of their patients agreeing with this statement. In 2011/12, this had increased to 89% or more. The distribution curve shifted to the right over time (i.e. more person-centred) for all practices except those with very high scores (over 95%) in 2009/10.
3.8.8 The doctor shows consideration for the patient’s personal circumstances when treating them

This is probably the most relevant question to person-centeredness in the Better Together survey. The distribution curve shows the largest shift to the right. Fifty percent of practices had 87% or more of their patients agreeing with this statement in 2009/10. This increased to 92% in 2011/12.

3.8.9 The doctor talks in a way that helps the patient to understand their condition and treatment

The results for this question shifted to left over time, showing a small decrease in the proportion of patients agreeing with the statement. In 2009/10, 92% or more of patients agreed with the statement in 50% of practices. In 2011/12, this had reduced to 90% or more of patients.
3.8.10 The fast frequent feedback approach described in the March 2012 Quality Report has recently completed the second round of questionnaires. Results are being analysed and a report will be prepared. The advantage of this approach over the Better Together Survey is that the results are analysed at the level of the doctor rather than the practice. Doctors are therefore able to get individual feedback on their person-centeredness and address any issues which arise.

3.8.11 All practice level data has been provided to each CH(C)P management team for discussion by their respective Quality Improvement Teams. CH(C)Ps are responsible for providing support to GP practices where there are identified areas of concern. Monitoring and reporting will be via the CH(C)P Quality Improvement Teams and Sub-committees; Primary Care Joint Management Group; Primary Care Community & REAS Healthcare Governance Group and the Primary and Community Partnership Committee.

3.9 A National Approach to the Management of Serious Adverse Events in Scotland

3.9.1 Healthcare Improvement Scotland (HIS) have been commissioned by the Scottish Government Cabinet Secretary for Health, Wellbeing & Cities Strategy to develop a national framework for the management of adverse events, in response to the publication of the HIS report on ‘The Management of Significant Adverse Events in NHS Ayrshire & Arran’.

3.9.2 This work includes a baseline of current and future planned approaches at a Board level to the management of adverse events. All Boards were asked to submit baseline information by 7th September against the Ayrshire & Arran Report Board recommendations to inform the development of the framework and review programme.

3.9.3 The aim of the HIS review programme is to examine through Board visits the governance arrangements and process relating to the management of adverse events with a particular focus on significant adverse events in order to seek assurance that appropriate learning and improvement takes place to reduce the risk of events recurring.

3.9.4 The visits will which start in November 2012 and Boards will be given six weeks notice, and will include interviews with staff at different levels in the organisation.

3.9.5 A detailed review of the management and learning from significant adverse events will be going to the Healthcare Governance & Risk Management Committee in October 2012.
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.\(^1\) Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focusing on one data point (as below) may be misleading.

### Quality Ambition: Person-centred

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

### Quality Ambition: Safe

#### 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

<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>
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<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>114.92</td>
<td>105.85</td>
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<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
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</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>0.96</td>
<td>1.00</td>
</tr>
</tbody>
</table>

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\(^1\) 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>
</tbody>
</table>
| Goal: 85% of complaints responded to within 20 days | **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 '09</td>
<td>83%</td>
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<tr>
<td>May '09</td>
<td>94%</td>
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<td>Jun '09</td>
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<td>Aug '10</td>
<td>80%</td>
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<tr>
<td>Nov '10</td>
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</tr>
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<td>Jan '11</td>
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<tr>
<td>Jun '12</td>
<td>81%</td>
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</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>
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<tr>
<td>May '09</td>
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<tr>
<td>Jun '09</td>
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<td>Feb '12</td>
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<tr>
<td>Mar '12</td>
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Data Source: Datix

| Title: 3-day Complaints Response Rate |
Title: 3-day Complaints Response Rate
Numerator: Number of complaints responses within 20 days
Denominator: Number of all complaints responses
Goal: 100% formal acknowledgement within 3 working days

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Compliant</th>
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<td>Apr '11</td>
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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.

<table>
<thead>
<tr>
<th>Safe: Reduction in mortality</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals)</td>
<td>Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – March 2012</td>
</tr>
<tr>
<td>Numerator: Total number of in-hospital deaths and deaths within 30 days of discharge from hospital</td>
<td>Data Source: ISD (Quarterly)</td>
</tr>
<tr>
<td>Denominator: Predicted total number of deaths</td>
<td></td>
</tr>
<tr>
<td>Goal: National goal 15% reduction against 2006/07 baseline by 2012.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe: Reduction in Incidents with Harm and improved Incident Management</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Incident Management Key Performance indicators (KPIs)</td>
<td>Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – March 2012</td>
</tr>
<tr>
<td>Title: Incidents with harm</td>
<td></td>
</tr>
</tbody>
</table>

Data Source: ISD (Quarterly)
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

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

Data Source: Datix

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

Process Measure

Data Source: Local Audits (QIDS)

---

Outcome Measure

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

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 June 2012 – 0.33

Outcome Measure

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

Data Source: Health Protection Scotland

Month-Year

Number of CDI Episodes

Results below the dotted line = Achieving HEAT Target

Month-Year


Month-Year

90.00 80.00 70.00 60.00 50.00 40.00 30.00 20.00 10.00 0.00

Month


Month-Year

HEAT Target  CDI  Trend
### Safe: Compliance with Peripheral Vascular Bundles

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

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Staph. aureus bacteraemias (SABs) rate against HEAT Target 2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)</td>
</tr>
<tr>
<td>Goal</td>
<td>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 June 2012 – 0.33</td>
</tr>
</tbody>
</table>

### Process Measure

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

### Outcome Measure

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

**Data Source:** Health Protection Scotland
**Safe: Improved management of the deteriorating patient. Compliance with Early Warning Score Bundle**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent compliance with the EWS Bundle (NHS Lothian Acute Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>The total number of SEWS observations completed correctly</td>
</tr>
<tr>
<td>Denominator:</td>
<td>The total number of observations reviewed per month. <strong>n=11,265</strong></td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Process Measure</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source Data: Local Audits (QIDS)</td>
<td></td>
<td>OUTCOME MEASURE TO BE DETERMINED</td>
</tr>
</tbody>
</table>
### Safe: Improvement in Medicines Reconciliation

**Title:** Percent of patients with medication reconciliation performed (NHS Lothian Acute Hospitals) (Pilot Site=One Ward)

**Numerator:** Total number of patients with medication reconciliation performed

**Denominator:** Total number of patients reviewed. **n=15 per month**

**Goal:** 95% Compliance

<table>
<thead>
<tr>
<th>Month</th>
<th>Process Measure</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compliance with Medicines Reconciliation</td>
<td>OUTCOME MEASURE TO BE DETERMINED</td>
</tr>
</tbody>
</table>

![Graph showing compliance with medicines reconciliation over months]
Quality Ambition: Effective

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

<table>
<thead>
<tr>
<th>Effective: Reduction in in-patient Falls - Delivering Better Care</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Percent compliance with Falls Prevention CQI (NHS Lothian Acute Hospitals)</td>
<td>Title: Patient Falls with Harm</td>
</tr>
<tr>
<td>Numerator: No. of patients fully compliant</td>
<td>Numerator: Number of falls reported with harm, moderate, major/ death</td>
</tr>
<tr>
<td>Denominator: Total no. of patients reviewed per month n=964</td>
<td>Goal: 95% Compliance</td>
</tr>
</tbody>
</table>

Data Source: Datix

**Process Measure**

NHS Lothian

Compliance with Clinical Quality Indicator: Falls

Data Source: Datix

**Outcome Measure**

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

Data Source: Datix

Harm = Codes (Moderate/Major/Death)
### 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

**Goal:** 95% Compliance

---

### Process Measure

Data Source: Datix

![Process Measure Chart](chart1)

### Outcome Measure

Data Source: Datix

![Outcome Measure Chart](chart2)
**Effective: Delivering Better Care - Reduction in Nursing Medication Administration Incidents**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Number of Nursing Medication incidents per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of all medication incidents</td>
</tr>
<tr>
<td>Goal:</td>
<td>10% reduction in all nursing and midwifery medication errors by March 2013</td>
</tr>
</tbody>
</table>

**Outcome Measure**

**Number of Nursing Administration of Medication Incidents:**

- **All incidents**
- **Baseline Median**
- **Extended Median**
- **Target Median**

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

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

**Process Measure**

**HEAT target**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Jun-10</td>
<td>70%</td>
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<tr>
<td>Jul-10</td>
<td>75%</td>
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<td>Aug-10</td>
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<td>Sep-10</td>
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<td>Oct-10</td>
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<td>Mar-12</td>
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</table>

**Trend**

**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 with swallow screen on day of admission**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Apr-10</td>
<td>50%</td>
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<td>May-10</td>
<td>55%</td>
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<td>Jun-10</td>
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<td>Jul-10</td>
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<td>Mar-12</td>
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</tbody>
</table>

**Trend**

**Title:** Stroke Treatment Measures

| **Numerator:** | Number of admitted patients with initial diagnosis stroke that have a brain scan on the day of admission |
| **Denominator:** | Number of patients admitted with initial diagnosis of stroke |
| **Goal:** | 80% of patients with initial diagnosis of stroke should receive a brain scan on day of admission |

**Process Measure**

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

<table>
<thead>
<tr>
<th>Time period</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Apr-10</td>
<td>40%</td>
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<tr>
<td>May-10</td>
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<td>Jun-10</td>
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<td>Jul-10</td>
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<td>Mar-12</td>
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</table>

**Trend**
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  
10 September 2012  
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Dr Elizabeth Bream  
Consultant in Public Health  
10 September 2012  
Elizabeth.bream@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Supporting 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)
AREA CLINICAL FORUM CONSTITUTION

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approves the proposed amended constitution of the Area Clinical Forum, agreed at the Area Clinical Forum meeting held on 2 August 2012.

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

2 Recommendations

The Board is recommended to:

2.1 Approve the proposed amended constitution for the Area Clinical Forum

3 Discussion of Key Issues

3.1 The constitution has been revised to include the Nurse Director in the ex-officio membership of the Forum. As other Executive Directors are already included in the ex-officio membership, this revision will formalise the Nurse Director’s engagement with the Forum. The Divisional Medical Director has been removed from the ex officio membership. The relevant amendments to the revised Constitution are highlighted in section 3 under ‘ex officio members’ and under the minute distribution at section 8. (Appendix 1)

4 Key Risks

4.1 There are no risks associated with this proposal.

5 Risk Register

5.1 There are no implications for NHS Lothian’s risk register.

6 Impact on Health Inequalities

6.1 This document is to advise the NHS Board of a constitutional amendment to the Area Clinical Forum. It is assumed that an equality impact assessment is not required for this document.

7 Impact on Inequalities

7.1 Refer to 6.1 above
8 Involving People

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

9 Resource Implications

9.1 There are no resource implications involved.

David Farquharson
Medical Director
28 August 2012
David.Farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Lothian Area Clinical Forum Constitution August 2012
LOTHIAN NHS BOARD

AREA CLINICAL FORUM

CONSTITUTION

1 NAME
The Committee will be known as the Lothian NHS Board Area Clinical Forum.

2 DUTIES AND FUNCTIONS
The Forum will actively seek the views of professionals working within NHS Lothian about service delivery and health improvement through the professional advisory committees and other appropriate channels.

The Forum will promote these views to the service and to Lothian NHS Board.

The Forum will respond to requests from either the service or the Board to investigate or take forward particular issues where clinical input is required.

The Forum will seek to share best practice across Lothian.

3 MEMBERSHIP OF THE FORUM
The membership of the Forum will be as follows:

The Chair and Vice Chair of each of the following recognised professional advisory committees -

Lothian Area Dental Committee
Lothian Allied Health Professions Committee
Lothian Area Medical Committee
Lothian Area Nursing & Midwifery Advisory Committee
Lothian Area Optical Committee
Lothian Area Pharmaceutical Committee

The Chair and Vice Chair of these other committees -

Lothian Area Healthcare Scientists Committee
Lothian Area Clinical Psychologists Committee
GP Sub-Committee of Lothian Area Medical Committee

Provision should also be made to augment the membership by including representation from any new professional advisory committee established at the behest of the Scottish Government or the NHS Board.
A lay member will be either appointed for a fixed term of office of up to two years, or co-opted as appropriate.

With the exception of the lay representative, members and their deputies must normally be clinicians.

**Ex Officio Members**
The Director of Public Health and Health Policy, Medical Director and Nurse Director of NHS Lothian will receive a standing invitation to attend meetings and will be circulated with copies of the agenda and previous minutes.

**Attending**
Persons other than members may be invited to attend a meeting for discussion of specific items at the request of the Chair or Secretary. Such persons will be allowed to participate in the discussion but will not have a vote.

4 **SUB-COMMITTEES**
The Forum may appoint ad hoc Sub-Committees as appropriate to consider and provide advice on specific issues.

5 **TENURE OF OFFICE**
The Committee membership will be reviewed in September of each year.
Since the membership is drawn from the Professional Committees, tenure of office will depend on the constitutions of these committees.

6 **OFFICERS OF THE FORUM**
   a **Chair of the Area Clinical Forum**
The Forum will elect a Chair in September of each alternate year.
The Chair of the Area Clinical Forum will be chosen by the members of the Forum from among their number.
If more than one person puts themselves forward, then an election shall be held. The clerk to the forum shall act as returning officer. The vote shall be by secret ballot. If there are more than two candidates, then the person with the fewest votes will be eliminated from each round of the election until one candidate has a simple majority.
When an election for Chair is being held in advance of taking office, then the people eligible to stand for election and to vote will be the people who will hold the office of Chair of their respective advisory committees at the time the new Chair takes office.
In cases where the members of an Area Clinical Forum choose to replace their
Chair before the expiry of their term of appointment as a member of the NHS Board, the new Chair would have to be formally appointed as a NHS Board member. In the same way, if NHS Board membership expires and is not renewed, then that person must resign as Chair of the Area Clinical Forum (but may remain as a member of the Forum).

b  Vice Chair

The Vice Chair will be elected in the same way as the Chair every two years.

7  NOTICE OF MEETINGS

The NHS Board will provide a clerk to the Forum who will be responsible for ensuring that the agenda and relevant papers are issued at least one week before meetings whenever possible.

8  MINUTES

The clerk will ensure that minutes are drawn up of each meeting and are sent to each ACF member
the Chief Executive of NHS Lothian
the Director of Public Health and Health Policy
the Medical Director of NHS Lothian
the Nurse Director of NHS Lothian

9  MEETINGS

Meetings will be held at least four times per year.

A quorum of the Forum will be four.

10  COMMITTEE DECISION

Each member of the forum will have one vote. The Chair will, in addition to a substantive vote, have a casting vote to be used in the event of a tied vote.

Where the Forum is asked to give advice on a matter and a majority decision is reached the Chair will report the majority view but will also make known any minority opinion and present the supporting arguments for both viewpoints.

11  ALTERATIONS TO THE CONSTITUTION AND STANDING ORDERS

Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Forum provided a notice of the proposed alteration is circulated with the notice of the meeting and that the proposal is seconded and supported by two-thirds of the members present and voting at the meeting.

The constitution will be submitted to the NHS Board for approval.

August 2012; approved at NHS Lothian Board XXXXXX
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:

- Maintenance of enhanced weekly surveillance of Meticillin Resistant *Staphylococcus aureus* and Meticillin Sensitive *Staphylococcus aureus* Bacteraemia to target resources for a sustained reduction.
- 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 process for approval.
- Support ongoing mandatory surveillance
- Integration of the Meticillin Resistant *Staphylococcus aureus* screening programme into the core Infection Prevention and Control surveillance requirements.
- Continued improvements in cleaning regimes and the healthcare environment
- Increased compliance with best practice, as recommended by the Antimicrobial Management Team.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 15 episodes of *Staphylococcus aureus* Bacteraemia recorded in August 2012 (0 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*), compared to 21 in July 2012 (2 Meticillin Resistant *Staphylococcus aureus*, 19 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 0.29 (updated to August 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 29 episodes of *Clostridium difficile* Infection in patients aged 65 or over in August 2012, compared to 18 in July 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 0.33 (updated to August 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: In preparedness for the coming Norovirus season NHS Lothian’s Norovirus winter planning meeting will be held on the 11th of September 2012, taking note of recent recommendations from the recent Norovirus Summit and Health Protection Scotland guidance.

3.4 The 20th bi-monthly national hand hygiene audit report was published by Health Protection Scotland (HPS) on 25th July 2012. This indicates that NHS Lothian is achieving a hand hygiene compliance of 97% which exceeds the national compliance of 96%. Table below shows a breakdown of staff groups comparing both national and local compliance.

<table>
<thead>
<tr>
<th>National Compliance (%)</th>
<th>NHS Lothian compliance (%)</th>
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<tr>
<td>Overall compliance</td>
<td>96</td>
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<td>Nurse</td>
<td>97</td>
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<td>Medical</td>
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<td>Ancillary/other</td>
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<td>Allied Health Professional (AHP)</td>
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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. Hand hygiene signage has been improved at ward/department entrances throughout all main sites to raise awareness amongst patients, visitors and staff. The draft escalation policy for non compliance with hand hygiene is currently awaiting approval by Partnership Forum and Local Negotiating Committee (LNC).

3.5 Mandatory Surgical Site Infection Surveillance (SSI): Monthly and quarterly reports are compiled and distributed to the clinical areas and any actions required are discussed. These reports/figures are placed in the information display boards for staff, patients and visitors to peruse. For July 2012 there were 403 procedures performed and 8 surgical site infections detected with an SSI rate of 2.0 %. All infections were associated with caesarean section. Case review meetings have been held at St Johns and the Royal Infirmary to investigate the increase in infections in caesarean sections in the month of July.

Table below includes Surgical Site Infections for Abdominal hysterectomy (inpatient), Caesarean section (inpatient and post-discharge to day 10), Hip arthroplasty (inpatient and readmission to day 30) and Repair of neck of femur (inpatient) procedures within NHS Lothian, July 2012.

<table>
<thead>
<tr>
<th>Lothian Procedures</th>
<th>Number of Procedures</th>
<th>SSI no.</th>
<th>SSI rate</th>
<th>95% Confidence Interval</th>
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<tr>
<td>Abdominal hysterectomy</td>
<td>30</td>
<td>0</td>
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<td>0.0 to 11.4</td>
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<td>Caesarean Section</td>
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<td>8</td>
<td>3.3</td>
<td>1.7 to 6.4</td>
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<td>Hip Arthroscopy</td>
<td>102</td>
<td>0</td>
<td>0.0</td>
<td>0.0 to 3.6</td>
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<td>Repair of Neck of Femur</td>
<td>31</td>
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<td>0.0 to 11.0</td>
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3.6 MRSA Screening Key Performance Indicators (KPIs): Currently being reviewed by Health Protection Scotland in conjunction with the Boards. It is envisaged that the revised data collection requirements for the KPIs will be agreed by October, trialled by Boards and in place by March 2013. In the interim the surveillance team continues to measure compliance via three weekly snapshot audits of the ward areas to assess compliance with the clinical risk assessment and swab taking. This is then fed back to the wards. If the compliance level is below 90% the ward is re-audited the following week. If the compliance level remains below 90% a Situation Background Assessment Recommendation (SBAR) is completed and this discussed with ward staff. The Clinical Nurse Managers then receive a quarterly audit of their wards compliance. This will enable NHS Lothian to embed the process over the coming year and ensure that the policy is being followed.

3.7 The Healthcare Environment Inspectorate published their report on the unannounced inspection of the Royal Hospital for Sick Children on 21st of August 2012. The report, relating to the inspection on 11th of July 2012, noted that the hospital was clean and recognised the efforts being made by the team at the Hospital in both infection control and cleanliness. The Healthcare Environment Inspectorate identified three requirements: Charge nurses should have greater oversight of all infection prevention and control activity in their area; all staff should implement standard infection control precautions, particularly in relation to waste disposal and personal protective equipment; all staff must comply with the national dress code. There were also three recommendations: all infection prevention and control information in wards; should be kept up to date; action plans produced following an audit should demonstrate clearly when actions have been completed; staff should continue to review and refine implementation of peripheral vascular bundles. As a result of the HEI visit an action plan has been completed. All requirements were given a priority rating of Medium which allows a 3 months timescale to address the issues raised.

3.7.1 The Healthcare Environment Inspectorate has requested that NHS Lothian update their Healthcare Associated Infection Self Assessment by 21st of September 2012.

3.8 Incidents: the Infection Prevention and Control Team have been involved in investigating several incidents, including:
- Norovirus at Liberton Hospital – debrief organised
- Increased number of patients with *Clostridium difficile* within NHS Lothian
- Increased incident of Surgical Site Infections following Caesarean section

3.9 Antimicrobial Management Team:
UHD Antibiotic Prescribing Guidelines: The UHD Antibiotic Prescribing Guidelines have been reviewed, updated and uploaded on to the intranet in time for the new intake of junior doctors at the beginning of August.

Education: The AMT delivers education programmes to non-medical prescribers on prudent antibiotic prescribing and continues to participate in the mandatory induction and on-going training programmes for junior clinicians.

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 (100% compliance) and below the target level for the Royal Infirmary (with 90% compliance) and St John’s Hospital.

3
(with 80% 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 increased to exceed the target level in the last month and administration of single dose antibiotic prophylaxis is also above the target level (100% compliance with Guidelines and administration of a single dose).

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Consideration of bed allocation and patient movement is necessary for patients identified as colonised with Meticillin Resistant *Staphylococcus aureus* as part of the Meticillin Resistant *Staphylococcus aureus* screening programme.
- Failure to comply with hand hygiene increases the potential risk of transmission of infection.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Increased numbers of healthcare associated infections leads to adverse patient harm as well as failure to comply with Health Efficiency Access Treatment Target.
- There is the potential for Healthcare Environment Inspectorate inspectors to find adverse areas of cleanliness or standards of practice, which undermines the organisation’s commitment to a healthier, safer healthcare environment and could lead to adverse publicity for NHS Lothian and loss of public/patient confidence.
- Infection Prevention and Control Team do not have sustainable resources to comply with Meticillin Resistant *Staphylococcus aureus* screening Key Performance Indicators set by HPS, which involves manual data entry into internet based system.

5 Risk Register

5.1 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 the ongoing work with Infection Prevention and control, and 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 There have been no specific issues with the Equality Diversity Impact Assessment, as Healthcare Associated Infection is an ongoing issue. 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

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  
10 September 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 15 SAB recorded during August 2012 (0 MRSA & 15 MSSA). The lowest number recorded in the last 12 month period is 15 (August 2012).

**CDI** There were 40 CDI recorded in August 2012, 29 were in aged 65 & over. February 2012 recorded the lowest number in the last 12 month period with 20 cases.

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

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

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

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

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

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**MSSA Bacteraemia Cases**

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Staphylococcus aureus Bacteraemia (SAB)
There were 2 SAB recorded during August 2012.

Clostridium difficile Infection (CDI)
There were 9 CDI recorded during August 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
Western General Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB with the onset greater than 48 hours after admission recorded during August 2012.

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

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

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### Total Staphylococcus aureus Bacteraemia (SAB) Cases

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### MRSA Bacteraemia Cases

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

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

**Clostridium difficile Infection (CDI)**
There were 6 CDI recorded during August 2012.

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**Hand Hygiene Monitoring Compliance**

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**Liberton Hospital**

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

*Clostridium difficile* Infection (CDI)
There were 2 CDI recorded during August 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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MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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Staphylococcus aureus Bacteraemia (SAB)
There were no SAB with the onset greater than 48 hours after admission recorded during August 2012.

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

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

---

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

**Hand Hygiene Monitoring Compliance**

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

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**MRSA Bacteraemia Cases**

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

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**MSSA Bacteraemia Cases**

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**Community Hospitals**

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

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

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

<table>
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**Total Staphylococcus aureus** Bacteraemia (SAB) Cases

**MRSA Bacteraemia Cases**

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

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<td>2</td>
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<td>1</td>
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<td>0</td>
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</tbody>
</table>

**MSSA Bacteraemia Cases**
**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 August 2012 there were 12 SAB recorded.

**Clostridium difficile** Infection (CDI)
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice’s.
During August 2012 there were 15 CDI recorded.

This is the new Report Card Format introduced by Scottish Government July 2011.
THE SECOND JOINT HEALTH PROTECTION PLAN

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board support the implementation of the second Joint Health Protection Plan. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 Support the implementation of the second Joint Health Protection Plan 2012-14, in collaboration with Local Authorities as required by the 2008 Public Health (Scotland) Act.

3 Discussion of Key Issues

3.1 The 2008 Public Health (Scotland) Act requires Health Boards to develop and publish a two-year plan relating to public health protection, in consultation with relevant Local Authorities and in accordance with guidance issued by Scottish Ministers. The 2010 Scottish Government guidance on managing public health incidents emphasises the need for Health Boards and Local Authorities to form joint Incident Management Teams, provide the necessary resources for incident management on a twenty-four hour basis and ensure continuous improvement in the quality of incident management.

3.2 The Joint Health Protection Plan Steering Group finalised the second Joint Health Protection Plan 2012-2014 on 1/4/2012; the Plan is operational and has been ratified by the relevant Local Authorities.

3.3 The first Joint Health Protection Plan 2010-2012 provided guidance for the introduction of systems, identified resources required for delivering health protection and mapped out key components for implementing the Public Health (Scotland) Act. In addition, the second Plan identifies joint working areas between NHS Lothian and the four Local Authorities and key priorities to be implemented over the next two years. It focuses on developing the joint planning process by linking with local departmental plans and ensuring all health protection objectives match closely those of wider NHS and Local Authority planning systems.
4 Key Risks

4.1 As the 2008 Public Health (Scotland) Act requires Health Boards to develop and publish a two-year plan relating to public health protection in consultation with relevant Local Authorities, failure to implement the Plan could result in NHS Lothian failing to meet its statutory obligations.

4.2 Capacity plans should ensure that NHS Lothian and partner organisations can meet their statutory responsibilities under the Public Health (Scotland) Act and Civil Contingencies Acts.

5 Risk Register

5.1 There are no new risks associated with this Plan at present. The implications of Lothian becoming an international shipping hub under the International Health regulations are currently being scoped.

6 Impact on Inequality, Including Health Inequalities

6.1 NHS Lothian, with assistance from partners, is carrying out an impact assessment to evaluate and address health inequalities. The Plan is designed to contribute to delivery of the following specific objectives that support reducing inequalities, addressing the social determinants of health and considering health in all policies:
1. Reduce the health, social and economic burden of communicable disease
2. Reduce the impact of HIV/AIDS and TB
3. Reduce the health consequences of emergencies
4. Promote a healthy environment

7 Involving People

7.1 Involving people is achieved by working across the NHS, Local Authorities, wider public sector, the voluntary sector and other community groups when planning health services and policies. Patient and public involvement in health protection activities takes place through service provision planning and research interventions; individual interaction; group interaction; information and educational proactive media releases; helplines; through patient/public representatives on groups such as Hepatitis C Action Plan groups and the Lothian Infection Control Advisory Committee.

8 Resource Implications

8.1 Funds need to be set aside to compensate individuals who suffer loss of earning as a result of Public Health orders. This is monitored jointly by Public Health and Finance and addressed from strategic reserves. To date, the cost has been less than £10,000 per annum.

8.2 Funds need to be set aside for eHealth development. The procurement of incident management software that facilitates surveillance and early detection of incidents, accurate logging of information, monitoring actions, report writing and audit is being developed by Health Protection Scotland and the Scottish Government. A business
plan has been agreed; NHS Lothian’s share is approximately £50,000 per annum with the Scottish Government funding most of the development and infrastructure.

8.3 Clinical, professional, technical, scientific and support staff costs related to implementing and monitoring the Plan, exercises and training activities and equipment provision are being met within existing resources.

Dr Alison McCallum
Director of Public Health and Health Policy

Dr Richard Othieno
Consultant in Public Health Medicine

23 August 2012
Alison.McCallum@nhslothian.scot.nhs.uk
Richard.Othieno@nhslothian.scot.nhs.uk

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Foreword

This is the second Lothian Joint Health Protection Plan, produced as a requirement under the Public Health etc (Scotland) Act 2008. This plan has been prepared in close collaboration between NHS Lothian and the four Local Authorities of the City of Edinburgh, East Lothian, Midlothian and West Lothian.

The first plan provided guidance for the introduction of systems, identified resources that are required for delivery of health protection in Lothian and mapped out key components for implementing the Public Health Act. This plan, in addition, identifies joint areas of working between NHS Lothian and the four local authorities and key priorities to be implemented over the next two years.

NHS Lothian Public Health and Health Policy Directorate, of which the Health Protection Team (HPT) is a part, already work closely with colleagues in Environmental Health at Lothian Councils in the investigation and management of cases involving communicable diseases and environmental hazards. The Public Health etc. (Scotland) Act 2008 (The Act) has been helpful in clarifying roles and responsibilities in this existing arrangement.

Scotland’s goals in reducing mortality and morbidity from communicable disease, reducing exposure to environmental hazards, improving health, wellbeing, the quality and sustainability of the environment are set out in the national and international policy documents. These are echoed in the key objectives of the communicable disease and environmental health functions of NHS Lothian and Local Authorities which are:

- To reduce preventable illness and death from communicable disease
- To identify potential outbreaks of communicable disease at an early stage so that effective control measures can be put in place as soon as possible
- To improve the ability to prevent further outbreaks, and
- To work with partner agencies to put in place measures for effective management of non-communicable disease public health incidents and health improvement measures to mitigate health impact of environmental hazards.

The Act has also provided an opportunity to develop our planning process, linking not only local departmental plans but also ensuring that our objectives match closely those of the wider NHS and Lothian Councils’ planning systems. Over the next two years we will continue to work towards meeting these objectives, reporting progress on an annual basis through the existing planning processes.

The collaborative approach between NHS and local authorities has been re-emphasised in the 2011 Scottish Government guidance on managing public health incidents. The guidance clarifies the role of NHS Boards in sharing statutory responsibility for improving and protecting public health with Local Authorities and other partner agencies. Critical in this role is the joint formation of incident
management teams, the provision of the necessary resources for management of incidents on a 24 hour basis and the continuous improvement of the quality of incident management.

This plan also supports key priorities identified in the Single Outcome Agreements\(^2\) (SOA) for each of the local authority areas\(^{30-33}\) between the Councils, NHS Lothian and their other community planning partners, particularly in relation to the Scottish Government national outcomes for health improvement, reducing health inequalities and delivering quality public services.

We wish to continue to improve our knowledge and the quality of the service we provide for the population of Lothian and welcome comments on this plan – please send these to health.protection@nhslothian.scot.nhs.uk

---

Dr Alison McCallum  
Director of Public Health and Health Policy  
NHS Lothian

Professor James Barbour  
Chief Executive  
NHS Lothian

Ms Angela Leitch  
Chief Executive  
East Lothian Council

Ms Sue Bruce  
Chief Executive  
City of Edinburgh Council

Mr Kenneth Lawrie  
Chief Executive  
Midlothian Council

Mr Graham Hope  
Chief Executive  
West Lothian Council
1. Preface

This joint plan for NHS Lothian and Local Authorities has been produced in accordance with the Part 1 guidance for the new Public Health etc. (Scotland) Act 2008\(^1\). This aims to:

- Provide clarity about which agency and persons have overall responsibility in protecting the public health, for example ensuring lessons learned from the fatal accident inquiry into the Central Scotland E. coli O157 outbreak\(^3\).

- Ensure preparedness and enhance co-operation among agencies in combating major emergencies, for example bioterrorism and lessons from SARS.

- Resolve gaps and uncertainties in the adequacy of statutory powers that might be required for communicable disease control, particularly for emerging hazards, for example early interventions in avian or pandemic flu.

- Update the principles and concepts underpinning public health legislation for the twenty-first century to reflect changes in public health ethics and values, new scientific developments and the response to globalisation.

Purpose of the plan

The purpose of the plan is to provide an overview of health protection (communicable disease and environmental health) priorities, provision and preparedness and to support the collaborative arrangements that exist between NHS Lothian and Local Authorities. A joint overall steering group will continue to oversee the plan’s implementation.

Geographical extent of the plan

This plan covers the NHS Lothian Health Board area, which includes the City of Edinburgh, East Lothian, Midlothian and West Lothian Councils.

Statutory responsibility

NHS Lothian has the statutory responsibility to produce this plan in consultation with the City of Edinburgh, East Lothian, Midlothian and West Lothian Councils.

Authors

The plan has been written through a consultative process by a working group comprising NHS Lothian’s Director of Public Health and Health Policy, a Consultant in Public Health Medicine and other staff members and the Chief Officers of Environmental Health of the City of Edinburgh, East Lothian, Midlothian and West Lothian Councils. The agency representatives at the steering group which developed the plan were:
Governance arrangements
This plan has been approved by the Executive Management Team of NHS Lothian, each of the Councils and the relevant elected member forum of each Local Authority. It has been noted by NHS Lothian’s Lothian Infection Control Area Committee (LICAC) and Healthcare Governance and Risk Management Committee (HGRM).

Status
This plan is a public document and can be accessed by the public from NHS Lothian and Local Authorities’ websites. Variations of this plan will be subject to consultation with the partner local authorities. This plan covers the period 2012-2014. This plan will be formally reviewed every two years.
2. Overview of the Lothians

2.1 Population

Lothian is a geographically diverse area covering approximately 700 square miles, with a population of 837,000. The largest population centre is the City of Edinburgh (population 472,000). The remaining area is split into East Lothian (96,000), Midlothian (81,000) and West Lothian (170,000). The gender ratio is 48% male to 52% female.

The age profile shows that 16% of the Lothian population is 20-29 years old, as compared to the Scottish average of 10%. This difference is attributed to the large numbers of students attending higher education institutions across Lothian. Figure 1 illustrates the current population profile by age and sex of Lothian.

![Figure 1: Lothian estimated population by age and sex: June 2010](image)

The population growth rate in Lothian is higher than any other Scottish Health Board. By 2023, the population of Lothian is expected to have increased by 12%, compared to a national rate of 5%. The population of East Lothian is expected to increase the most, with a 20% increase projected by 2023, from 96,100 in 2008 to 115,186. The population of older adults in Lothian is also expected to grow significantly in the next ten to fifteen years as people are living longer due to improvements in health. The population of residents aged 65 years or older in Lothian is expected to rise by 16% by 2023, from 120,585 in 2008 to 139,879. This rise will be most noticeable in West Lothian, which has traditionally had a younger demographic than other areas in Lothian but whose population of...
Residents aged 65 years or older, is expected to increase by 28% from 22,097 in 2008 to 28,285\textsuperscript{4,5}.

**Migration and ethnicity**

The most recent data available for the ethnic make-up of Lothian is from the 2001 National Census, data from the 2011 census is expected during the life of this plan. In 2001, the population of the Lothians was made up of predominantly ‘White Scottish’ (83.84%), ‘Other White British’ (9.39%) and ‘Other White’ (2.85%). The remaining groups made up 3.92\textsuperscript{6}. There has been a significant rise in the migrant population over the last ten years, with the highest increase reported in the City of Edinburgh Council area (Figure 2).

![Figure 2: Net Migration to Lothian by Local Authority Area: 2009/10](image)

Net migration figures have fluctuated over the past five years. East and West Lothian saw an increase up to 2008/09 but figures have generally since been decreasing. The migration rate increased steadily up to 2008/09 but has since decreased. On average between 2008-10 there was a net inflow of 5,098 people into City of Edinburgh per year, meaning that more people entered City of Edinburgh (29,538 per year) than left (24,440 per year) (Fig 2).

The Department of Work and Pensions collects information on the number of National Insurance Number allocations to overseas nationals. Table 1 shows the five most common countries of origin associated with National Insurance numbers issued to overseas nationals in 2007 by council area. This highlights G8 countries, Australia, India and the Republic of Ireland. It should be noted that these figures do not include dependants or adults who are not economically active.
Table 1: Countries of origin of persons seeking a National Insurance Number allocation in 2007.

<table>
<thead>
<tr>
<th>Council Area</th>
<th>Number of countries of origin</th>
<th>Top five most common countries of origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Edinburgh</td>
<td>80</td>
<td>Poland, Australia, India, Spain, Republic of Ireland</td>
</tr>
<tr>
<td>West Lothian</td>
<td>20</td>
<td>Poland, Slovakia, India, Hungary, Latvia</td>
</tr>
<tr>
<td>East Lothian</td>
<td>19</td>
<td>Poland, Lithuania, India, Republic of Ireland, France</td>
</tr>
<tr>
<td>Midlothian</td>
<td>10</td>
<td>Poland, Germany, Australia, Italy, Slovakia</td>
</tr>
</tbody>
</table>

Source: GRO(S)

Culture
Lothian is a host to major cultural, educational and political establishments and events, which can present challenging health protection and emergency planning issues. These include:

- Edinburgh is the capital city, with the Scottish Parliament and Executive, Holyrood Palace and Edinburgh Castle.
- Higher education institutions – Edinburgh has four universities and several colleges, with a total student population of 35,000.
- There are five teaching hospitals, with a staffing population of 28,000.
- There are twelve annual international festivals, including the Edinburgh Festival, which bring many thousands of visitors to the city.
- There are major sporting events, such as rugby internationals, football matches and open golf championships.
- On occasion, Edinburgh hosts major world events such as the G8 Summit, the Commonwealth Games and Royal events.

Transport
Lothian has a complex transport network linking it to major cities in the rest of Scotland and United Kingdom. These include:

- Major trunk roads include A1, A720 (city bypass), M8, M9, A68 and A7.
- Edinburgh airport, Waverley and Haymarket railway stations and St Andrews bus station. These are destinations and connection points for many local and international travellers.
- Water transport – Lothian hosts the Leith Docks and Hound Point where many international vessels berth. It also has proximity to the Rosyth European Ferry Terminal.
- Lothian also has a canal that links Edinburgh directly with Glasgow. The canal is now largely used for recreational purposes.
- A new tram system for the City of Edinburgh is currently under development.
- Traffic pollution contributes to poor air quality. Air quality is monitored in all Lothian Local Authorities. There are three air quality management areas (AQMA) in Edinburgh (the city centre, Leith and Corstorphine); one in
Midlothian (Pathhead – primarily due to particulate matter, influenced by fossil fuel burning) and one in West Lothian (Broxburn). It is likely further areas will be added to or extended in the foreseeable future...

- There were almost 370,000 licensed vehicles in Lothian in 2008. Car ownership patterns reflect the provision of public transport. In 2008, there were 0.32 cars per head of population in the City of Edinburgh, whereas in East Lothian, Midlothian and West Lothian there were more than 0.42 cars per head of population.

- Cycling – safe cycle routes are not yet comprehensive, they are established in some locations and are in development in others. Considerable effort is being devoted to safe walk routes to school for children to address traffic congestion, in conjunction with work on preventing obesity and reducing the proportion of people who are inactive.

### 2.2 Disease Burden

The most common causes of death among the people of Lothian in the period 2010/2011 are listed in Figure 3. The physical environment plays a significant role in the causation of the top ten diseases which contribute to death in Lothian. Infectious disease processes feature as one of the top twenty causes of death in Lothian.

**Figure 3: Causes of death (crude rates) in the Lothian during the financial year 2010/2011**

Source: GROS, NHS Lothian Health Intelligence Unit
Communicable Diseases
The number of cases of notifiable diseases reported to the NHS Lothian HPT between 2009 and 2011 is shown in Table 2. Gastrointestinal diseases are the most common notifiable infectious disease conditions. Each case requires follow up by the HPT operation team and colleagues in Environmental Health, to ensure appropriate control measures are in place and to investigate the source of the infection.

The number of tuberculosis (TB) cases in Lothian has risen since 2003. In 2011 there were 77 notifications compared with 74 (a three-year average from 2004 to 2006) and 57 between 2000 -2003. The average incidence rate is now 10.6 per 100,000 (average from 2008 to 2010) in Lothian up from 9.4 per 100,000 (average from 2005 to 2007).

The city of Edinburgh has higher rates of TB than other parts of Lothian with the highest average annual rate from 2008-2010 in the North East of the city (19.8 per 100,000) and the South East (17.9 per 100,000).

The proportion of non respiratory cases has increased to 40% (44/110) of total cases in 2010. Between 1999 to 2000 31% of TB cases in Lothian were born outside the UK, by 2004 this proportion had risen to nearly 50% and by 2010 57% (63/110) of cases were born outside the UK.

Although only a small proportion of the total public health notifications are for TB, each TB case requires a large input of nursing and public health time to identify contacts and ensure that adherence is maintained during the six months treatment period. The complex nature of TB requires a multidisciplinary approach from TB nurses, clinical teams in primary and secondary care, microbiology and public health. In NHS Lothian regular multidisciplinary TB meetings are held to review all cases in Lothian. Over recent years the TB nursing service has expanded to cope with the larger number of TB cases being seen in NHS Lothian. Each case is contact traced and close contacts, for example household members, are screened to identify linked TB cases. This is necessary to control the spread of disease.

Table 2: Number of cases of notifiable diseases in NHS Lothian, 2009 – 2011

<table>
<thead>
<tr>
<th>Notifiable Diseases/Organisms</th>
<th>2009</th>
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<tr>
<td>Chickenpox*</td>
<td>2831</td>
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<td>n/a</td>
</tr>
<tr>
<td>Campylobacter</td>
<td>1246</td>
<td>1234</td>
<td>934</td>
</tr>
<tr>
<td>Mumps</td>
<td>334</td>
<td>132</td>
<td>94</td>
</tr>
<tr>
<td>Salmonella</td>
<td>138</td>
<td>177</td>
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<tr>
<td>Cryptosporidium</td>
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<tr>
<td>Viral Hepatitis*</td>
<td>81</td>
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<tr>
<td>Giardia</td>
<td>66</td>
<td>63</td>
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<td>Tuberculosis (Resp)</td>
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<td>Tuberculosis (Non-Resp)</td>
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<tr>
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<td>43</td>
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</tr>
<tr>
<td>Disease</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Bacillary Dysentery</td>
<td>33</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>E Coli O157</td>
<td>27</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Whooping Cough</td>
<td>16</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Meningococcal Infect</td>
<td>10</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Rubella</td>
<td>9</td>
<td>6</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Food Poisoning*</td>
<td>5</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Entamoeba*</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Measles</td>
<td>&lt;5</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Lyme Disease*</td>
<td>&lt;5</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Erysipelas*</td>
<td>&lt;5</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Meningitis – Other</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Legionellosis</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Vibrio cholerae</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Listeria monocytogenes</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>E. coli (Non O157 VTEC)</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Haemophilus influenza type B</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5051</td>
<td>2001</td>
<td>1455</td>
</tr>
</tbody>
</table>

*no longer notifiable. n/a – not available

Source: SIDSS V2

NB notifiable diseases are based on clinical notifications

The countries in the European Region of the WHO, including Scotland, are committed to the elimination of measles and rubella by 2015 through increased rates of vaccine uptake. Childhood immunisation rates in NHS Lothian are amongst the highest in the UK for an urban population and close to the Scottish national average (Figure 4, Figure 5). However, there are differences in the uptake of immunisation between localities in NHS Lothian and work is underway to increase immunisation uptake among children and young people aged under 19 years in groups and settings where immunization coverage is low. This will involve the of mapping differences in uptake to geography, demography and local service characteristics, the identification of barriers to uptake and approaches that can overcome them and then the implementation of whole system and targeted changes to the immunisation programme.

**Vaccine preventable diseases** (for example, whooping cough (pertussis), measles, mumps and rubella) account for a small but significant proportion of notifications in Lothian. Each notification and laboratory confirmed case is followed up by the HPT to reduce the likelihood of further cases and offer vaccination if required.
**Figure 4: Rates of Childhood Immunisation Coverage at 24 Months for Lothian, 2001 to 2010**

Source: SIRS Immunisation System, Information and Statistics Division (ISD) Scotland

**Figure 5: Rates of Childhood Immunisation Coverage at 12 Months for Lothian, 2001 to 2010**

Source: SIRS Immunisation System, Information and Statistics Division (ISD) Scotland

**Environment and Health**

The European Public Health Association, in its 2011 report\(^{39}\), noted that the environment is increasingly more complex and the link between health and environment has become so evident that it recommends immediate action by all governments and public health communities. According to a recent WHO study\(^{36}\),

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about 24% of the global burden of disease and 23% of deaths are attributable to environmental risk factors. In a country like Scotland, WHO estimates that the proportion of the total burden of disease attributable to environmental risk factors is about 14%. Of the total global burden of disease, WHO estimates that 5.7% was attributable to environmental exposure to chemicals, the largest contributors being indoor smoke from solid fuel use, outdoor air pollution and second-hand smoke. The greatest impacts on health are on rates of cancers, cardiovascular disease, injuries and neuropsychiatric disorders.

Creating safe and positive environments for health requires us to think, plan and deliver in new and more effective ways. The quality of the environment can vary between different areas and communities. There is evidence that people who are socially and economically disadvantaged often live in the worst environments. Poor environment can affect people’s health and wellbeing and can add to the burden of social and economic deprivation. The causes of these inequalities are often complex and long-standing. Some of the environmental problems are due to the historical location of industry and communities; others are the result of the impacts of new developments such as traffic, urban planning that has not prioritised healthy built environments. Tackling environmental inequalities and ensuring that all people have access to a good quality environment in the future is a continuing challenge. The responsibilities of health and local authorities are outlined in Good Places, Better Health.

The contribution of physical surroundings to the health of those living in our most deprived areas of society is significant, a view increasingly supported by the flow of evidence. There are indications that there is no significant socioeconomic gradient in the level of known, direct environmental hazards to human health. Frequently though, less affluent communities are untidy, damaged and lacking in amenities. These factors create neighbourhoods which are often alienating and even threatening. This creates indirect environmental hazards to human health that act through a more complex causal pathway. This produces an unhealthy built environment that contributes to a cocktail of disadvantage inconsistent with health and wellbeing for adults and children.

Health outcomes are consistently poorer in communities with poor neighbourhood environments. In Equally Well, the Health Inequalities Task Force highlighted the need to work to reduce further exposure to factors in the physical and social environments that cause stress, damage health and wellbeing and contribute to health inequalities. Action to improve housing, increasing physical activity or reducing traffic pollution can only happen by working with local authority partners to identify opportunities for health improvement in areas such as land use planning, transport, housing and environment.

The responsibilities of environmental and public health professionals for protecting and improving the environment include responding to current incidents, events and situations and preventing avoidable hazards and the consequent risks to public health by intervening before exposure has occurred.
The environmental protection functions undertaken by environmental health professionals complement those undertaken by the NHS. Health Boards and Local Authorities have a duty to co-operate in pursuit of protecting and improving the health and wellbeing of the local population. Environmental Health professionals advise on the development of laws, regulations and policies at local, national and international level and carry the major responsibility for local implementation and enforcement in the following areas:

- Air quality
- Contaminated land sites
- Noise and other statutory nuisances
- Recreational water quality
- Drinking water quality – particularly private supplies
- Food safety
- Living and working conditions
- Intentional and unintentional injuries at home and at work
- Public safety - exposure to hazardous substances
- Skin piercing and sunbed regulation

The NHS role is complementary and focuses on prevention, assessment, protection and mitigation of human exposure to environmental hazards and their health effects. In addition to food and water, these include:

- Chemicals, toxins, and poisons
- Ionising and non-ionising radiation – Electromagnetic Frequencies (EMF)
- Physical hazards – particulates, fibres and other factors related to the physical environment including climate change, extremes of heat, cold, flooding
- Accidental or deliberate or malicious release scenarios including Chemical Biological, Radiological and Nuclear (CBRN) warfare agents

Systematic approaches are used to assess the potential positive and negative impact of developments on those who will be affected. The tools employed include: Health Impact Assessment, Strategic Environmental Assessment, Environmental Impact Assessment, screening of Pollution, Prevention and Control applications, assessment of planning applications and investigating the health issues associated with contaminated land. These are essential elements of this work programme.

In a major incident, joint working is essential to ensure that the Scientific and Technical Advice to the Strategic Co-ordinating Group reflects the complementary expertise of public health and environmental health professionals.

3. Health protection planning infrastructure

NHS Lothian and the Local Authority Environmental Health Department(s) have shared health protection plans, some of which are developed jointly between the agencies, while others are produced nationally (Appendix III). The plans are normally developed and reviewed every three years.
4. National and local priorities

4.1 National Priorities

Scottish Government long term goals and priorities are aligned with those of the UK and Europe for protecting and improving health. The World Health Organisation (WHO) European Region is pursuing health in all policies as a key objective of policy making. This also includes a commitment to reducing disease inequalities in health outcomes across societies. The current Health 21 framework advocates ‘generating action from many sectors to ensure more health-promoting physical, economic, social and cultural environments for people’.

In 2007, the WHO’s Commission on the Social Determinants of Health set out the evidence for change and objectives for action, as did the recent Fair Society, Healthier Lives Strategic Review of Health Inequalities in England post 2010, Equally Well and Good Places, Better Health have already established Scottish priorities in terms of tackling health inequalities and the importance of the links between environment and health.

The Scottish Government now operates under a National Outcomes Framework with a commitment to ‘focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.’ In addition, the Government Economic Strategy includes population growth as a key component of future sustainable economic development. Among the Scottish Government’s five strategic objectives are commitments to a Scotland that is healthier, wealthier, fairer, safer, stronger and greener. These objectives are linked to a series of outcomes and associated indicators. A concordat, agreed by Convention of Scottish Local Authorities (COSLA), set the terms of a new relationship between the Scottish Government and local government. The development of a Single Outcome Agreement (SOA) formed an important part of this relationship. The SOAs produced for each Local Authority area contain an overview of how the local community planning partners (including the Local Authority and NHS Lothian) will promote the Scottish Government’s fifteen National Outcomes and how these link to local outcomes. Health Boards and Local Authorities commit to delivering these outcomes jointly:

- Our children have the best start in life and are ready to succeed.
- We live longer, healthier lives.
- We have tackled the significant inequalities in Scottish society.
- We have improved the life chances for children, young people and families at risk.
- We live our lives safe from crime, disorder and danger.
- We live in well-designed, sustainable places where we are able to access the amenities and services we need.
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
• We value and enjoy our built and natural environment and protect it and enhance it for future generations.
• We reduce the local and global environmental impact of our consumption and production.
• Our public services are high quality, continually improving, efficient and responsive to local people’s needs.

The delivery of these activities aligns with a wide range of national and local strategies, including:

• *Good Places, Better Health. A New Approach to Environment and Health in Scotland* (Scottish Government 2008): this is an implementation plan looking at how the physical environment influences health. The Environmental Health contribution will be in protecting these environments.

• *A Children’s Environment and Health Strategy for the UK* (Health Protection Agency): this is a strategy for protecting children’s health, including ensuring that they are free from food and water based infection, noise, heavy metals and breathe clean air, all of which are core Environmental Health activities.

• *The Food Standards Agency (FSA) Strategic Plan* (2010): this has three key targets: food safety; eating for health; choice. These are addressed through routine enforcement work, and developing work with the Community Health [Care] Partnerships (CHP/CHCP) in promoting healthy eating choices in local catering establishments.

• All councils have their own Anti-Social Behaviour Strategy documents. These recognise and value the importance of partnership working at various levels to tackle behavioural factors that impact on the health and resilience of local communities. Through their public health teams, Local Authorities contribute to tackling many of the environmental health issues impacting on people’s wellbeing. This helps Local Authorities to fulfil their duty to improve quality of life as set out in the Local Government in Scotland Act 2003.

*Health and Safety Executive (HSE) Five-Year Strategy (2009)*: Local authorities operate in partnership with HSE to ensure that duty holders manage their workplaces with due regard to the health and safety of their workforce and those affected by their work activities. To achieve this, local authorities provide advice and guidance on what the law requires, conduct inspections and investigations and take enforcement action where appropriate.

**Table 3** shows health protection priority activities undertaken by local authorities in the Lothians. This list is not exhaustive but illustrates the range of services within the four authorities.

**Table 3: Local authority priority activities**

<table>
<thead>
<tr>
<th>Local authority priority activities</th>
<th></th>
</tr>
</thead>
</table>
| **Corporate and Business Advice**  
– advising on local environmental health and public safety matters | Supporting Business through advice and training to meet Environmental Health Standards  
Civic government licensing  
Advisor to Licensing Board |
| **Emergency Planning**  
– training for and responding to emergencies | Flood management  
Emergency planning preparedness  
Scientific services advice |
| **Food safety**  
– securing the hygienic standards of premises, and the compositional standards of food and water | Food Hygiene Inspections (cleanliness)  
Food Standards Inspections (composition)  
Food Sampling – Bacteriological  
Food Sampling – Chemical  
Food Alerts |
| **Hazards**  
– securing consumer and public safety issues | Petroleum Licensing  
Explosive Safety/Licensing  
Consumer/product Safety  
Anti-counterfeiting  
Chemical incidents |
| **Housing**  
– securing residential accommodation meets minimum standards | Housing Support Services  
Rough Sleeping Initiatives  
Housing Standards Issues  
Houses in multiple occupation  
Caravan Site Licensing |
| **Public Health & Nuisance**  
– investigation and enforcement of public health nuisances and concerns | General Public Health/nuisance  
Communicable Disease Investigation  
Pest control  
Port Health control  
Mortuaries and Crematoria  
National assistance Act burials etc  
Smoking in public places |
| **Occupational Health & Safety**  
– securing health, safety and welfare standards in local workplaces | Accident Investigation  
Health and Safety Inspections & other interventions  
Register of cooling towers (Legionella)  
Sun bed regulation  
Regulation of tattooing and skin piercing |
| **Pollution and contamination**  
– environmental monitoring and investigation of incidents and concerns | Noise Control  
Contaminated Land  
Chemicals and oil spills  
Radiation Monitoring  
Air Quality Monitoring  
Vehicle emission testing  
Consultee on Planning Applications (Fumes, dust, noise impact of developments on health, contaminated land remediation)  
Environmental impact assessment |
| **Water Quality**  
– monitoring of drinking water and recreational water quality | Water Sampling – Private and Public supplies  
Swimming Pool Sampling  
Recreational water quality – coastal and inland waters |
| **Animal Health**  
– investigation & enforcement of | Animal Health and Welfare  
Animal Feed Stuffs |
4.2 Local health protection priorities

4.2.1 NHS Lothian

Health protection priorities in Lothian are determined by international, national and locally identified potential hazards. The national priorities are set by the Scottish Government. Local priorities are determined as part of the annual planning process during which hazards and potential hazards are identified. Prevention and mitigation are then allocated appropriate resources. The Chief Medical Officer for Scotland identified the 2008-2010 national health protection priorities listed below. These remain as key national health protection priorities.

- Healthcare Associated Infections (HAI) and antimicrobial resistance
- Vaccine preventable diseases and their impact on current and planned immunisation programmes.
- A potential pandemic of influenza.
- Environmental exposures which have an adverse impact on health.
- Gastro-intestinal and zoonotic infections.
- Hepatitis C and other blood borne viruses.

4.2.2 Health Improvement, Efficiency, Access to services and Treatment (HEAT) targets13

HEAT targets are a core set of national objectives, targets and measures for the NHS. The targets are set for a three year period and progress towards them is measured through the Local Delivery Plan (LDP) process. Two of the targets relate to reduction in Healthcare Associated Infection and improvement in childhood immunisations. Under these targets NHS Lothian will focus its efforts towards:

- Further reducing healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.
- Improving childhood immunisations and vaccine uptake to 95% for all childhood primary and booster vaccinations by analysing uptake by practice regions and identify localised actions for improving uptake.

Specific programme priorities include:

- Eradicating measles and rubella by 2015
- Viral hepatitis: To reduce the avoidable burden of ill-health and premature death, including liver failure, NHS Lothian will implement actions on hepatitis B and C outlined in the Scottish Government Sexual Health and Blood Borne Virus Framework through the NHS Lothian Hepatitis C Managed Care Network (MCN).
• Pandemic Flu Plan: NHS Lothian continues to develop robust plans and ensure the pandemic flu plan is kept up-to-date and to target at risk and occupational group with vaccination.

• Influenza A(H1N1) Pandemic: To contribute to the reduction in the burden of disease from respiratory infections and their complications, ongoing surveillance of cases of influenza A(H1N1) continues and NHS Lothian will ensure arrangements are in place to offer vaccination to the Lothian population against this virus as appropriate.

• HPV vaccine programme: To reduce the burden of HPV related disease, specifically avoidable death from cervical cancer, NHS Lothian continues to implement the HPV programme for girls (born on or after September 1993) who are in and out of school. Out of hours services and GP practices are involved in delivery of the programme to improve uptake.

• Tuberculosis (TB) control and prevention: To prevent the spread of TB, and to reduce the burden of disease, particularly among people who have other illnesses, NHS Lothian is implementing the national TB action plan published in 2011. It is introducing a dynamic web based surveillance system that provides real time functionality which is efficient and easy to use; exploring local ways of identifying new entrants, implementing local systems of case-finding for latent TB infection in these entrants; working with statutory and voluntary organisations and groups who regularly come into contact with new entrants to support GP registration; ensuring that primary care staff are able to assess new entrants and refer as appropriate in line with national guidance, and engaging with primary care teams to highlight the increased risk of TB amongst problem alcohol users.

• HIV action plan: To reduce the burden of avoidable infection and illness, NHS Lothian will develop an integrated care pathway that includes prevention, early diagnosis, effective care and treatment provision to implement HIV standards produced by Healthcare Improvement Scotland in 2011.

4.2.3 Emergency Planning and Business Continuity

NHS Lothian is required to ensure emergency planning preparedness and business continuity in accordance with the Civil Contingencies Act of 2004. NHS Lothian has robust arrangements in place to manage major incidents and emergency planning, including business continuity plans with clear accountability arrangements that have been rated ‘green’ by Scottish Government Resilience. The Major Incident Strategic Response Plan continues to be updated in conformity with the national guidance, ‘Preparing Scotland’.

4.3 Health protection risks/challenges unique to the Lothians and how they are managed

While there are shared health protection risks nation wide, Lothian also has its own unique ones. The Public Health etc. (Scotland) Act 2008 and other legislation provide a statutory basis for interventions and there is a shared risk assessment process with stakeholders. These stakeholders include
Environmental Health and other appropriate local authority services, the police and fire services, the Scottish Ambulance Services (SAS), Scottish Water (SW) and the Scottish Environment Protection Agency (SEPA). The risks and challenges unique to Lothian and how they are managed are detailed in Table 4. In addition, Appendix II lists key health protection plans to manage incidents.

<table>
<thead>
<tr>
<th>Unique Situation/Position</th>
<th>Risk/Challenges</th>
<th>Mitigation Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Host to several universities with large numbers of students in Halls of residence, flats and houses, for example, the University of Edinburgh has 16,000 students.</td>
<td>Increased opportunity for introduction and spread of infection. Increased use of houses in multiple occupation (HMO).</td>
<td>NHS Lothian works closely with universities regards monitoring and control of infection such as mumps and meningitis. Local authorities regulate HMOs.</td>
</tr>
<tr>
<td>University centres for research including veterinary schools, nuclear medicine, biohazards and life sciences research and bio-research facilities, for example Pentland Science Park.</td>
<td>Bio-hazards, use of radioactive materials.</td>
<td>National arrangements are in place for the regulation and control of nuclear medicine and biohazards in the universities and hospitals.</td>
</tr>
<tr>
<td>Host to Scotland’s Capital City, Holyrood Palace, and the Scottish Parliament and associated VIPs.</td>
<td>Increased potential for terrorist incidents.</td>
<td>Lothian and Borders has emergency plans for CBRN20 incidents and major incidents. City of Edinburgh Council is developing an evacuation plan.</td>
</tr>
<tr>
<td>Centre of culture which hosts annual festivals, Hogmanay / New Year celebrations, international events such as the G8 and major international sporting events (for example World Cup Sevens rugby), as well as associated VIPs.</td>
<td>Brings together populations from different parts of the world with a risk of new infection coming into the areas. There is potential risk of terrorism in large crowds.</td>
<td>Annual multi-agency plans are in place for such events. The Hogmanay plan is tested prior to the season starting. Appropriate plans are put in place for international events.</td>
</tr>
<tr>
<td>Port Health - Major local and international transport hubs in the local area including: Edinburgh Airport, Leith Harbour, South Queensferry terminal, Waverley/Haymarket Train Stations, St Andrews Bus Station.</td>
<td>There is a risk of imported infectious diseases from other countries.</td>
<td>NHS Lothian and City of Edinburgh Council have a port health response plan developed in collaboration with the airport authorities. Plans are underway for the development of other port health plans. International Health Regulations exist in the event of a serious infectious disease emerging locally.</td>
</tr>
<tr>
<td>Sites of potential flooding, for example River Esk, Almond, Water of Leith, Braid Burn, Burdiehouse Burn, Figgate Burn, River</td>
<td>Climate change is presenting a potential risk of Increased opportunity for displacement of individuals due to flooding, plus disease</td>
<td>Emergency flood response plans are in place. Flood Prevention Act duties are undertaken by local authorities.</td>
</tr>
<tr>
<td>Unique Situation/Position</td>
<td>Risk/Challenges</td>
<td>Mitigation Measures</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tyne, Biel water, Brocks Burn and Linlithgow Mains.</td>
<td>risk after any flooding incident.</td>
<td></td>
</tr>
<tr>
<td>Host to Torness Nuclear Power Station.</td>
<td>Risk of nuclear incident. Public concern.</td>
<td>Emergency plans are in place with partnership agencies.</td>
</tr>
<tr>
<td>Host to Addiewell (West Lothian) and Edinburgh prisons – includes vulnerable populations.</td>
<td>Prison population known to be at higher risk of hepatitis B, HIV and TB. As a closed communal setting it is also at risk of communicable disease outbreaks. This population also has an increased burden of non-communicable disease.</td>
<td>NHS Lothian has close working relationship with prison staff for the provision of appropriate preventive measures and early intervention in incidents and outbreaks.</td>
</tr>
<tr>
<td>Old reservoirs and water treatment plants in need of development.</td>
<td>Potential risk of contamination of drinking water supply.</td>
<td>Scottish Water has long term plan for replacement of the installations. Regular sampling and monitoring of supply and distribution system</td>
</tr>
<tr>
<td>Private water supplies in more remote rural communities across the area.</td>
<td>Risk of contamination with infection and chemicals.</td>
<td>Routine sampling and monitoring by Environmental Health with grant aid available to improve the quality of the water supply.</td>
</tr>
<tr>
<td>Coastal water quality along the Firth of Forth is critical to the high quality environment for residents and visitors.</td>
<td>These waters have a potential of flooding or being contaminated by agents such as oil spillage which could be a risk to public health.</td>
<td>Multi agency emergency plans, including the Waste Water Incident Plan. Local monitoring by LAs and SEPA.</td>
</tr>
<tr>
<td>Tourism is a major contributor to local economy</td>
<td>Loss of reputation if major public health incident</td>
<td>Incident management plans Food and water safety controls.</td>
</tr>
<tr>
<td>Potential emissions and incidents relating to industrial processes in the area including: distilling and brewing; electricity generation; open cast mining and quarrying; cement manufacture.</td>
<td>Risk of major incidents and release of toxic chemicals. Increase air pollution from routine emissions. Legionella in cooling towers.</td>
<td>All the agencies have major incident plans which are regularly exercised. Local authorities maintain cooling towers registers.</td>
</tr>
<tr>
<td>Legacy of an industrial history and the associated issues of contaminated land including ex-mining areas and former landfill sites.</td>
<td>Potential chemical environmental pollution. Complaints from communities with assertions of health risk.</td>
<td>Contaminated land issues are addressed either by enforcing conditions attached to planning consents or invoking the powers contained in part IIA of the Environmental Protection Act (EPA) 1990. Monitoring by the</td>
</tr>
<tr>
<td>Unique Situation/Position</td>
<td>Risk/Challenges</td>
<td>Mitigation Measures</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>West Lothian hosts the second largest poultry flock in Scotland, arable beef and dairy</td>
<td>Potential animal health risks (for example bird flu and other zoonoses).</td>
<td>Disease contingency plans are in place with relevant partner agencies (East Lothian, SG,</td>
</tr>
<tr>
<td>farming and an operational slaughterhouse.</td>
<td></td>
<td>Police, Animal Health)</td>
</tr>
<tr>
<td>Substance misuse.</td>
<td>Substance misuse is a common cause of ill health, death and drug related crimes.</td>
<td>Most people with substance misuse problems are cared for by General Practitioners.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive range of multi-agency, evidence based prevention, treatment and care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>services in place coordinated through Alcohol and Drug Partnerships, HIV, Hepatitis B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and C action plans.</td>
</tr>
<tr>
<td>Air quality issues.</td>
<td>Increased risk of respiratory and cardiovascular diseases.</td>
<td>Local authorities monitor air quality declaring Air Quality Management Areas (AQMAs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and developing action plans as appropriate.</td>
</tr>
</tbody>
</table>

**4.4 Dealing with Public health incidents or outbreaks**

Across the Lothians a number of health protection incidents and outbreaks of communicable diseases are dealt with each year. As reported in the Director of Public Health Annual Reports, there were 40 incidents in 2010 and 24 in 2011. About a quarter of these incidents are related to healthcare associated infections. Where necessary, these incidents and outbreaks have been managed within joint multi-agency and multi-disciplinary frameworks involving NHS Lothian and one or more of the four Local authorities. Larger or more complex incidents involve the Lothian and Borders Strategic Co-ordinating Group (L&B SCG), for example, the Dalmeny Tank Farm incident of 2011 and the Pandemic Influenza outbreak in 2009. Some of the other incidents managed in the same period have been smaller in scale but have required specialist expertise and a considerable amount of resources to manage.

As part of the continuous improvement of incident and outbreak management, NHS Lothian, the Local Authorities and other partner agencies are revising and amending policies and practice. Lessons learned are disseminated actively to spread learning, including by debriefing meetings, final reports and review of the implementation of recommendations.
5. Resources and operational arrangements

NHS Lothian and the four local authorities in Lothian are committed to complying with the requirements stipulated in the 2011 Scottish Government guidance, on Management of public health incidents\(^5\), as a priority. This will include providing staff trained to the agreed standard that are able to participate in Incident Management Teams (IMTs). The guidance also sets out the level of resources regarded as adequate and the support required to manage public health incidents.

5.1 Staffing

NHS Lothian and the four Local Authorities have each appointed competent persons and share competent persons lists, in accordance with the Public Health etc (Scotland) Act 2008. Table 5 shows the numbers of competent persons appointed by each agency. Each of the agencies will maintain sufficient numbers of competent persons and update the lists as appropriate. The next formal review of competent persons will be carried out in 2014.

Table 5: Designated Competent Persons as designated under the Public Health etc (Scotland) Act 2008

<table>
<thead>
<tr>
<th>Agency</th>
<th>NHS Lothian</th>
<th>City of Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated competent persons</td>
<td>12</td>
<td>41</td>
<td>9</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

In addition to the designated competent persons, local authorities can call upon a number of other staff who work within the overall remit of their environmental services to assist in the investigation of incidents if necessary and appropriate.

5.2 IT and communications technology

Information and Communications technologies are available to NHS Lothian and local authorities to facilitate health protection and environmental health work, including the management of incidents and outbreaks are set out below.

5.2.1 NHS Lothian Electronic Guidance and guidelines:

- NHS Lothian staff have access on the web e-library – the NHS electronic health library.
- NHS Lothian Public Health Staff who work out of hours are provided with a set of local guidance and guidelines for reference.
- NHS Lothian Health Protection Team (HPT) keeps a database of on-call guidance.
- SHPIR, the Scottish Health Protection Information Resource (Health Protection Scotland [HPS]) provides a suit of key nationally updated guidance.
• On-call staff have access to international travel advice and guidance via TRAVAX website.

Information Technology:
• Mobile phones and bleeps are issued to out of hours staff.
• Encrypted laptops and encrypted memory sticks are available for staff to take home when on-call.
• A standard operating procedure for establishing a telephone helpline within NHS Lothian is currently being developed by the HPT and Telecommunication Department is nearing completion. This will ensure that a helpline can be set up rapidly, where it is considered appropriate to have an additional point of contact for the public during an incident, to supplement NHS24.
• TRAK, the patient management system, is used for accessing laboratory results and information relating to hospital patients.
• NHS Lothian SCI-store e-results, the Scottish Care Information System are used by GPs for notification to the board and storage of laboratory results used for managing patients.
• Scottish Environmental Incident Surveillance System (SEISS) is a database of environmental health incidents in Scotland.
• Toxbase, a database that provides information on toxin and poisons for managing cases and incidents.
• The Scottish Infectious Disease Surveillance System (version 2) (SIDSS 2,) for infectious diseases is used for notification by Boards to HPS.
• The Scottish Immune Recall System (SIRS) is a database used as a call and re-call system immunisation programmes.
• Community Health Index (CHI) provides authorised members of staff patient identifier information which is used for tracing patients. Access is controlled by the Director of Public Health and Health Policy as Guardian of the CHI.
• The Electronic Communication of Surveillance in Scotland (ECOSS) is used for laboratory services notification to NHS Lothian Public Health Directorate and from the Directorate to HPS.
• The Airwave encrypted digital radio system was installed within NHS Lothian, in March 2011 with base sets, provided by Scottish Ambulance Service, located in our Emergency Departments. Two hand-held radios were issued by Scottish Government to Emergency Planning for use during a major incident.
• NHS Lothian is part of MTPAS, the Mobile Telecommunications Privileged Access Scheme. Under this scheme a Network Service Provider (NSP) a single special privileged access SIM cards (MTPAS SIMs) to Category 1 (including NHS Lothian) and 2 responders, as defined in the Civil Contingencies Act (CCA) 2004, to allow continued communication when there is a network congestion or shutdown.

5.2.2 Local Authorities
Local authorities have databases with addresses and contact details for all food businesses. These systems are capable of interrogation and can be used to produce specific premises lists subject to the coding structures used. Edinburgh and West Lothian use Authority Public Protection (APP) by Civica; East and Midlothian use the Uniform system by IDOX technology.

- The Airwave encrypted digital radio system has been adopted by the Local Authorities Emergency Planning and Business Continuity Services. Two hand-held radios were issued by Scottish Government to each LA for Emergency Planning for use during a major incident. Additional handsets may be accessed in the event of an emergency.
- A number of the Lothian Local Authorities have key personnel who are also part of MTPAS, the Mobile Telecommunications Privileged Access Scheme to allow continued communication when there is a network congestion or shutdown.

5.3 Scientific and Laboratory Services

The scientific and laboratory services which NHS Lothian and local authorities require for surveillance and management of public health incidents, which are currently available include:

- NHS microbiological and biological laboratories based at the Royal Infirmary of Edinburgh and the national reference laboratories.
- Edinburgh Scientific Services
- Scottish water laboratories
- Scottish Environment Protection Agency (SEPA) Laboratories
- Foods Standards Agencies (FSA) Food Control Laboratory
- Health Protection Scotland analytical and epidemiological support
- Scottish Poisons Unit
- Privately Contracted Laboratories

5.4 Collaborative arrangements

Organisational arrangements are in place to facilitate good collaborative working between NHS Lothian, Local Authorities and other health protection partners, including Animal Health Services, Scottish Water and other utility companies, the FSA and SEPA. As part of emergency planning arrangements, these agencies are represented at the Strategic Co-ordinating Group (SCG) bi-monthly tactical group meeting and may attend quarterly meetings. Lothian Infection Control Advisory Committee also meets on a bi-monthly basis to review policies.
and infection control issues. Health protection incident review activities also take place in a number of committees and groups. These include:

- Hepatitis C Managed Care Network holds an annual event.
- Immunisation incidents are reviewed at the Local Immunisation Co-ordinating Group (LICOG) meetings.
- The Avian and Pandemic Influenza Planning Group (AIPG) meets two to three times a year.
- The NHS Health Protection Joint Liaison Group Meeting’ is held quarterly.
- Research and teaching programmes between NHS Lothian and Edinburgh universities.

Figure 6 is an illustrative summary of the joint working and areas of collaboration between NHS Lothian and the four Lothian Local Authorities. The details on specific areas of joint working are in Appendix I.

Figure 6: **Joint health protection activities between NHS Lothian and Lothian Local Authorities.** (Illustrative rather than comprehensive)
5.4 Out of hours response arrangements

5.4.1 NHS Lothian

NHS Lothian out of hours arrangement involves the provision of on call staff. Public Health and Health Policy provides a 24/7 response and there is a contacts directory and a call-out process from the Royal Infirmary Edinburgh (RIE) switchboard in the event of an emergency. In the case of major incidents and outbreaks such as a flu pandemic situation, support from other parts of the Directorate, for example, scientific and analytical staff in the Health Intelligence Unit, for weekend reporting as and when required. The on call team can be contacted out of hours on 0131 242 1000.

5.4.2 Local Authorities

The four Local Authorities have emergency out-of-hours procedures in place. These are accessed through call centres within each authority. The FSA has lists of nominated contact officers for each authority in case of emergency food borne incidents. Contact centre details are:

- City of Edinburgh 0131 200 2000
- East Lothian Council 01875 612 818
- Midlothian Council 0131 663 7211
- West Lothian Council 01506 775 000

5.5 Reviewing Health Protection Standard Operating Procedures (SOP) or guidance

The Directorate of Public Health and Health Policy has standard operating procedures for significant infectious diseases and major outbreaks. The Health Protection Team workplan includes reviewing standard operating procedures with partners. Those requiring review are identified based on their review date or the emergence of new national guidance.

Debriefs for significant incidents or major outbreaks are held to learn lessons from how they have been managed. These debriefs can be multi-agency and multi-disciplinary within the Directorate as appropriate.

The Local Authorities have standard operating procedures for a wide range of environmental health functions, including food safety and health and safety incidents. The two standard operating procedures, which are developed jointly between the Directorate of Public Health and the Local Authorities, are the sporadic food borne disease and gastrointestinal illness and the major outbreak plans.

NHS Lothian and the Local Authorities will continue to review operating procedures, including those that relate to the Public Health etc. (Scotland) Act 2008 duties (Appendix III).
5.6 Staff knowledge, skills and training

The following arrangements are in place for ensuring the maintenance of knowledge, skills and competencies for staff with health protection duties.

5.6.1 NHS Lothian

The Director of Public Health and Health Policy issues a weekly professional update that includes training opportunities, courses and conferences as well as updates on policy, evidence and key meetings.

HPT organises, as a minimum, twice yearly on-call updates as part of regular continuing professional development (CPD) sessions within NHS Lothian’s Directorate of Public Health and Health Policy. Additional related sessions, providing training and exercising for Emergency Planning, are also provided. HPT will inform on-call staff of other training day courses and conferences organised regionally or nationally and all staff on-call are required to participate in an Emergency Planning exercise on an annual basis. All on-call staff are required to spend a full week with HPT at least every two years. This is arranged with the operational team at mutually convenient times. Ideally staff will be offered the opportunity to attend the HPS on call course once every two years. There are limited places available each year for Health Protection Scotland (HPS) on call and Scientific and Technical Advice Cell (STAC) training. NHS Lothian supports CPD requirements for registered medical and other public health and the knowledge and skills framework requirements for professional, scientific and support staff for whom formal registration requirements are not yet in place.

5.6.2 Lothian Local Authorities

All Local Authorities have procedures in place for annual review of staff development needs, including support for meeting professional CPD requirements where appropriate. All environmental health staff are encouraged to attend training or update events organised by NHS Lothian, HPS, the Royal Environmental Health Institute of Scotland (REHIS) and Food Standards Agency, for example. All local authority staff working in food safety and food standards are required to meet minimum competency and the ongoing professional development requirements of the Food Law Code of Practice. Similar formal requirements have been developed in relation to staff working in relation to occupational health and safety. NHS Lothian and the Local Authorities will keep training requirements under review, including developing joint training opportunities, particularly in relation to the Public Health etc (Scotland) Act 2008 duties (Appendix II).
6. Capacity and resilience

6.1 NHS Lothian

NHS Lothian, in conjunction with Local Authorities and HPS, last assessed the capacity and resilience of local health protection services in the spring of 2009. The assessment put a set of criteria into place and these were used to assess the status of health protection services. These criteria covered a number of areas, including: team composition; resources and education; communication mechanisms and technology; information management and facilities standards; policies; procedures; joint working and governance; on call and surveillance arrangements.

In the early part of 2011, NHS Scotland Resilience, following a review of emergency preparedness as part of a national audit of Health Boards, noted that there continues to be a proactive attitude towards emergency planning in NHS Lothian, which reaches through to the wider organisation.

NHS Lothian is developing more extensive mutual aid arrangement with neighbouring Health Boards and reciprocal appointment of Competent Persons as required by the new Public Health etc. (Scotland) Act 2008.

6.2 Local Authorities

Each of the Local Authorities provides a core level of trained and competent staff to deliver a wide range of statutory environmental health duties. Local authorities undertake their own service reviews on a regular basis. In addition they are subject to external scrutiny by the FSA audit branch in relation to meeting the requirements of food safety legislation. Historically, all of the Local Authorities have been able to provide health protection related services.

6.3 Approach to regulation

We will develop a work programme to introduce new ways of working designed to minimise the adverse impact of deregulation on the ability of the Health Board and Local Authorities to comply with their duties to protect and improve the health and wellbeing of the population. In developing our priorities for action we will examine the population impact of potential adverse events against the level of risk they pose and the likelihood of occurrence. Used appropriately, regulation is an efficient, effective and equitable tool for improvement. We will introduce new interventions designed to improve performance and new tools to measure our achievements.

7. Public involvement and feedback

7.1 NHS Lothian

7.1.1 Patient and Public Involvement
In NHS Lothian, involving patients and the public means involving them in how health services are designed and delivered. This is achieved by working in partnership with local authorities, the voluntary sector and other community groups when planning health services and health policies.

Patient and public involvement in NHS Lothian health protection activities takes place largely during individual interaction with cases and contact of cases, general educational messages sent out as a preventive measure during incidents and outbreaks. Public involvement during these incidents and outbreaks takes place via proactive media releases and response to media queries and a public helpline, if established. In addition, feedback is obtained during a variety of conferences and working groups. For example, the Hepatitis C Action Plan sub-groups and Lothian Infection Control Advisory Committee have public representatives.

7.1.2 Staff and Partnership
The NHS Lothian Partnership Forum has been established as part of an area-wide employee relations framework that allows staff to influence how NHS Lothian works. In health protection terms this forum provides the opportunity of early involvement and the ability to influence decision making on health protection issues which affect staff. Partnership involvement is considered essential when any incident moves from being a Problem Assessment Group (PAG) which is a professional assessment to an Incident Management Team. One of the most obvious is helping to ensure when staff screening is necessary as part of incident management.

7.2 Lothian Local Authorities
Local authorities carry out a variety of client and community consultation and feedback activities, using the results to improve the efficiency and effectiveness of service delivery. However, for the purposes of the Joint Health Protection Plan, the main area of cross-client contact by environmental health staff is the investigation of incidences of gastrointestinal infections out-with a hospital setting.

8. Monitoring and review
An action plan has been developed (Appendix II) to ensure that this Joint Health Protection Plan is implemented effectively. The plan will be kept under strategic review by the steering group comprising the Director of Public Health and Health Policy, NHS Lothian and the Chief Officer(s) of Environmental Health of City of Edinburgh, East Lothian, Midlothian and West Lothian Councils.

The detailed implementation of the plan (see action plan Appendix II) including review of incidents, procedures, staff training will continue to be the responsibility of the NHS Health Protection Joint Liaison Group, which meets quarterly in Lothian.
9. References

   http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/publicact

2. Scottish Government. Single Outcome Agreements (for the Local Authorities) 
   http://www.scotland.gov.uk/News/Releases/2008/06/30092907

3. Pennington et al. Report on the circumstances leading to the 1996 outbreak of 
   infection with E.coli O157 in Central Scotland, the implications for food safety and the 
   lessons to be learned. Scottish Office. 1996.

4. General Register Office for Scotland (GROS). General Register Office for Scotland 
   (GRO(S)) Mid-year population estimates 2008. 2008.

   Based) - Projected population by council and NHS board area (2008-based), 2008- 
   2033. 
   http://www.gro-scotland.gov.uk/files2/stats/population-projections/2008-based-pop-


8. Scottish Infectious Disease Surveillance System v2 (SIDSS 2) NHS Lothian Health 
   Protection Team and GRO(S) Mid-year population estimates.

9. Scottish Infectious Disease Surveillance System v2 (SIDSS 2) NHS Lothian Health 


    http://www.scotland.gov.uk/About/scotPerforms/outcomes


    Emergencies http://scrutinyreview.org/Publications/2007/06/12094636/0

    2009.


    http://openscotland.net/Publications/2004/10/20146/45686


19. Lothian and Borders Strategic Coordinating Group (SCG). Community Risk Register 
    version 4. 409.

20. Lothian and Borders Emergency Planning Strategic Coordinating Group (L & B 


Appendix I: Joint Health Protection Activities

Priorities: We have specified what are the current deliverables for completion in 2012-14, what are for delivery in two to three years time or, for further in the future. These can be listed as:

- **Deliverables** - for the coming year with expected outcomes and milestones;
- **Developmental** - for a specific timescale beyond the coming year with expected outcomes and/or milestones listed and;
- **Directional** – Horizon scanning for future public health issues;
- **Sustainability** - We ensure that once targets are reached we can maintain that level.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Health Protection Issues</th>
<th>Local Authority Role</th>
<th>NHS Health Protection Role</th>
<th>Joint NHS/Local Authority role</th>
<th>Priority level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health incidents</td>
<td>Ensuring the most effective protection of public through NHS and Local Authorities co-operation in investigation and control of outbreaks</td>
<td>Perform duties and functions defined under the Public Health (S) Act. Assign appropriate staff and contribute resources required for the investigation and control of incidents and outbreaks. Exclude workers in high-risk occupations confirmed as having relevant infectious disease.</td>
<td>Perform duties and functions defined under the new Public Health (S) Act. Provide leadership for investigation of public health incidents and outbreaks. Pay for exclusion of high risk workers.</td>
<td>Draw up joint plans for the investigation and control of incidents and outbreaks. Participate in incident and outbreak investigation, review and audits. Participate in multiagency exercises and planning events.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Port Health</td>
<td>Potential risk of importation of exotic infection from other countries. Increased potential for drug use. Lothian has major local and international transport hubs in the local area including:</td>
<td>Inspection of ships for hygiene and vermin/pests. Monitoring of water supplies. Enforcement of international health regulations, a designated port authority for the purpose of issuing ship sanitation etc. certificates.</td>
<td>Imposing appropriate Controls on ships and passengers when disease reported or suspected. Liaison with other agencies and health authorities.</td>
<td>Development of Joint operational plans. Response to airport call outs. Reducing risk of disease entering country via ports. Ship Sanitation. Vermin control.</td>
<td>Deliverable</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Subject</th>
<th>Health Protection Issues</th>
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<th>Joint NHS/Local Authority role</th>
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<tbody>
<tr>
<td>Mass Gatherings</td>
<td>Lothian is a centre of culture which hosts annual festivals, Hogmanay /New Year celebrations, international events such as the G8 and major international sporting events (e.g. World Cup Sevens rugby), as well as associated VIPs. This brings together populations from different parts of the world with a risk of new infection coming into the areas. There is potential risk of terrorism in large crowds.</td>
<td>Work with the police to ensure safety at venues. Various licensing activities for entertainment, civic government, alcohol.</td>
<td>Ensure that Accident and Emergency department in hospitals have emergency plans to receive casualties. Work with other agencies to ensure adequate presence of first aiders.</td>
<td>Develop and test Hogmanay plans prior to the season starting. Monitor upcoming events and put in place appropriate plans for international and other large size events. Identify and plan mitigation measures for public health issues that the Commonwealth Games in Glasgow (2014) may impact on Lothian.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Climate change.</td>
<td>Climate change presents a potential risk of Increased displacement of individuals due to flooding, plus disease risk after any flooding. Incident sites of potential flooding include River Esk, Almond, Water of Leith, Braid Burn, Burdiehouse Burn, Figgate Burn, River Tyne, Biel water, Brocks Burn and</td>
<td>Put in place emergency flood response plans dealing with displacement and remediation. Implement Flood Prevention Act duties.</td>
<td>Provide advice on potential health risk in the event of flooding. Ensure healthcare provision for vulnerable populations during flood incidents. Provide healthcare to the affected individuals Contribute to the local authority flood plans.</td>
<td>Participate in multiagency exercises and flood planning events. Participate in multiagency flood incident management. Develop plans in line with Scottish Govt Climate Change Adaptation framework 2012</td>
<td>Sustainable</td>
</tr>
<tr>
<td>Subject</td>
<td>Health Protection Issues</td>
<td>Local Authority Role</td>
<td>NHS Health Protection Role</td>
<td>Joint NHS/Local Authority role</td>
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<tr>
<td>Radiation - Ionising and non-ionising</td>
<td>Linlithgow Mains.</td>
<td></td>
<td>Identify NHS Lothian sites that are vulnerable to flood risk and establish plans to mitigate the risk and ensure business continuity. Implement NHS Lothian Strategic Development strategy with actions to reduce carbon emissions</td>
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<td></td>
<td>Potential risk to public from radiation sources. Risk of nuclear incident. Risk of malicious release (terrorism). Sunbed use increasing cancer risk. Radon accumulations increasing cancer risks.</td>
<td>Draw up a multi-agency off-site nuclear incident plan. Inspection and appropriate licensing of sun-bed operators. Monitor of radon gas in public building owned by the local authority and support families to monitor homes in potentially affected areas.</td>
<td>Contribute to a multiagency off-site plan. Monitor of radon gas in public building owned by the NHS and support families to monitor homes in potentially affected areas.</td>
<td></td>
<td>Deliverable</td>
</tr>
<tr>
<td>Good Places Better Health™ (National Health Policy) issues</td>
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<tr>
<td>Prison accommodation.</td>
<td>Lothian hosts two prisons – includes vulnerable populations. Increased risk of disease outbreaks such as hepatitis B, HIV and tuberculosis among prisoners.</td>
<td>Inspection of Prison kitchens under food safety and food standards legislation.</td>
<td>Develop close working relationship with prison staff for the provision of appropriate preventive measures and early intervention in incidents and outbreaks.</td>
<td>Participate in incident and disease outbreak investigation and control.</td>
<td>Deliverable</td>
</tr>
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</table>

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<tr>
<th><strong>University accommodation</strong></th>
<th>Lothian hosts several universities with large numbers of students for example the university of Edinburgh has 16,000 students. Increased opportunity for introduction and spread of infection. Increase use of Houses in Multiple Occupation (HMO).</th>
<th>Regulation of HMOs. Investigation of housing standards issues. Protection of Private tenants through registration of private landlords. Promote Landlord Accreditation to increase standards above the statutory minimum</th>
<th>Put in place plans to work with university authorities in monitoring and control of infection such as mumps and meningitis.</th>
<th>Investigate and manage incident of infections and outbreaks when they occur.</th>
<th>Developmental</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Air quality.</strong></td>
<td>Potential emissions and incidents relating to industrial processes in the area including: distilling and brewing, electricity generation, open cast mining and quarrying, cement manufacture etc. Risk of major incidents and release of toxic chemicals. Increase air pollution from routine emissions. Increased risk of respiratory and cardiovascular diseases.</td>
<td>Monitor air quality compliance with legislative standards. Declaration of Air Quality Management areas as appropriate and formulation of action plans. Respond to planning applications where air quality may be impacted. Participate in the vehicle emissions and vehicle idling partnership.</td>
<td>Contribute to the development of the national Air Quality Monitoring during major incidents. Ad hoc and advice on analyses of health impacts of air quality.</td>
<td>Participate in multiagency air quality exercises and planning events. Participate in multiagency air quality incident management. Consultation on air quality action plans.</td>
<td>Developmental</td>
</tr>
<tr>
<td>Home Safety</td>
<td>Carbon monoxide poisoning. Fire risk. Safety of appliances. Risk from goods bought</td>
<td>Advice and complaint investigation about the safety of goods sold. Potential for surveys and test purchasing to check the safety of good sold. Powers to seize unsafe goods.</td>
<td>Possibility of being asked for advice on potential risk to humans from products (e.g. those containing specific substances) Proactively offer advice to vulnerable populations in contact with clinical services e.g. children under 5. NHS Lothian also funds a range of child safety projects. Monitoring of accidents via routine data Health Impact Assessments of housing development and regeneration schemes. Ad hoc advice and support relating to health impacts of housing.</td>
<td>Health Impact Assessments of housing development and regeneration schemes.</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>Poor quality, energy inefficient housing is associated with respiratory ill health and winter mortality and fuel poverty. Overcrowding is associated with poor health. Housing design features may affect mental health, accessibility and risk of domestic injury.</td>
<td>Work in partnership with housing services to assess quality of housing with regard to the Tolerable Standard and to use statutory powers to secure improvement where funding permits or is of significant public health risk. Conduct the registration of Private Landlords scheme</td>
<td>Support for health impact assessments of housing developments.</td>
<td>Health Impact Assessments of housing development and regeneration schemes.</td>
<td></td>
</tr>
</tbody>
</table>
| Contaminated Land | Lothian has a legacy of an industrial history and the associated issues of contaminated land including ex mining areas, former landfill sites etc.  
Potential chemical environmental pollution.  
Complaints from communities with assertions of health risk. | Identification of contaminated land and addressing problems found in accordance with national guidance contained in part IIA of EPA 1990.( guidance is not contained in statute also most issues of contamination are dealt with as part of the Planning process as part of redevelopment  
Monitoring of sites and investigation and control of incidents where there is potential human exposure.  
Use a phased, risk based approach to the identification, investigation and remediation of contaminated land sites. | Statutory consultee advising on risk to human from a wide variety of contaminants.  
Investigation of assertions of risk and assessment of impact of remediation measures.  
Investigate contaminated land and take action to ensure health risks are eliminated or adequately reduced. | Developmental |
| Greenspace | High quality accessible green space is associated with better mental health and increased physical activity. | Open space strategy | Ad hoc advice on benefits of green space.  
Build into work on physical activity.  
Support for community gardening projects and greening of NHS estate. | Health impact assessments of green pace proposals | Developmental |
<table>
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<tr>
<th>Transport</th>
<th>Transport can affect air quality, physical activity, injuries, access to health-promoting facilities, noise, community severance etc</th>
<th>Local Transport Strategy</th>
<th>Advice on health issues arising from transport policies and proposals</th>
<th>Health impact assessments of transport policy and strategy</th>
<th>Developmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of public realm</td>
<td>Design of public spaces may affect levels of physical activity, mental wellbeing, social cohesion etc.</td>
<td>Planning policies – formulation, implantation and monitoring</td>
<td>Advice on health issues arising from planning proposals</td>
<td>Health impact assessment of planning policies</td>
<td>Developmental</td>
</tr>
<tr>
<td>Strategic Environmental Assessment</td>
<td>SEA includes consideration of Human Health</td>
<td>Offer ad hoc advice and support on health issues in SEAs</td>
<td>Joint work on scope of SEAs</td>
<td>Developmental</td>
<td></td>
</tr>
<tr>
<td>Equally Well11 (joint work to tackle the social determinants of health inequalities) – National health policy</td>
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</tr>
<tr>
<td>Animal Health and zoonotic diseases</td>
<td>Procedures supporting the control of BSE, bird flu, rabies, bovine tuberculosis etc.</td>
<td>Monitoring of controls on animal health. Appropriate formal and informal action to deal with problems found.</td>
<td>Working with Animal health to monitor the occurrence of zoonotic disease in livestock and domestic animals. Advice on potential risk to human arising from animal health</td>
<td>Investigation and control of incidents and outbreaks of zoonotic diseases.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Smoking, alcohol and substance misuse</td>
<td>Monitoring of controls imposed as part of animal diseases, such as animal movement orders.</td>
<td>activities including outbreaks of animal diseases. Advice on vaccination to population at risk including travel abroad.</td>
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<tr>
<td>Noise Control</td>
<td>Responsibility for ensuring goods are not sold to those under 18. Age Related Sales Tobacco, Cigarette, Lighter Refills Fireworks. No-smoking legislation implementation regarding smoking in public places. Licensing standards officer's interventions regarding age verification policy and responsible drinking.</td>
<td>Follow up of individual cases of infection connected with substance misuse. Assess alerts about contaminated alcohol and new drugs causing potential ill health. Advise on appropriate measures to prevent and treat HIV, Hepatitis B and C. Develop and implement action plans through the HCV MCN.</td>
<td>Participant in disease incident and outbreaks related to substance misuse Underlying and long term issues addressed through planning and delivery of services in partnership through the Smoking &amp; Health, Alcohol and Drug Partnerships (ADPs) and Community Safety Partnerships.</td>
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<tr>
<td>Noise Control</td>
<td>Anti social behaviour. Exposure to occupational noise. Exposure to nuisance noise which may affect health. Powers to issue fixed penalty notices for anti-social activities. Powers to investigate and control noise nuisance generally through statutory nuisance legislation of licensing regime. Powers of H&amp;S enforcement where excessive noise may be encountered in the workplace</td>
<td>Advice on health effects on humans arising from noise producing activity.</td>
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<tr>
<td>Licensing</td>
<td>Activities Including: Alcohol, Street Trading, Tattooing &amp; Skin Piercing Petroleum. Alcohol related health harm and community safety linked to availability. Spread of infection such as hepatitis B and C and sexually transmitted diseases. Monitoring of alcohol licensing via licensing standards officers Licensing monitoring and inspection of street traders, tattooists, skin piercers and petroleum storage. Dealing with complaints and taking appropriate informal or formal action. Advice on health risks of activities, the impact of alcohol on population health and the link with outlet density. Advice on implementing the public health principle in alcohol licensing including on licensing conditions and/or options to control problems and arising from incidents Underlying and long term issues around alcohol misuse addressed through planning and delivery of services in partnership through the Alcohol and Drug Partnerships (ADPs) and Community Safety Partnerships.</td>
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<tr>
<td>Pest Control</td>
<td>Vermin — potential to spread disease. Insects — disease spread potential, can arise from unhygienic conditions with human health risk. Inspection of area for vermin and pests taking appropriate informal or formal action to address problems found. Treating of vermin and insects (discretionary). Advice on potential risk to humans from a variety of pests. Investigation and control of pest related diseases.</td>
<td></td>
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</tr>
<tr>
<td>Dog Control</td>
<td>Stray dogs — safety and potential for disease spread Dog fouling — potential to spread disease. Dangerous dog threat or attack. Uplift of stray dogs Enforcement of fouling and dangerous dog Legislation Promote responsible dog ownership to minimise Barking, fouling and poor control. Advice on potential risk to humans from dog fouling Linkages to promotional work on best practice and other dog related issues Investigation and control of zoonotic disease related to dogs.</td>
<td></td>
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</tr>
<tr>
<td>Public Health Nuisances</td>
<td>Variety of statutory nuisance conditions affecting local residents / community. Monitor area and respond to complaints with regard to statutory nuisance issues such as dirty houses, unhygienic living conditions, drainage problems, odour problems, etc. Advice on risks and effects on the health of occupants and other relevant persons. Follow up complaints and investigate nuisance that affect public health.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<p>| Lothian | Joint Health Protection Plans | Approved: 1 April 2012 Final version Revision due: March 2014 | Page 44 of 61 |
| Houses in Multiple Occupation and Private sector rental accommodation | Nuisance and health effects on occupants from poor living conditions and disrepair. Overcrowding, fire, safety. | Licensing of HMOs and registration of Private Landlords. Monitor local housing for defects and respond to complaints. Inspect for compliance. Enforce against unlicensed/unregistered Premises. | Advice on risks and effects on the health of occupants and other relevant persons. Advice on risks to health of Occupants. | Joint investigation as appropriate for HMO related public health incident | Developmental |
| Health &amp; Safety at Work. | Illness or injury to persons. | Enforcement of Health and Safety legislation: to reduce the incidence of accidents and ill health at work in partnership with the HSE. This involves adherence to inspection/sampling programme, participation in national campaigns and other interventions as directed by HSE and investigation of accidents and complaints. | Advice on health risks (Healthy Working Lives) | Explore the link between LA health and safety investigations/ intervention planning to NHS accident/ emergency data. | Developmental |
| Water Supplies | Old reservoirs and water treatment plants in need of development. Risk from consumption of contaminated water supplies. Lead in Water Guidance relating to WHO standards 2012. | Regulation and monitoring of private water supplies and ensuring national standards are met. Administer grant assistance scheme for improvement of private water supply quality. | Work with Scottish Water to ensure regular sampling and monitoring of supply and distribution system. Advice on medical aspects of risk to individuals and groups. | Investigation of water related infections and contaminants of drinking water supply. A Health Protection Joint Liaison Subgroup on private water supply. | Deliverable |</p>
<table>
<thead>
<tr>
<th>Food Safety</th>
<th>Reduction in food poisoning: Ensure food ingredients are safe and food appropriately labelled to ensure vulnerable people are protected (e.g. — allergens)</th>
<th>Inspection of food premises, inspection of production facilities for hygiene and composition, sampling of food to check for compliance with standards, promotion of good hygienic practice, promotion and information on labelling/composition</th>
<th>Advice on medical aspects on request, linkages to promotional work on hygienic practices and other food related issues, expert advice on potential health effects arising from conditions found.</th>
<th>Investigation and control of foodborne infectious disease incidents and outbreaks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food hygiene and food standards</td>
<td>Food is a potential vehicle for transmission of infectious diseases.</td>
<td>Implement an effective inspection programme based on a risk based approach including adherence to inspection/sampling/ audit programmes, provision of food hygiene and food safety training to business community, there is adoptive not required participation in national campaigns as promoted by FSA, investigation of food-borne illnesses, investigation of complaints and provision of information to the public on good food hygiene practice via local publicity campaigns e.g. Food Safety Week.</td>
<td>Promote hand washing practice and food hygiene to members of the general public during incidents.</td>
<td>Participate in investigation of incidents and outbreaks of food borne and gastrointestinal infections.</td>
</tr>
<tr>
<td>TB services</td>
<td>Increasing numbers of TB cases, drug resistance, poor compliance amongst vulnerable groups such as people who are homeless, or with problematic alcohol and/or drug use.</td>
<td>Provision of housing to vulnerable groups</td>
<td>Investigation and management of TB incidents.</td>
<td>Deliverable</td>
</tr>
<tr>
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</tr>
<tr>
<td>Sexual Health and HIV services</td>
<td>Preventing spread of sexually transmitted infections</td>
<td>Licensing of sex shops / establishments</td>
<td>Diagnosis, counselling and treatment of cases.</td>
<td>Joint planning for sexual health and HIV – strategy development HIV treatment and care – joint agreement for milestone home.</td>
</tr>
<tr>
<td>Care Settings and Health Improvement, Efficiency, Access Treatment (HEAT) Targets</td>
<td>There is a risk of patients who are free from infection acquiring it from care institutions when they get admitted for other reasons.</td>
<td>Food hygiene inspections of hospital catering. Expert support and advice for healthcare associated infections</td>
<td>NHS Lothian has plans to achieve a reduction of the rate of <em>Clostridium difficile</em> infections in patients aged 65 and over to 0.39 cases or less per 1,000 total occupied bed days by 2013. To further reduce healthcare associated infections so that by March 2013 NHS Lothian's <em>Staphylococcus aureus</em> bacteraemia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of <em>Clostridium difficile</em> infections</td>
<td>Investigation of incidents/outbreaks</td>
</tr>
<tr>
<td>Deliverable</td>
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</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Childhood Vaccinations</strong></td>
<td></td>
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</tr>
<tr>
<td>There is a risk of vaccine preventable diseases to re-emerge or cause outbreaks when the population vaccination coverage is low. Recent examples have been outbreak of measles and mumps.</td>
<td></td>
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</tr>
<tr>
<td>Education – school and further employment, work with local businesses</td>
<td></td>
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</tr>
<tr>
<td>NHS Lothian has a childhood immunisation programme that aims to vaccinate at least 95% of children according to national schedules</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(2011 uptake of MMR at 24 months was 93.5%).</td>
<td></td>
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<tr>
<td><strong>Human papilloma virus (HPV) vaccine programme:</strong></td>
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</tr>
<tr>
<td>HPV infection is responsible for the development of almost all cases (90+%) of cervical cancer. Effective against the two strains. HPV vaccines are of the virus. The HPV vaccine for girls aged 12 to 13 years is aimed at protection against 70% of cervical cancers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Lothian continues to implement the HPV programme with catch up for S4, S5 and girls who are out of school.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Viral hepatitis</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prevention of BBV in drug users, increasing testing in high risk groups, ensuring immunisation policies in place for hepatitis B in at risk groups, collaborative working to ensure patients supported through assessment and treatment for hepatitis C</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Regulation of tattooing and other high risk activities</td>
<td></td>
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</tr>
<tr>
<td>NHS Lothian actions outlined in the Scottish Government Sexual Health and Blood Borne Virus framework are being implemented through the NHS Lothian Viral Hepatitis Managed Care Network (MCN).</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Social worker involvement in hepatitis MCN  Joint working via alcohol and drug action teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reservoirs of infection</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Approved: 1 April 2012  Final version**

**Revision due: March 2014**
<table>
<thead>
<tr>
<th>Pandemic Influenza</th>
<th>A pandemic is one of the most severe national challenges likely to affect Scotland and Lothian. Proportionate planning and drawing on lessons learnt from H1N1 is essential for mitigation of the potential impact of a pandemic.</th>
<th>Develop local plans for response and recovery from a pandemic.</th>
<th>NHS Lothian continues to identify, treat and monitor cases of influenza A(H1N1) and will ensure arrangements are in place to offer vaccination to the Lothian population against this virus as appropriate.</th>
<th>Participate in Lothian and Borders Strategic Coordinating Group pandemic planning process.</th>
<th>Sustainable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health (S) Act 2008</td>
<td>Information sharing (NHS &amp; local authorities) and joint analysis</td>
<td>Sharing information is essential for effective implementation of health protection interventions.</td>
<td>NHS Lothian has arrangement for ensuring that Health professionals employed or contracted have the training and support necessary to allow them to balance their responsibilities for patient confidentiality, with public safety and health protection when sharing information.</td>
<td>Regularly review effectiveness of arrangement for information sharing between NHS Lothian and local authorities.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Provision of Mortuaries</td>
<td>Improper or delayed disposal of dead bodies can result in spread of infection</td>
<td>Arrangement for disposal of dead under National Assistance Act provisions. Provision of mortuary facilities</td>
<td>Advice on health risks in relation to contaminated/infected bodies.</td>
<td>Joint investigations as necessary</td>
<td>Developmental</td>
</tr>
</tbody>
</table>
## Appendix II: Joint Health Protection Action Plan

<table>
<thead>
<tr>
<th>Reference Section</th>
<th>Action</th>
<th>Responsibility</th>
<th>Timescale</th>
<th>Outcome</th>
<th>Priority Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The steering group will continue to oversee the implementation of the plan.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Regular review of planned activities</td>
<td>Deliverable</td>
</tr>
<tr>
<td>1</td>
<td>Ensure implementation and compliance with all the requirements within the act</td>
<td>DPH/Chief EHO and Lead CPHM and respective teams</td>
<td>Annual</td>
<td>Implement all aspects of the new act according to the law.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>2.2</td>
<td>Investigate of assertions of risk and assessment of impact of remediation measures.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Adequate risk assessment and risk management carried out</td>
<td>Deliverable</td>
</tr>
<tr>
<td>2.2</td>
<td>Investigate contaminated land and take action to ensure health risks are eliminated or adequately reduced.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Adequate risk assessment and risk management carried out</td>
<td>Deliverable</td>
</tr>
<tr>
<td>2.2</td>
<td>Carry out health impact assessments of greenspace, transport policy and strategy proposals, planning policies and joint work on scope of SEAs</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>HIA reports available to inform policy and planning</td>
<td>Developmental</td>
</tr>
<tr>
<td>4.1</td>
<td>Health Impact Assessments of housing development and regeneration schemes.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>HIA reports available to inform housing policy</td>
<td>Developmental</td>
</tr>
<tr>
<td>4.1</td>
<td>Address underlying and long term issues through planning and delivery of services in partnership through the Smoking &amp; Health, Alcohol and Drug Partnerships (ADPs) and Community Safety Partnerships.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Declining substance misuse rates and associated long term issues</td>
<td>Sustainable</td>
</tr>
<tr>
<td>4.1</td>
<td>Investigation and control of pest related diseases zoonotic disease related to dogs.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Reduced pest incidents and zoonotic diseases</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.1</td>
<td>Follow up complaints and investigate nuisance that affect public health.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Reduced complaints associated with nuisances.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.3</td>
<td>Reduce risk of disease entering country via ports by responding to airport call outs, ship sanitation inspection and vermin control.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Prompt response to port health call out</td>
<td>Sustainable</td>
</tr>
<tr>
<td>4.3</td>
<td>Develop and test emergency plans for mass gathering including national and international events such as games and sports and the Hogmanay plans prior to the season starting.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Event health emergencies adequately handled</td>
<td>Sustainable</td>
</tr>
<tr>
<td>4.3</td>
<td>Participate in multiagency climate change mitigation emergency plans such as flood plans. Develop plans in line with Scottish Govt Climate Change Adaptation framework 2012.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Continuous mitigation of environment impact arising from climate change</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.3</td>
<td>Participate in multiagency radiation exercises and planning events.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Two-yearly</td>
<td>Staff capacity and resilience for response to radiation incidents improved</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.3</td>
<td>Participate in multiagency air quality exercises and planning events and consultations on air quality action plans.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Effective response to air quality incidents</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.4</td>
<td>Ensure that lessons learnt from incidents and outbreak informs the development and review of plans.</td>
<td>DPH/Chief EHO and Lead CPHM and respective teams</td>
<td>Annual</td>
<td>Plans and SOPs are suited to local needs.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Joint planning for sexual health and HIV – strategy development HIV treatment and care – joint agreement for milestone home.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Joint sexual health and HIV strategy in place and used.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Involve social workers in hepatitis Managed Clinical Networks. Joint working via alcohol and drug action teams</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Social workers participate in Hepatitis MCN</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Participate in multiagency exercises and planning events.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Continuous improvement of staff capacity and resilience</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5</td>
<td>Draw up joint plans for the investigation and control of incidents and outbreaks. and audits</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Dec 2012</td>
<td>Plans in place and applied</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.1</td>
<td>Share lists of competent persons as required by the act</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Agencies have up-to-date lists of competent persons for Lothian</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.1</td>
<td>Appoint and review competent persons list.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Sufficient numbers of competent persons within agencies</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.5</td>
<td>Hold major incident plan exercise (joint LA/ NHS Lothian) Regularly exercise key health protection plans including GI and food incidents and the major incident plan.</td>
<td>PH/EHO/Med/Vet/SW liaison group</td>
<td>Annual</td>
<td>Update of plans based on exercises. Staff trained during exercises.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.5</td>
<td>NHS Lothian and the Local Authorities will keep Standard Operating Procedures (SOPs) under review, including developing and reviewing procedures up-to-date in relation to the Public Health etc (Scotland) Act 2008 duties.</td>
<td>Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>Staff working with updated SOPs</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.5</td>
<td>Review Lothian Joint Health Protection Plan (2012)</td>
<td>DPH/Chief EHO and Lead CPHMNHS</td>
<td>April 2014</td>
<td>Revised plan in place and up-to-date.</td>
<td>Sustainable</td>
</tr>
<tr>
<td>5.6</td>
<td>Developing joint training opportunities, particularly in relation to the Public Health etc (Scotland) Act 2008 duties.</td>
<td>DPH/Chief EHO and Lead CPHM Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>Joint training taking place.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Deliverable</td>
<td>Description</td>
<td>Responsible Parties</td>
<td>Frequency</td>
<td>Comments</td>
<td></td>
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<tr>
<td>-------------</td>
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</tr>
<tr>
<td>5.6.2</td>
<td>NHS Lothian and the Local Authorities will keep training requirements under review, including for competent persons and investigator knowledge and skills, developing joint training opportunities, particularly in relation to the Public Health etc (Scotland) Act 2008 duties.</td>
<td>Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>List of training requirement in place and shared with staff</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Assess capacity and resilience to provide health protection services in Lothian</td>
<td>DPH/Chief EHO and Lead CPHM NHS Lothian and LA s</td>
<td>Annual</td>
<td>NHS Lothian and Lothian Local Authorities have sufficient numbers of competent persons and investigators for both in and out of hours interventions</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Explore and identify new ways of working in response to revised approach to regulation.</td>
<td>DPH/Chief EHO and Lead CPHM NHS Lothian and LA s</td>
<td>Annual</td>
<td>New ways of working identified and applied.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Explore mechanisms for improved public involvement activities for health protection in all agencies.</td>
<td>Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>Review of plans with consideration of public input.</td>
<td></td>
</tr>
<tr>
<td>5.2, 5.3</td>
<td>Ensure the acquisition and use of appropriate information technology for the investigation and management of outbreaks and incidents</td>
<td>DPH/Chief EHO and Lead CPHM and respective teams</td>
<td>Annual</td>
<td>Accurate recording and reporting of incidents and outbreaks. Timely availability of epidemiologic al information.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix III: Key health protection plans for the Lothian area

<table>
<thead>
<tr>
<th>Shared Plans</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian and Borders Police Major Incident Plan</td>
<td>01/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>Lothian and Borders Emergency Planning Strategic Co-ordinating Group</td>
<td>05/2010</td>
<td>05/2012</td>
</tr>
<tr>
<td>Generic Emergency Plan (maintained by SCG Co-ordinator)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lothian and Borders Emergency Planning Strategic Co-ordinating Group</td>
<td>05/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>Pandemic Influenza (maintained by SCG Co-ordinator)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lothian and Borders Emergency Planning Strategic Co-ordinating Group</td>
<td>04/2011</td>
<td>Under review</td>
</tr>
<tr>
<td>Community Risk Register</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lothian and Borders Emergency Planning Strategic Co-ordinating Group</td>
<td>05/2011</td>
<td>05/2012</td>
</tr>
<tr>
<td>Public Communications Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lothian and Borders Emergency Planning Strategic Co-ordinating Group</td>
<td>05/2010</td>
<td>Due to be replaced by a National plan being</td>
</tr>
<tr>
<td>Animal Health Plan</td>
<td></td>
<td>developed by Animal Health</td>
</tr>
<tr>
<td>The City of Edinburgh Council Emergency Plan (General Plan for the Council's</td>
<td>02/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>response to Serious Emergencies or Major Incidents).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The City of Edinburgh Council Pipelines Emergency Plan (Statutory Requirement</td>
<td>01/2009</td>
<td>Under review</td>
</tr>
<tr>
<td>under the Pipelines Safety Regulations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A draft plan is being developed for Edinburgh City Centre Evacuation by</td>
<td>11/2011</td>
<td>11/2014</td>
</tr>
<tr>
<td>Lothian and Borders Police and the City of Edinburgh Council, partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>organisations will be consulted in due course.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Edinburgh Model Response Plan (maintained by Lothian and Borders</td>
<td>05/2011</td>
<td>05/2012</td>
</tr>
<tr>
<td>Police)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Borders Pandemic Influenza Plan</td>
<td>02/2009</td>
<td>Under review</td>
</tr>
<tr>
<td>The City of Edinburgh Council BP Dalmeny Installation Off Site Plan (Statutory</td>
<td>12/2011</td>
<td>12/2014</td>
</tr>
<tr>
<td>Requirement under the Control of Major Accident Hazards Regulations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Port Health Plan</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Lothian and Borders Police Severe Weather plan</td>
<td>07/2011</td>
<td>06/2012</td>
</tr>
<tr>
<td>Scottish Waterborne Hazard Plan</td>
<td>07/2010</td>
<td>02/2012</td>
</tr>
<tr>
<td>The City of Edinburgh Council Emergency Flooding Plan (To be replaced by</td>
<td>11/2011</td>
<td>11/2012</td>
</tr>
<tr>
<td>a joint Lothian and Borders Police/City of Edinburgh Council Flooding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Plan in next few months.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sporadic food and gastrointestinal infection incidents plans</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Blue Green Algae in Inland Waters Assessment and Control etc. Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Shared Plans</td>
<td>Last Review Date</td>
<td>Next Review Date</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Shared Waste Water Incident Plan</td>
<td>2009</td>
<td>07/2012</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>NHS Lothian</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian Major Outbreak Plan for Lothian</td>
<td>2009</td>
<td>2012</td>
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<tr>
<td>NHS Lothian Major Incident Strategic Response Plan</td>
<td>2010</td>
<td>Oct 2011</td>
</tr>
<tr>
<td>Contingency Plan for Pandemic Influenza: Strategic Policy</td>
<td></td>
<td>March 2012</td>
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<tr>
<td>NHS Lothian and Port Health Authority</td>
<td>Procedure for cases of illness in vessels arriving at Leith and other anchorages in Lothian.</td>
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<tr>
<td>NHS Lothian and Port Health Authority</td>
<td>Procedure for cases of illness in aircraft arriving in Edinburgh</td>
<td>09/2009</td>
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<tr>
<td>Drug and Alcohol Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Sexual Health and Blood Borne Virus Framework</td>
<td>2011</td>
<td>2015</td>
</tr>
<tr>
<td>NHS Lothian Standard Operating procedures for specific diseases including meningitis, E.coli O157.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City of Edinburgh Council</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Business Continuity Plan</td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td>Council Emergency Plan</td>
<td>2007</td>
<td>2009</td>
</tr>
<tr>
<td>Business Continuity Pandemic Flu Plan</td>
<td>2009</td>
<td>2011</td>
</tr>
<tr>
<td>Bereavement Management Response to Pandemic Situations</td>
<td>2009</td>
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<table>
<thead>
<tr>
<th>West Lothian Council</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
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</thead>
<tbody>
<tr>
<td>West Lothian Major Incident Plan</td>
<td>2008</td>
<td>2010</td>
</tr>
<tr>
<td>Severe Weather Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Major Accident Hazard Pipelines Emergency Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Control of Major Accident Hazard Off Site Emergency Plan</td>
<td>2006</td>
<td>2010</td>
</tr>
<tr>
<td>Livingston Shopping Centre Emergency Plan</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>East Lothian Council</td>
<td>Last Review Date</td>
<td>Next Review Date</td>
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<tr>
<td>-------------------------------------------------</td>
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<td>------------------</td>
</tr>
<tr>
<td>Business Continuity Plan</td>
<td>2011</td>
<td>2012</td>
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<tr>
<td>Torness Off Site Emergency Plan</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>Corporate Emergency Plan</td>
<td>2011</td>
<td>2012</td>
</tr>
<tr>
<td>Chemical Incident Plan</td>
<td>2009</td>
<td></td>
</tr>
<tr>
<td>Oil Pollution Plan</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Severe weather response plan</td>
<td>2011</td>
<td>2013</td>
</tr>
<tr>
<td>Pipeline Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies Emergency Plan</td>
<td>2009</td>
<td>2012</td>
</tr>
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<table>
<thead>
<tr>
<th>Midlothian Council</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
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</thead>
<tbody>
<tr>
<td>Midlothian Registered Care Homes Stage 2 Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Midlothian Council Business Continuity Plans (Midlothian Council Services)</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Recovery Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Midlothian Council Emergency Plan</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Fuel Plan</td>
<td>2010</td>
<td>2012</td>
</tr>
<tr>
<td>LBSCG Pandemic Influenza guidelines</td>
<td>2009</td>
<td>2009</td>
</tr>
<tr>
<td>Midlothian Council Avian Flu Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Midlothian Council Severe Weather Plan</td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td>Pipeline plan</td>
<td>2008</td>
<td>2011</td>
</tr>
<tr>
<td>Midlothian Council Food Service Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>LBSCG Disease of Animals Plan</td>
<td>2010</td>
<td>2013</td>
</tr>
<tr>
<td>Rabies Outbreak Contingency Plan</td>
<td>2010</td>
<td>2013</td>
</tr>
<tr>
<td>Avian Influenza and Newcastle disease plan</td>
<td>2010</td>
<td>2013</td>
</tr>
</tbody>
</table>
## Appendix IV: Significant public health incidents or outbreaks 2010-2011

### NHS Lothian

#### Business Continuity:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pandemic Flu</strong></td>
<td></td>
</tr>
<tr>
<td>Chemical / radiological and biological</td>
<td></td>
</tr>
<tr>
<td>Contaminated land in Fauldhouse with alleged cancer cluster</td>
<td></td>
</tr>
<tr>
<td>Investigation of alleged increased respiratory disease following traffic diversion</td>
<td></td>
</tr>
<tr>
<td>Fire in a printing factory in West Lothian resulting in the release of chromium in air and local rivers</td>
<td></td>
</tr>
<tr>
<td>Burst pipe at Dalmeny Tank Farm with release of yellow liquid into the Forth estuary and hydrogen sulphide gas into the atmosphere</td>
<td></td>
</tr>
<tr>
<td>Cryptosporidium among University of Edinburgh veterinary students</td>
<td></td>
</tr>
<tr>
<td><strong>Water</strong></td>
<td></td>
</tr>
<tr>
<td>High lead levels in a block of flats at Cambridge Street</td>
<td></td>
</tr>
<tr>
<td><strong>Food</strong></td>
<td></td>
</tr>
<tr>
<td>Outbreak of norovirus at the Marriott Hotel in Edinburgh</td>
<td></td>
</tr>
<tr>
<td>Salmonella bareilly in bean sprouts</td>
<td></td>
</tr>
<tr>
<td><strong>Specific Diseases</strong></td>
<td>Swift liaison with HPS and Police to ensure no malicious involvement</td>
</tr>
<tr>
<td>Burkholderia pseudomallei bacterium (melioidosis) a rare organism listed as a potential bioterrorism agent</td>
<td></td>
</tr>
<tr>
<td>Three measles outbreak in 2011</td>
<td>Improved working arrangements with Virology and Occupational Health Department. Vaccination of MMR offered to staff</td>
</tr>
<tr>
<td>Diarrhoea and vomiting in a school trip, Saltersgate special needs school, Merchiston Castle and Ballgreen primary schools.</td>
<td></td>
</tr>
<tr>
<td>Syphilis in prison</td>
<td></td>
</tr>
<tr>
<td>Acinetobacter (an emerging infection) a gram negative bacterium resistant to nearly antibiotics intensive care unit at the RIE</td>
<td></td>
</tr>
</tbody>
</table>
### Incident/Outbreak

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>E coli in Nursery</td>
<td></td>
</tr>
<tr>
<td>campylobacter increase</td>
<td></td>
</tr>
</tbody>
</table>

### Health Care Acquired Infections (HAI)

<table>
<thead>
<tr>
<th>HPT assisted in investigating the following HAI infections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outbreak of respiratory syncytial virus in Haematology ward (WGH)</td>
</tr>
<tr>
<td>Two outbreaks of parainfluenza type 3 at the WGH</td>
</tr>
<tr>
<td>C difficile in at RIE</td>
</tr>
<tr>
<td>Atypical Mycobacterium at the WGH</td>
</tr>
<tr>
<td>MRSA at the neonatal unit at RIE</td>
</tr>
<tr>
<td>Norovirus ward 108 at the RIE</td>
</tr>
<tr>
<td>Invasive group A Streptococcus Aureus (IGAS) in Liberton hospital, WGH,</td>
</tr>
</tbody>
</table>

### Blood Borne Viruses

<table>
<thead>
<tr>
<th>Investigation of unlicensed tattooist with possible transmission of bloodborne viruses.</th>
<th>A look back exercise reviewed procedures University improved its Lab supervision of students and accreditation procedures for lab staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>An anonymised investigation of possible CJD identified by a novel technique in a blood donor</td>
<td></td>
</tr>
</tbody>
</table>

### Tuberculosis

<table>
<thead>
<tr>
<th>Increase in TB cases and incidents – 11 incidents of TB required full investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of new staff to support TB activities.</td>
</tr>
</tbody>
</table>

### Vaccine Related

| Five cold chain incidents |     |

### City of Edinburgh Council:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental (EIA)</td>
<td></td>
</tr>
<tr>
<td>Seafield sewage treatment works pump failure resulting in environmental pollution</td>
<td>See previous reference to shared Wastewater Treatment plan</td>
</tr>
</tbody>
</table>

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Lothian Joint Health Protection Plans  
Approved: 1 April 2012  Final version  
Revision due: March 2014
### West Lothian Council:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental (EIA)</td>
<td></td>
</tr>
<tr>
<td>Redevelopment of former Polkemmet Colliery, Whitburn</td>
<td></td>
</tr>
<tr>
<td>Redevelopment of former Riddochhill Colliery, Blackburn</td>
<td></td>
</tr>
<tr>
<td>Upgrading of Newbridge Junction to Bathgate railway</td>
<td>Heavy overnight engineering works in densely populated areas</td>
</tr>
<tr>
<td>Conversion of abandoned railway course / cycle path to operational railway</td>
<td></td>
</tr>
<tr>
<td>Demolition of asbestos clad former ‘Edgar Allen’ Foundry, Bathgate</td>
<td></td>
</tr>
<tr>
<td>Major Fire at Campbell’s Prime Meat, Brock’s Way, Broxburn (May 2009)</td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
</tr>
<tr>
<td>Major Flooding in Broxburn incident</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
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<tr>
<td>Sudan dye incidents</td>
<td></td>
</tr>
<tr>
<td>Specific Diseases</td>
<td></td>
</tr>
</tbody>
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### East Lothian Council:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pandemic Flu</td>
<td></td>
</tr>
<tr>
<td>National Swine flu (Influenza A - H1N1) outbreak (2009)</td>
<td>Business Continuity Plan and Corporate Emergency Plan reviewed and updated to take account of Flu Pandemic</td>
</tr>
<tr>
<td>Chemical / radiological and biological</td>
<td></td>
</tr>
<tr>
<td>Petrol leakage incident North Berwick (2008)</td>
<td>Review of procedures undertaken</td>
</tr>
<tr>
<td>Environmental (EIA)</td>
<td></td>
</tr>
<tr>
<td>Forth River sewage spill</td>
<td>As for City of Edinburgh - Review of FSA procedures underway</td>
</tr>
<tr>
<td>Avian Flu/ Newcastle Disease</td>
<td></td>
</tr>
<tr>
<td>Newcastle disease outbreak (2008)</td>
<td>Avian Flu/ Newcastle Disease plan reviewed</td>
</tr>
<tr>
<td>Incident/Outbreak</td>
<td>Improvement to plans</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>Influenza A (H1N1) Outbreak 2009</td>
<td>Business Continuity Plan and Corporate Emergency Plan reviewed and updated</td>
</tr>
</tbody>
</table>

Midlothian Council:
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>APP</td>
<td>Authority Public Protection</td>
</tr>
<tr>
<td>AIPG</td>
<td>Avian &amp; Influenza Pandemic Group</td>
</tr>
<tr>
<td>AQMA</td>
<td>Air Quality Management Area</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Bourne Viruses</td>
</tr>
<tr>
<td>CBRN</td>
<td>Chemical Biological, Radiological &amp; Nuclear</td>
</tr>
<tr>
<td>CEC</td>
<td>City of Edinburgh Council</td>
</tr>
<tr>
<td>CNS</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>COSLA</td>
<td>Convention of Scottish Local Authorities</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CPHM</td>
<td>Consultant in Public Health Medicine</td>
</tr>
<tr>
<td>DPH</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EHO</td>
<td>Environmental Health Officer</td>
</tr>
<tr>
<td>ELC</td>
<td>East Lothian Council</td>
</tr>
<tr>
<td>EMF</td>
<td>Electromagnetic Field</td>
</tr>
<tr>
<td>FSA</td>
<td>Food Standards Agency</td>
</tr>
<tr>
<td>GROS</td>
<td>General Register Office for Scotland</td>
</tr>
<tr>
<td>HCAI</td>
<td>Healthcare Associated Infections</td>
</tr>
<tr>
<td>HEAT</td>
<td>Health Improvement, Efficiency, Access Treatment</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HPS</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>HPT</td>
<td>Health Protection Team</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papiloma Virus</td>
</tr>
<tr>
<td>LBSCG</td>
<td>Lothian and Borders Scottish Co-ordinating Group</td>
</tr>
<tr>
<td>LICAC</td>
<td>Lothian Infection Control Advisory Committee</td>
</tr>
<tr>
<td>MC</td>
<td>Midlothian Council</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles, Mumps Rubella</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
</tr>
<tr>
<td>MTPAS</td>
<td>Mobile Telecommunications Privileged Access Scheme</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>REHIS</td>
<td>Royal Environmental Health Institute of Scotland</td>
</tr>
<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
</tr>
<tr>
<td>SEISS</td>
<td>Scottish Epidemiology Infection Surveillance System</td>
</tr>
<tr>
<td>SEPA</td>
<td>Scottish Environment Protection Agency</td>
</tr>
<tr>
<td>SHPIMS</td>
<td>Scottish Health Protection Information Management System</td>
</tr>
<tr>
<td>SHPIR</td>
<td>Scottish Health Protection Information Resource</td>
</tr>
<tr>
<td>SIDNEY</td>
<td>Scottish Infectious Diseases Notification Electronic eYe</td>
</tr>
<tr>
<td>SOA</td>
<td>Single Outcome Agreement</td>
</tr>
<tr>
<td>STAC</td>
<td>Science and Technical Cell Course</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>SW</td>
<td>Scottish Water</td>
</tr>
<tr>
<td>WHIP</td>
<td>Worcestershire Health Informatics Programme</td>
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</tbody>
</table>
REPORT FROM THE ORGAN DONATION COMMITTEE 2011/12

1. Purpose of the Report

1.1 To report to the Board on progress with organ donation and related activity in NHS Lothian for the year 2011-2012 (i.e. 1/4/11– 31/3/12).

1.2 Any members 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 the reassurance it provides that NHS Lothian is fully engaged with the task of contributing to the government’s goal of improving the UK’s organ donation rate.

2.2 Note that the population of Lothian registered for Organ Donation remains the highest in Scotland.

2.3 Support the proposal to create a memorial in Lothian to those who have donated organs and tissue.

3. Discussion of Key Issues

3.1 National context

3.1.1 The UK has long had one of the lowest rates of organ donation. In 2007 the UK rate was 12.9 donors per million population compared with 15.3 in Germany, 20.7 in Finland and 35.5 in Spain. In 2008 a national (UK) Organ Donation Task Force published 14 recommendations for improvement, ranging across issues of day-to-day clinical management to complex definitional, ethical and legal matters as well as professional and public education.

3.1.2 The UK Task Force set as the target a 50% increase in the donation rate by 2013, this target has been met this calendar year. Total deceased donors in Scotland increased from 54 in 2007/08 to 81 in 2011/12. In Scotland the rate per million of population increased from 10.6 in 2007/08 to 15.5 in 2011/12.

3.1.3 Although NHS Lothian is a key contributor to organ donation (and transplantation) in Scotland, in most areas the number of potential donors is both small and highly variable. Therefore, individual Boards have not been set specific targets. Instead, each Board is tasked with maximising its own performance, and this goal is driving the Committee’s work.
3.2 **NHS Lothian structures**

3.2.1 The Board’s Organ Donation Committee first met in May 2009. In 2011-12 it held 4 meetings, as required. Membership has expanded to include an Emergency Medicine Consultant and a Senior Nurse from the Emergency Medicine (EM) department Royal Infirmary of Edinburgh (RIE), in view of the rising role of the EM department in donor identification. Minutes of meetings go to the Healthcare Governance and Risk Management Committee and, in turn, to the Board.

3.2.2 Responsibility for promotion and coordination of organ donation at clinical level is vested in the Board’s three Clinical (medical) Leads for Organ Donation who cover RIE, Western General Hospital (WGH) & St John’s and the Royal Hospital for Sick Children (RHSC), and in three Specialist Nurses for Organ Donation, two based in RIE, one in WGH. The RHSC is also supported by a Specialist Nurse for Organ Donation along with Yorkhill Hospital in Glasgow; NHS Lothian also has a peripatetic Tissue Donor Co-ordinator. Organ donation activity is monitored by the Potential Donor Audit (PDA) and the data passed to NHS Blood and Transplant. In turn, NHS BT issues 6-monthly activity reports that enable Boards to compare their own performance with national statistics (see 3.4).

3.2.3 Ensuring that no opportunity for organ donation is missed anywhere across the organisation is one of the key roles of the Committee. Any missed cases must be reported to the Committee. Two missed cases occurred during 2011-12, but only one might have carried the potential for organ donation, the other definitely not. Difficulties with eye and tissue retrievals were noted, and these are being addressed by the Medical Director with colleagues in Ophthalmology and Anatomical Pathology.

3.3 **Awareness-raising**

3.3.1 Awareness-raising about organ donation and encouraging sign-up to the NHS Organ Donor Register (ODR) is important because family authorisation for donation is much more likely when they know (or are told) that the person had registered their wish to become an organ donor. Under the Human Tissue (Scotland) Act 2006 where authorisation has been given by the individual the nearest relatives have no legal right to overrule those wishes. Obviously at such a distressing time, the subject needs to be dealt with in a sensitive manner. Under current legislation and following discussions/exploration about the families’ concerns, if they are still of the same opinion then the family or Physician caring for the patient will be asked to sign a Retraction of patient authorisation form.

3.3.2 The Committee worked with Communications on the second ‘Sign up to save a life’ app, and a successful Transplant Week had resulted in an article in the Edinburgh Evening News on Organ Donation. Other Boards expressed an interest in using the Lothian sign up to save a life campaign.

3.3.3 In the whole of 2011 there was an increase of 8.7% of new Lothian registrations. At end of March 2012 there were over 2 million people on the organ donation register in Scotland. Thus 38.8% of Scotland’s population was on the OD Register, and in Lothian, it reached 45.8% (n= 382,938), the highest in Scotland.
3.3.4 Future campaigns will continue to focus on the groups that are least well represented on the ODR (incl. males and ethnic minority groups) and everyday publicity of organ donation will continue in ‘Connections’ and by making NHS BT-provided leaflets available in patient and visitor areas in all hospitals and GP practices across NHS Lothian. New patients registering with a GP are now routinely invited (on the form) to join the Organ Donor Register, but unfortunately the options to register for small bowel or tissue donation were not available. This has been raised with the national GP software users group. GP practices in Lothian also received suggested wording to add to repeat prescriptions to encourage registration for organ donation.

3.3.5 Following comments received that Organ Donation information was difficult to find on the NHS Lothian intranet, Communications Directorate has information accessible under both “Organ Donation” and “Transplant” on the healthcare home page.

3.3.6 Currently, there is a national memorial to those who have donated organs and tissue sited in Kelvingrove Gallery, Glasgow. The “Seat of Life” is funded by NHSBT, and each time an organ or tissue is donated, the family are offered the opportunity to add an engraved leaf to the seat. The seat is nearly full, and NHSBT would be keen to work with the NHS Lothian Organ Donation Committee to create and fund a memorial in Lothian. The Organ Donation Committee and NHSBT propose a small working group including, amongst others, patient representatives and Anne Mulligan, Chaplain RIE to take this forward and to report back to the Organ Donation Committee.

3.4 Transplant and Donation activity

3.4.1 The committee was delighted to note that the Lothian transplant teams had performed their thousandth liver and kidney transplants this year. NHS Lothian is one of Scotland’s two transplant centres. From 1/4/11-31/3/12, in addition to 26 patients transplanted from 26 living donors, 83 patients received transplants. 59 of these received organs from 17 donors after brain death (DBD) and the other 24 from 11 donors after circulatory death (DCD). The numbers of organs transplanted by type were kidney (33 DBD, 18 DCD), pancreas (9 DBD, 2 DCD), liver (16 DBC, 14 DCD), heart (2 DBD) and lung (7 DBD).

3.4.2 The twice-yearly NHS BT activity reports on donation are based on a verified version of the data provided to them from Boards using the Potential Donor Audit (PDA). Figures are returned confidentially to each Health Board, also broken down by hospital, and with UK data for comparison. Appendix 1 shows key statistics extracted for this report from the NHSBT report for 2011-2012, received in July.
3.4.3 NHS Lothian is performing above the UK average on all of the key parameters of donation after brain death (DBD). The conversion rate (i.e. conversion of a potential donation into an actual one) has increased dramatically to 81% compared with the national average of 55%. The Committee has agreed that neurological death testing consistently should reach 100% and feedback should be given to clinicians in all cases when this is not done. The rate of referral to a SN-OD has risen to 92%. The authorisation rate (i.e. family authorisation), has remained high at 69%, but this can be increased and, for that reason, all staff who act as ‘requesters’ are offered special communication training.

Where NHS Lothian falls short of UK average figures is in donation after circulatory death (DCD). The problem lies in the inherent difficulty of identifying ‘imminent death’ despite recent national review of the criteria. The Committee has supported the more conservative approach of the Clinical leads for Organ Donation (CLODs) in NHS Lothian so that patients are not referred as potential DCD donors, and families are not approached, when it is obvious that donation and transplantation will not be viable. Although our referral rate is low (33% c.f. 53% for the UK), it has doubled in the last year, and our conversion rate is almost twice the national average (22% c.f. 13%).

3.4.4 Tissue donation continues to be actively facilitated in Lothian. Emergency Medicine at RIE had 8 Multi Tissue Donors (including HV’s, corneas tendons and Skin) aged 65 yrs and under, and 9 Corneal Only Donors over the age of 65 (therefore not suitable for other Tissues)

Emergency Medicine at St John’s Hospital had 3 Multi Tissue Donors and 2 Corneal Only Donors

Total Multi Tissue Donation within Lothian 11 donors
Total Corneal only Donation within Lothian 11 donors

3.4.5 The Scottish Transplant Group is developing a Category II DCD pilot programme based in the emergency department at the RIE.

4. **Key risks**

4.1 There are no key risks attached to the recommendation in paragraph 2.1.

5. **Risk Register**

5.1 Failure of NHS Lothian to fully engage in organ donation would impact on patient experience and care.

6. **Impact on Inequality, Including Health Inequalities**

6.1 Advice has been given that a formal impact assessment of this report is not required.
7. **Involving People**

7.1 The Committee benefits by having a donor family member. A transplant recipient has joined the committee this year. NHS BT recommends that both perspectives are represented.

8. **Resource Implications**

8.1 There are no resource implications of the recommendation in para 2.1. In the longer term, more organ donors (and organs) carry cost implications for donating and transplant units and teams. At the same time, transplantation has recognised cost benefit as the treatment of choice for those patients from whom there is no other option. Reimbursement of donor costs are received from NHS BT allocated to critical care service budgets and included in the business plan for these units.

Dr Richard Williams  
Chair of the Organ Donation Committee  
1 September 2012  
Richard.Williams@lothian.scot.nhs.uk  
Emily.O'Connor@nhslothian.scot.nhs.uk (Committee Administrator)

**List of Appendices**

Appendix 1: Key statistics extracted from the activity report on organ donation provided to NHS Lothian by NHS BT in July 2012 for the year 2011-2012.
APPENDIX 1

Key statistics extracted from the activity report on organ donation provided to NHS Lothian by NHS BT in July 2012 for the year 2011-2012.
The full report (12 pages) can be obtained on request.

1 April 11 –30 March 12

<table>
<thead>
<tr>
<th></th>
<th>DBD</th>
<th>DCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ND tested rate</td>
<td>89 (97)</td>
<td>74 (72)</td>
</tr>
<tr>
<td>Referral rate</td>
<td>92 (74)</td>
<td>91 (85)</td>
</tr>
<tr>
<td>Approach rate</td>
<td>100 (100)</td>
<td>93 (93)</td>
</tr>
<tr>
<td>Adjusted authorisation rate</td>
<td>69 (70)</td>
<td>64 (65)</td>
</tr>
<tr>
<td>Observed authorisation rate</td>
<td>86 (67)</td>
<td>-</td>
</tr>
<tr>
<td>Conversion rate</td>
<td>81 (67)</td>
<td>55 (54)</td>
</tr>
</tbody>
</table>

All figures are percentages

Data from 1 April 2010 to 31 March 2011 are shown in parentheses for comparison purposes

Abbreviations:-
DBD = Donors after Brain Death, DCD = Donors after Circulatory Death
ND = Neurological Death

Definitions:-
Referral rate = % referred to/discussed with a SN-OD (Specialist Nurse for Organ Donation)
Approach rate = % of families of potential donor approached for authorisation
Authorisation rate = % families approached who authorised (adjusted = for ethnicity)
Conversion rate = % of potential donors who became actual donors

Comments/explanatory notes:
1. NHS Lothian’s ND (neurological death) testing rate is well above the UK average.
2. Referral of potential donors to SN-ODs (Specialist Nurses for Organ Donation) is regarded as best practice and, even although we have expert CLODs (Clinical Leads for Organ Donation) in NHS Lothian, the Committee has asked to see an improvement in the referral rate, particularly for DBD.
3. DCD statistics are more complex, as explained in the report, on account of the difficulty of defining ‘imminent death anticipated’. This is under review. Meantime, the Committee supports the cautious stance of our CLODs in order to avoid an approach to families when there is expert clinical judgement that actual donation is very unlikely to be feasible.
COMMITTEE CHAIRS AND MEMBERSHIP

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree to appoint Chairs and members of the 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 appoint the following as Chairs of Board Committees:

- Finance & Property Committee: George Walker
- Staff Governance Committee: Alex Joyce (when Eddie Egan demits office)
- Audit & Risk Committee: Jeremy Brettell
- Healthcare Governance Committee: Morag Bryce
- Remuneration Committee: Charles Winstanley
- Dental Appeal Panel: Shulah Allan
- East Lothian Community Health Partnership: Michael Ash
- Edinburgh Joint Board of Governance: Shulah Allan (Joint Chair)
- Midlothian Community Health Partnership: Michael Ash
- Doctors Support Scheme Assessment & Evaluation Group: Richard Williams

2.2 It is recommended that the Board agrees to appoint the following members to Board Committees (in addition to existing members):

- Finance & Property Committee: Jeremy Brettell; Ricky Henderson
- Staff Governance Committee: Donald Grant; Graeme Warner; Robert Wilson, Alison Meiklejohn; Alison Mitchell
- Audit & Risk Committee: Morag Bryce; Catherine Johnstone; Michael Ash
- Healthcare Governance Committee: Alex Joyce; Frank Toner; Alison Meiklejohn, Graeme Warner; Robert Wilson
- Remuneration Committee: Michael Ash; Alex Joyce
- Dental Appeal Panel: Shulah Allan
- West Lothian Community Health & Care Partnership Sub-Committee: Alison Mitchell
- West Lothian Community Health & Care Partnership Board: Alison Mitchell
- St John’s Hospital Stakeholder Group: Alison Mitchell
2.3 It is recommended that the Board agrees to appoint the following representatives proposed by the West Lothian Community Health & Care Partnership Sub-Committee as members of the Sub-Committee (now a Board responsibility following the dissolution of the Primary & Community Partnership Committee):

- Stephen Duncan (replacing Stewart Murdoch as representative for Scottish Ambulance Service); Annabel Ross (replacing George Mackie as representative for General Practitioners)

3 Key Risk

3.1 If Chairs and members are not appointed the Board Committees will cease to function and the Board will be in breach of its statutory responsibilities.

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
24 September 2012
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Details of Board Committees showing Chairs and members.
<table>
<thead>
<tr>
<th>Committee</th>
<th>Remit</th>
<th>Members</th>
<th>Meets</th>
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</thead>
<tbody>
<tr>
<td>Finance &amp; Property Committee *</td>
<td>To review the development of the Board’s Financial Strategy and the Board’s financial performance. To ensure that the Clinical Strategy is supported financially, and that expenditure is in line with the Board’s financial targets.</td>
<td>Charles Winstanley (Chair) Michael Ash Alex Joyce George Walker Julie McDowell Iain Whyte</td>
<td>4 times per year</td>
</tr>
<tr>
<td>Staff Governance Committee *</td>
<td>To support and maintain a culture within NHS Lothian where the delivery of the highest possible standard of care is the responsibility of everyone working within the system. To ensure that the Board’s governance arrangements are effective and that there is effective and open communication and collaboration.</td>
<td>Alex Joyce (Chair) Donald Grant Julie McDowell Alison Meiklejohn Alison Mitchell Iain Whyte (until 31 October 2012) Graeme Warner Robert Wilson Alan Boyter Meagre Bryce Catherine Johnstone Ricky Henderson Billy Peacock</td>
<td>6 times per year</td>
</tr>
<tr>
<td>Audit &amp; Risk Committee *</td>
<td>To investigate any activity within its terms of reference. To seek any involvement with potential conflicts of interest and to ensure that the Board and senior management are aware of any conflicts of interest. To ensure that the Board and senior management are aware of any arrangements that might constitute a conflict of interest.</td>
<td>Jeremy Brettell (Chair); Michael Ash Kay Blair Morag Bryce (from 1 November 2012) Alex Joyce George Walker Julie McDowell Iain Whyte (until 31 October 2012) Richard Williams</td>
<td>6 times per year</td>
</tr>
<tr>
<td>Healthcare Governance Committee *</td>
<td>To provide assurance to the Board that the quality of care delivered by NHS Lothian is what all reasonable people would expect of any health service. To ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored.</td>
<td>Morag Bryce (Chair) Shulah Allan Alison Meiklejohn Frank Toner Graeme Warner Robert Wilson Iain Whyte</td>
<td>6 times per year</td>
</tr>
<tr>
<td>Remuneration Committee *</td>
<td>To consider new applications by community pharmacies for the inclusion of their names in the pharmaceutical list, in accordance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995, as amended.</td>
<td>Charles Winstanley (Chair) Michael Ash Alex Joyce George Walker Julie McDowell Iain Whyte</td>
<td>4 times per year</td>
</tr>
<tr>
<td>Pharmacy Practices Committee *</td>
<td>To discuss and review the overall performance of NHS Lothian in relation to the Health Plan and the Accountability Review: take an overview of the Performance Management and Pay structure; Review and monitor changes to the NHS Executive Directors’ remuneration.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
<tr>
<td>Edinburgh Community Health Partnership Sub-Committee*</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust and the East Lothian Community Health Partnership.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
<tr>
<td>East Lothian Community Health Partnership Sub-Committee*</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust and the East Lothian Community Health Partnership.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
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<tr>
<td>Midlothian Community Health &amp; Care Partnership Sub-Committee*</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust and the Midlothian Community Health Partnership.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
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<td>1 time per year</td>
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<tr>
<td>West Lothian Community Health &amp; Care Partnership Sub-Committee*</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust and the West Lothian Community Health Partnership.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
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<tr>
<td>Reference Committee *</td>
<td>To review the development of the Board’s Financial Strategy and the Board’s financial performance. To ensure that the Clinical Strategy is supported financially, and that expenditure is in line with the Board’s financial targets.</td>
<td>Charles Winstanley (Chair) Michael Ash Alex Joyce George Walker Julie McDowell Iain Whyte</td>
<td>4 times per year</td>
</tr>
<tr>
<td>Dental Appeal Panel *</td>
<td>To consider new applications by community pharmacies for the inclusion of their names in the pharmaceutical list, in accordance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995, as amended.</td>
<td>Charles Winstanley (Chair) Michael Ash Alex Joyce George Walker Julie McDowell Iain Whyte</td>
<td>4 times per year</td>
</tr>
<tr>
<td>Discipline Committees for FHS Practitioners *</td>
<td>To discuss and review the overall performance of NHS Lothian in relation to the Health Plan and the Accountability Review: take an overview of the Performance Management and Pay structure; Review and monitor changes to the NHS Executive Directors’ remuneration.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
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<tr>
<td>Organ Donation Sub-Committee</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
<tr>
<td>Edinburgh Joint Board of Governance</td>
<td>To consider new applications by community pharmacies for the inclusion of their names in the pharmaceutical list, in accordance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995, as amended.</td>
<td>Charles Winstanley (Chair) Michael Ash Alex Joyce George Walker Julie McDowell Iain Whyte</td>
<td>4 times per year</td>
</tr>
<tr>
<td>St John’s Hospital Stakeholder Group</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
<tr>
<td>West Lothian Community Health &amp; Care Partnership Sub-Committee*</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust and the West Lothian Community Health Partnership.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
<tr>
<td>Doctors Support Scheme Assessment &amp; Evaluation Group*</td>
<td>To discuss and review the performance of the Edinburgh University Hospitals NHS Trust.</td>
<td>Shulah Allan (Chair) Alex Joyce Kay Blyth (from November 2012) Richard Williams Peter Johnston (Chair)</td>
<td>1 time per year</td>
</tr>
</tbody>
</table>

*mandatory Committees
1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the dates for Board and Committee meetings in 2013.

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

2 Recommendations

The Board is recommended to:

2.1 Agree the dates for Board and Committee meetings in 2013.

3 Discussion of Key Issues

3.1 The attached list of proposed Board and Committee dates includes final deadlines for the submission of papers for consideration at the relevant meetings. As the Board Committee structure is to be discussed earlier, dates are shown for the existing Committees with potential changes shown in grey. A full list of Committees and dates of meetings will be circulated to Board members after the meeting.

3.2 Relevant Committee Chairs have been consulted on these proposed dates.

4 Key Risks

4.1 If meetings of the Board’s Committees are not held in 2013 then the Board will fail to discharge some of its statutory responsibilities.

5 Risk Register

5.1 There are no implications for NHS Lothian’s Risk Register in this report and its recommendations.

6 Impact on Inequality, Including Health Inequalities

6.1 This is an administrative matter and the paper has no direct impact on inequalities.
7   Resource Implications

7.1 There are no resource implications arising from the recommendations in the report.

Peter Reith
Secretariat Manager
19 September 2012
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: List of Dates and Deadlines for Board and Committee meetings in 2013
LOTHIAN NHS BOARD

The deadlines for papers quoted are the last date and time on which final approved versions of papers will be accepted for agendas. Late papers will be placed on the agenda of the following meeting unless the Chair determines that they are urgent. Potential changes arising from earlier discussions on the Board Committee structure are shown in grey.

The dates of Board Meetings for 2013 are shown below together with the deadlines for submission of papers in electronic format for formal business meetings. Board Meetings are normally held on the fourth Wednesday of the month at 9:30 a.m. in the Boardroom (Meeting Rooms 7 & 8) at Waverley Gate.

### LOTHIAN NHS BOARD

<table>
<thead>
<tr>
<th>Date of Board Meeting</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<tr>
<td>23 January 2013</td>
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<tr>
<td>27 February 2013</td>
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<td>27 March 2013</td>
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<td>14 October 2013</td>
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<tr>
<td>27 November 2013</td>
<td>18 November 2013</td>
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<tr>
<td>No December Meeting</td>
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</table>

### FINANCE & PERFORMANCE REVIEW COMMITTEE/FINANCE & PROPERTY COMMITTEE

Meets six times a year normally on the second Wednesday of alternate months, at 9:00 a.m. in Meeting Room 7 at Waverley Gate.

<table>
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<tr>
<th>Date of Meeting</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<tr>
<td>13 February 2013</td>
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<td>1 April 2013</td>
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<tr>
<td>12 June 2013</td>
<td>3 June 2013</td>
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<tr>
<td>To be confirmed</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>9 October 2013</td>
<td>30 September 2013</td>
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<tr>
<td>11 December 2013</td>
<td>2 December 2013</td>
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</table>
STAFF GOVERNANCE COMMITTEE

Meets four times a year normally on the fifth Wednesday at 9:30 a.m. in Meeting Room 7 at Waverley Gate

<table>
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<tr>
<th>Date of Meetings</th>
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<td>31 July 2013</td>
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<tr>
<td>30 October 2013</td>
<td>21 October 2013</td>
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HEALTHCARE GOVERNANCE COMMITTEE

Meets six times a year normally on the first Tuesday of every second month from 9:00 a.m. - 12:00 noon in Meeting Room 7 at Waverley Gate

<table>
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<th>Date of Meeting</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<tr>
<td>3 December 2013</td>
<td>18 November 2013</td>
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AUDIT & RISK COMMITTEE

Meets five times a year normally on the last Tuesday of every second month at 9:00 a.m. in Meeting Room 7 at Waverley Gate

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<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<tr>
<td>26 February 2013</td>
<td>14 February 2013</td>
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<td>30 April 2013</td>
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<tr>
<td>17 December 2013</td>
<td>5 December 2013</td>
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* Annual Accounts Meeting.

OPERATIONAL AUDIT SUB-COMMITTEE

Meets five times a year normally on the last Monday of every second month at 9:30 a.m. in Meeting Room 7 at Waverley Gate

<table>
<thead>
<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<tr>
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<td>19 September 2013</td>
</tr>
<tr>
<td>25 November 2013</td>
<td>14 November 2013</td>
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</table>
SERVICE REDESIGN COMMITTEE
Meets five times a year normally on the third Monday of every second month at 2:00 p.m. in Meeting Room 7 at Waverley Gate

<table>
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<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<td>10 October 2013</td>
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<tr>
<td>16 December 2013</td>
<td>5 December 2013</td>
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MUTUALITY & EQUALITY GOVERNANCE COMMITTEE
Normally meets four times a year on the third Tuesday at 2:00 p.m. in Meeting Room 8 at Waverley Gate.

<table>
<thead>
<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - 9:00 a.m. on:</th>
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<tbody>
<tr>
<td>19 February 2013</td>
<td>7 February 2013</td>
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<td>19 November 2013</td>
<td>7 November 2013</td>
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REMUNERATION COMMITTEE
Normally meets five times a year on a Monday at 10:00 a.m. in Meeting Room 8 at Waverley Gate.

<table>
<thead>
<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - noon on:</th>
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<tr>
<td>12 February 2013</td>
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<td>2 July 2013</td>
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JOINT BOARD OF GOVERNANCE
Meetings are held every two months on a Monday at 3:00 p.m. usually in Meeting Room 7 at Waverley Gate.

<table>
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<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - noon on:</th>
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<tr>
<td>18 February 2013</td>
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ORGAN DONATION COMMITTEE

Normally meets four times a year on a **Thursday** at **2:00 p.m.** in **Meeting Room 8 at Waverley Gate**.

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<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - noon on:</th>
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<td>11 July 2013</td>
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<td>26 September 2013</td>
<td>12 September 2013</td>
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SOUTH EAST AND TAYSIDE REGIONAL PLANNING GROUP UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board that they note the progress that is being made through the South East and Tayside regional planning group.

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 information provided within the paper in relation to specific issues as they relate to NHS Lothian.

2.2 To note that the attached information is not exhaustive and is only a snap shot of the SEAT work plan. Additional briefing is provided in Annex 1 on a range issues currently being progressed.

3 Discussion of Key Issues

3.1 The Chair of SEAT has now moved to the Chief Executive of NHS Borders.

3.2 The Chair, along with the other Board Chief Executives are reviewing the current and future work plan.

3.3 Areas of work that are in development are in relation to regional cardiac planning following the completion of a number of national reviews, particularly trans aortic value implantation for which NHS Lothian has submitted a bid to host this service nationally.

3.4 Neonatal services – standards on the delivery of neonatal services are due to be published by the Scottish Government in the next month or two. NHS Lothian along with its SEAT partners have been reviewing the implications of the standards and the work that would be required to meet the standards once published. NHS Lothian has three facilities that would be affected by the application of the standards at St John’s Hospital, the Royal Hospital for Sick Children and at the Royal Infirmary of Edinburgh.
3.5 Learning disability and complex care needs. Significant work is now being driven forward in relation to taking forward the initial outputs from the SEAT work stream. A new commissioning model is being developed and complements the work that is now underway within Lothian in relation to inpatient and also community based learning disability services, as well as out of area placements. A further update on this can be brought to the Board but will also be ‘developed’ through the re-provision of the Royal Edinburgh Hospital.

3.6 Reshaping the medical workforce. This is a key work strand given medical workforce pressures that are and have been identified not just within NHS Lothian but regionally and nationally. This is a standing item on the SEAT meeting and will be discussed again on the 28th September. This will include work on paediatric workforce development.

3.7 In terms of future planning, work is commencing in relation to the publication of national reports into bariatric surgery and weight management; spinal – muscular skeletal review and vascular review. Each of these reports had a recommendation that the work be taken through regional planning groups and the Director of Regional Planning is now taking this forward. Colleagues from NHS Lothian are participating given the significant service delivery that we provide in each of these areas.

4 Key Risks

4.1 Partnership working is a key element of ensuring the successful delivery of the projects/works strands highlighted above. The work of the Interim Director with others is to ensure that we have an agreed work plan and that we minimise any risk to progress not being made and in turn maximise the opportunities offered through regional working.

5 Risk Register

5.1 Boards will be expected to record any issues as appropriate within their own risk register

6 Impact on Inequality, Including Health Inequalities

6.1 The thrust of all of the work streams identified above will be to either reduce inequalities or drive improvements in the delivery and access of care and treatment. No individual equality impact assessment has been undertaken in respect of writing this paper as this is simply highlighting and commenting on existing work streams.

7 Involving People

7.1 Within individual work streams people will be involved in the shaping of any proposals but also in any consultation that may be required in respect of any proposed changes to service delivery.
8 Resource Implications

8.1 The resource implications are none in respect of the writing of this paper which has simply acted to provide further information in respect of work already underway and fully supported.

Alex McMahon
Director of Strategic Planning and Primary Care
11 September 2012
Alex.mcmahon@nhslothian.scot.nhs.uk
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>Reference</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>CEL 19 (2012)</td>
<td>Trafficking in Human Beings</td>
<td>20/06/2012</td>
<td>D of Hr &amp; OD</td>
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<tr>
<td>3</td>
<td>CEL 22 (2012)</td>
<td>Staff Governance Standards: A Framework for NHSScotland Organisations and Employees</td>
<td>26/06/2012</td>
<td>D of HR &amp; OD</td>
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<td>4</td>
<td>PCA(P)(2012)11</td>
<td>Pharmaceutical Services: Amendment to Annex A: Discount Clawback Scale for priority Drugs</td>
<td>28/06/2012</td>
<td>D of F</td>
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<td>5</td>
<td>SGHD/CMO(2012)4</td>
<td>Human Papilloma Virus (HPV) Immunisation Programme 2012/13</td>
<td>04/07/2012</td>
<td>DPH</td>
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<td>6</td>
<td>CEL 23(2012)</td>
<td>Metal on Metal Hip Replacement – Monitoring Arrangements.</td>
<td>04/07/2012</td>
<td>MD</td>
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<td>8</td>
<td>CEL 25(2012)</td>
<td>NHSSCOTLAND Mobile Data Protection Standard</td>
<td>13/07/2012</td>
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<td>CMO(2012)6</td>
<td>Seasonal Influenza Vaccination Programme</td>
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<td>Recruitment to Salaried General Dental Practitioners Posts</td>
<td>01/08/2012</td>
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<td>Review of NHSScotland Pin Policies</td>
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<td>Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy</td>
<td>01/08/2012</td>
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<td>SGHD/CMO(2012)8</td>
<td>Guidance on Legal Issues Relevant to Donation Following Cardiac Death</td>
<td>03/08/2012</td>
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<td>Medical Revalidation: Annual Appraisal Documentation</td>
<td>03/08/2012</td>
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<td>PCA(P)(2012)12</td>
<td>Community Pharmacy Contract: Infrastructure Support – Staff Training</td>
<td>18/07/2012</td>
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<td>16</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>
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<td>PCA(O)(2012)4</td>
<td>General Ophthalmic Services 1. Increase in the Continuing Education and Training Allowance. 2. Increase in the Pre-registrations Supervisors Grant. 3. Revised Statement</td>
<td>9/08/2012</td>
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<td>Delivering Waiting Times</td>
<td>8/08/2012</td>
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<td>SPPA 06/2012</td>
<td>Annual Returns &amp; Tax Charges</td>
<td>13/08/2012</td>
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<td>21</td>
<td>PCA(P)(2012)014</td>
<td>Community Pharmacy services: Drugs tariff remuneration arrangements community migration shadow fees, payment supplement &amp; CMS capitation payments 1-July – 30 September 2012</td>
<td>29/8/2012</td>
<td>DSP&amp;PC</td>
</tr>
</tbody>
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Douglas Weir  
Corporate Services Manager  
20 September 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