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

AGENDA

Welcome to Members of the Public and the Press
Apologies for Absence

1. Items for Approval

1.1. Minutes of the Previous Board Meeting held on 27 November 2013  BH *
1.2. Workforce Risk Assessment  DF *
1.3. Performance Management  AMcM *
1.4. Healthcare Associated Infection Update  MJ *
1.5. Corporate Risk Register  DF *
1.6. Corporate Objectives  AMcM *
1.7. Health & Social Care Integration in East Lothian - Update on Shadow Board Arrangements  DAS *
1.8. Committee Membership  TD *
1.9. Audit & Risk Committee - Minutes of the Meeting held on 9 December 2013  JB *
1.10. Finance & Resources Committee - Minutes of the Meeting held on 18 December 2013  GW *
1.11. Healthcare Governance Committee - Minutes of the Meeting held on 3 December 2013  MB *
1.12. Strategic Planning Committee - Minutes of the Meetings held on 29 November & 13 December 2013 and 9 January 2014  BH *
1.13. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meetings held on 31 October & 19 December 2013  MA *
1.14. Edinburgh Shadow Health & Social Care Partnership Sub-Committee - Minutes of the Meeting held on 20 December 2013  RH *
1.15. Midlothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 28 November 2013  PJ *

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

For further information please contact Peter Reith, ☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
2. Items for Discussion (subject to review of the items for approval) (9:45am - 12:00pm)

2.1. Unscheduled Care MJ *
2.2. Waiting Times Performance, Progress and Elective Capacity Investment JC *
2.3. Delivering for Patients JC *
2.4. Scheduled Care Access Policy JC v
2.5. Quality Report DF/MJ *
2.6. Financial Position to 31 December 2013 SG *
2.7. Developing the Royal Victoria Hospital MJ *
2.8. Integration Process and Milestones: Public Bodies (Joint Working)(Scotland) Bill AMcM *
2.9. Creation of the Acute Hospitals Committee BH *

3. Next Development Session: Wednesday 5 March 2014 at 9:30 a.m. in the Boardroom, Waverley Gate.

4. Next Board Meeting: Wednesday 2 April 2014 at 9:30 a.m. in the Boardroom, Waverley Gate.

5. Resolution to take items in closed session

6. Minutes of the Previous Private Meeting held on 27 November 2013 BH ®

7. Matters Arising

8. Local Delivery Plan AMcM ®


10. Draft Strategic Plan AMcM ®

11. Any Other Competent Business

Board Meetings in 2014

<table>
<thead>
<tr>
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<tr>
<td>2 April 2014</td>
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<td>25 June 2014</td>
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<td>6 August 2014</td>
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Development Sessions in 2014

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<td>5 March 2014</td>
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<tbody>
<tr>
<td><strong>Medical Workforce Risk Assessment (26/06/13)</strong></td>
<td>AMcM</td>
<td>March 2014</td>
<td>Work under way. Staff and process agreed. Strategic Planning Committee met for the first time on 23\textsuperscript{rd} October. Monthly committee meetings and a Board Development session on the 17\textsuperscript{th} December.</td>
<td>In Progress</td>
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<td>• Strategic Plan to come to Board by March 2014.</td>
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<tr>
<td><strong>Renewing NHS Values (24/07/13)</strong></td>
<td>AMcM</td>
<td>TBC</td>
<td>The Associate Director of Workforce is leading on this process.</td>
<td>In Progress</td>
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<td>• Arrange engagement sessions for service teams.</td>
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<tr>
<td>• Development of the Implementation Plan to be included as a separate Board seminar.</td>
<td>AMcM</td>
<td>TBC</td>
<td>The Associate Director of Workforce is leading on this process.</td>
<td>In Progress</td>
</tr>
<tr>
<td><strong>Little France Campus Redevelopment (24/07/13)</strong></td>
<td>SG</td>
<td>January 2014</td>
<td>Workshop held with Consort and Lenders advisors and template Supplemental Agreement now agreed.</td>
<td>Completed</td>
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<tr>
<td>• Continue dialogue with Consort and their lenders with an objective of achieving betterment for future Supplemental Agreement.</td>
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<tr>
<td><strong>NHS Lothian Homeopathy Service</strong></td>
<td>AMcM</td>
<td>1 April 2014</td>
<td>Possible judicial review.</td>
<td>April 2014</td>
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<tr>
<td>• Cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014.</td>
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<td>• Arrange training for Board members on the interpretation of data focusing on meaningful outcomes.</td>
<td>SJM</td>
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<td>Action Required</td>
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<td><strong>Quality Report (23/10/13)</strong></td>
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<td>• Provide Healthcare Governance Committee briefing on stroke to all Board members.</td>
<td>MJ</td>
<td>January 2014</td>
<td>Distributed on 13 January 2014.</td>
<td>Completed</td>
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<tr>
<td><strong>Scottish Public Services Ombudsman Case 201200092 (23/10/13)</strong></td>
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<td>• Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance.</td>
<td>SRW</td>
<td>April 2014</td>
<td>A quarterly Customer Relations and Feedback Quality Report now goes to the Board that goes into detail about complaints, trends and actions. Feedback form the Short Life Working Group examining the future handling of complaints will be discussed at the Healthcare Governance Committee in March and come to the next Board meeting thereafter.</td>
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<td><strong>Winter Plan (23/10/13)</strong></td>
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<td>• A multidisciplinary approach to be taken to winter publicity distribution arrangements.</td>
<td>SRW</td>
<td>December 2013</td>
<td>The Scottish Government took the lead on this issue and NHS Lothian is fully joined into the 2013/2014 campaign, the materials associated with it and the necessary actions required to promote the campaign using all available communication channels. We had a very good response on social media platforms.</td>
<td>In Progress</td>
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<td><strong>Unscheduled Care / Winter Plan (27/11/13)</strong></td>
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<td>• A written report to be submitted for future meetings.</td>
<td>MJ</td>
<td>February 2014 onwards</td>
<td>Written report will now be submitted routinely.</td>
<td>Completed</td>
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<tr>
<td><strong>Medical Workforce Risk Assessment</strong></td>
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<td>Action Required</td>
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<td>• Further consideration is needed in a future paper around overall developments, staffing, culture &amp; values and their impact on individual areas including service redesign.</td>
<td>DF</td>
<td>TBC</td>
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<td>• The development of Primary Care to feature in the February Board paper and would address issues around CHP engagement.</td>
<td>DF</td>
<td>February 2014</td>
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<td>Waiting Times Performance, Progress &amp; Elective Capacity Investment</td>
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<td>• Further work needs to be undertaken around Psychological Therapies. A progress report to be made to the February Board meeting.</td>
<td>JC/JF</td>
<td>February 2014</td>
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Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 27 November 2013 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Executive Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mr J Crombie (Director of Scheduled Care); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Mrs M Hornett (Director of Unscheduled Care and Executive Nurse Director) and Professor A K McCallum (Director of Public Health and Health Policy).

Non-Executive Directors: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mr J Brettell; Dr M Bryce; Councillor D Grant; Councillor R Henderson; Professor J Iredale; Mr P Johnston; Councillor C Johnstone; Mr A Joyce (Employee Director); Mrs A Meiklejohn; Mrs A Mitchell; Councillor F Toner; Mr G Walker; Mr G Warner; Dr R Williams and Mr R Wilson.

In Attendance: Mrs S Ballard-Smith (Nurse Director); Mr J Forrest (Director of West Lothian Community Health and Care Partnership); Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information); Mrs E McHugh (Director of Health and Social Care Partnership Midlothian); Dr S Mackenzie (Medical Director for Quality Improvement for item 111); Mr J Paul (Management Trainee shadowing Mr Boyter); Mr D A Small (Director of Health and Social Care East Lothian); Mr D Weir (Corporate Services Manager); Mr N Wilson (Unscheduled Care Manager shadowing Mrs Hornett) and Mr S R Wilson (Director of Communications and Public Affairs).

Apologies for absence were received from Mrs K Blair, Mrs J McDowell and Mr G Warner. In an addition an apology from a non Board member was received from 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.

104. Welcome to Members of the Public and Press

104.1 The Chairman welcomed members of the public and press. He also welcomed Mr J Crombie, Director of Scheduled Care to his first formal Board meeting. The Chairman further welcomed Mr N Wilson, Unscheduled Care Manager who was shadowing Mrs Hornett and Mr J Paul, Management Trainee who was shadowing Mr Boyter to the meeting.
104.2 The Board welcomed a number of Health Administration students and teaching staff from Edinburgh Napier University who were in the public gallery.

105. **Items for Approval**

105.1 The Chairman advised the agenda for the current meeting had been circulated to Board members to scrutinise the papers and to advise whether any items should move from the approval to the discussion section of the agenda. It was noted that there had been no requests in this regard.

105.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the approval papers without further discussion: -

105.3 Minutes of the Previous Board Meeting held on 23 October 2013 – Approved.

105.4 **Performance Management** – The Board received the update on the current performance against a selection of 2013/14 Health, Efficiency and Treatment targets as set out in appendix 1. The Board noted that following discussion at its meeting on 25 September 2013, performance reporting to the Board and the Joint Management Team had been developed to improve alignment with the quality, Health Associated Infection, waiting times and Unscheduled Care Report, and to reduce duplication.

105.5 The Board noted that on a monthly basis the following HEAT targets and standards would be reported within the respective reports:

- Unscheduled Care
- HAI Report
- Quality Report
- Waiting Times Report
- Drug and Alcohol Waiting Times

105.6 The Board further noted that the NHS Lothian Internal Audit function had recently completed an audit of performance targets and reporting. The final report made recommendations to strengthen this report. The overall report had been marked ‘satisfactory’.

105.7 **Health Care Associated Infection Updated** – The Board agreed the following recommendations:

- Acknowledge receipt of the HAI reporting template for October 2013.

- Noted there were 25 episodes of staphylococcus aureus bacteraemia during October 2013 giving a current rate of 0.30 per 1000 bed, and this reflects performance outwith projected aim of 0.24 per 1000 bed days by March 2015.

- Supported staff to improve the clinical management of invasive devices in accordance with NHS Lothian and patient safety standards.
• Noted there were 52 episodes of clostridium difficile infection during October 2013 giving a current rate of 0.56 per 1000 bed days, and this reflects performance outwith projected aim of 0.32 per 1000 bed days by March 2015.

• Support the antimicrobial team activities in relation to antimicrobial prescribing review and reduction of antimicrobials associated with clostridium difficile.

105.8 The Human Resources and Organisational Development Strategy Annual Report – The Board noted the position achieved in respect of the Human Resources Strategy (appendix 1) from November 2012 – 2013 and the key achievements.

105.9 Finance and Resources Committee – Minutes of the meeting held on 9 October 2013 – Approved.

105.10 Staff Governance Committee – Minutes of the meeting held on 30 October 2013 – Approved.

105.11 Strategic Planning Committee – Minutes of the meeting held on 23 October 2013 – Approved.

105.12 East Lothian Community Health Partnership Sub-Committee – Minutes of the meeting held on 5 September 2013 – Approved.

105.13 Edinburgh Shadow Health and Social Care Partnership – Minutes of the meeting held on 18 October 2013 – Approved.

105.14 Midlothian Community Health Partnership Sub-Committee – Minutes of the meeting held on 26 September 2013 – Approved.

105.15 West Lothian Health and Care Partnership Sub-Committee – Minutes of the meeting held on 17 October 2013 – Approved.

105.16 West Lothian Health and Care Partnership Board – Minutes of the meeting held on 8 October 2013 – Approved.

Items for Discussion

106. Chairman’s Opening Remarks

106.1 The Chairman commented he had been reflecting on his first 6 months in post and it was noted during this period there had been changes to the Board meeting processes and the issuing of agendas. He commented the more familiar he had become with the context of the Board agenda the more he appreciated the high level of inter-dependence and inter-relationship around the topics discussed and this was sometimes not fully appreciated at the meeting.

106.2 The Chairman stressed the need for the Board to recognise the tight degree of hairline tolerance in place around the need to meet targets and crucially balance the books. In that respect it was important to take a holistic view of issues and avoid looking at individual separable areas. He felt such an approach would help
to avoid recurrence of previous errors of history. The Chairman stressed for the fundamentally crucial areas discussed at Board meetings the issue was not about marginal improvement but about making paradigm shifts.

107. Unscheduled Care / Winter Plan

107.1 The Director of Unscheduled Care commented the Board had undertaken a thorough discussion of this item at its previous meeting hence the verbal report. She commented however when the Board moved to bi-monthly meetings a formal written report would be submitted.

107.2 The Board noted during October 4 hour access compliance had been 94%. Stroke performance had improved to 84% and the delayed discharge position had worsened although it was anticipated there would be a slight improvement in November although this area still remained a major challenge.

107.3 The Board noted winter had arrived early and already there were outbreaks of norovirus. The Director of Unscheduled Care advised extra beds had been opened at short notice with a whole ward at the Royal Victoria Hospital having been opened in advance of the anticipated date. The Board were advised that the currently closed 10 orthopaedic beds at the Royal Infirmary of Edinburgh would be reopened the following week and this would improve the elective and unscheduled care position.

107.4 The Director of Unscheduled Care advised the winter planning process was on track and clarity was now in place in respect of the scheduled programme over the festive period. It was noted this work would include the availability of social work over the key festive days to ensure there was no avoidable dip in performance moving into the New Year. The Director of Unscheduled Care commented already discussions were in place about scaling down extra beds after the winter period to avoid downstream consequences around service provision and finances.

107.5 The Board noted in respect of delayed discharges the Edinburgh position continued to be the main pressure and direct leadership focus was being applied to this through weekly meetings with the Chief Executives of both NHS Lothian and the City of Edinburgh Council and other senior colleagues.

107.6 Mr Brettell commented the report had been reassuring and he would welcome a short written summary in future. He questioned what the biggest current concern was. The Director of Unscheduled Care advised managing the day to day bed capacity to balance scheduled and unscheduled care in order to get patients treated was the key issue.

107.7 The Board noted the update report on unscheduled care / winter planning.

108. Medical Workforce Risk Assessment

108.1 The Medical Director advised in respect of emergency medicine that clinical development fellows had been in post since August and there had been no
concerns about patient safety. There was evidence the service had been enhanced through the use of emergency nurse practitioners on a 24/7 basis and the availability of a consultant until 11pm. It was noted there had been no increase in patients transferred from St Johns Hospital. The Board noted further clinical development fellows would be appointed in August 2014 with the advertisements being posted in January 2014. The Medical Director advised that the model adopted to resolve issues in emergency medicine was being considered for use elsewhere. He drew the Board’s attention to the Edinburgh Emergency Care Website which was being used to raise worldwide attention to vacancies and improve recruitment and again commented this approach might well be replicated for other service areas.

108.2 The Medical Director reported in respect of paediatrics the situation was slightly less stable than in the previous month and advised that 1 consultant was leaving his post with plans in place for his replacement. It was noted there was also an increase in sickness levels although the December rota was secure. The Medical Director advised the recommendations of the Tailored Workforce Support Team (TWST) report in respect of the use of advanced nurse practitioners continued to be progressed.

108.3 The Board noted the two successful candidates from Myanmar had now started in post and were undertaking local induction and orientation programmes. It was anticipated it would be 3 – 4 months before they were able to work to their full potential.

108.4 The Board noted in respect of obstetrics and gynaecology a Short Life Working Group had been established to address Lothian and regional issues with there being particular concerns around maternity gaps. In anaesthetics the Associate Medical Director was actively speaking to trainees to ensure they were aware of Lothian employment opportunities at the end of their 6 month training period.

108.5 The Medical Director advised for the first time Primary Care featured in the report although there had been challenges in obtaining data although he felt it was important to give an indication of direction of travel and the challenges needed to address issues.

108.6 The Board was advised Lothian continued to input into national debate around medical manpower and noted there had been a pause in the reduction in trainee numbers and in some instances trainee numbers had been increased in specialties experiencing specific difficulties. The Medical Director commented in the Board paper he had attempted to show the progress being made to make Edinburgh an attractive place for medical staff to work.

108.7 The Board noted of the 135 FY1 doctors in Lothian only 48% were Edinburgh graduates and this opened an interesting dynamic about how best to ensure young doctors stayed in Lothian. It was noted the Government response to the Greenaway Report was awaited although it was anticipated a working group would be established to take forward and implement its recommendations.

108.8 Councillor Toner commented he welcomed the positive progress report especially around emergency medicine. In response to Councillor Toner the Medical Director
reiterated details of work around the TWST Report recommendations particularly in respect of training advanced neonatal and nurse practitioners.

108.9 Dr Bryce commented she welcomed the comprehensive report which had addressed risk assessment although it would be useful to see this expanded into a multi factorial workforce risk assessment. She felt within the United Kingdom there was a perfect storm brewing in respect of medical recruitment and it would therefore be useful to look at alternative methods of providing cover across the system. She commented it was important to recognise the system was under pressure and it would be useful to obtain qualitative data to test staff stress levels particularly in demanding and pressurised areas. The Medical Director agreed commenting in the fullness of time the title of the paper might need to change to reflect issues like this and service redesign.

108.10 The Director of Human Resources and Organisational Development advised modern healthcare was delivered by teams and he and the Director of Unscheduled Care had started to undertake a risk analysis on other professions in order to look at the risk of clinical and other staff groupings. It was noted the national staff survey had been held in June and the data was currently being cleansed with the outcomes expected in December at which point they would be discussed with the Health Care Governance and Staff Governance Committee prior to being brought back to the Board.

108.11 Professor Iredale commented he felt the approach taken to resolving the emergency medicine position exemplified the points made by the Chairman in his introductory comments. He commented it would be important to move the organisation from a standard model to looking at safe effective models to deliver on patient outcomes and safety. He felt the flexibility of the model used in emergency medicine should be the approach adopted for future. Professor Iredale commented although the medical recruitment position was currently difficulty he felt that Edinburgh and the Lothian’s had opportunities to recruit medical staff and available data suggested Lothian was still an attractive workplace.

108.12 Mr Walker commented in terms of learning experiences he would welcome information about redesign work across services particularly in respect of at risk areas. He advised he was aware consultant job plans were being reviewed. Mr Walker advised through the patient safety walkabouts a common theme was staff did not feel consulted and engaged with and people felt the service was done to them rather than being part of its development. He commented however he appreciated the good work being undertaken by the Medical Director.

108.13 Mrs Mitchell commented whilst much of the debate was around challenges at national / regional levels it would be important not to lose focus on factors that could be controlled locally. She commented she would welcome some comfort from management about what was being done on the ground around culture and values particularly in respect of obstetrics and gynaecology without waiting on the national approach.

108.14 The Chief Executive commented the establishment of the Short Life Working Group referred to by the Medical Director was about local actions with additional discussion being held on a regional basis. He commented in respect of complex
cases the main focus was around the Simpson Memorial Maternity Pavilion. He commented in respect of obstetrics there were three different rota in place in Lothian and explained these to the Board. He commented Mr Walker at the previous meeting had talked about the need to avoid a two tier workforce in Lothian and he stressed that changing extant rota agreements for consultants would require agreement if changes were to be made. He commented part of work of the Short Life Working Group would be to address and entice the obstetrics workforce to adopt a flexible approach and rotate through the Simpson Memorial Maternity Pavilion. The Chief Executive commented as previously stated NHS Lothian would continue to influence the national debate and confirmed the point made by the Medical Director that the National Reshaping Medical Workforce Committee was proposing an increase in training posts in some areas. He felt success in the future would require voluntary shifts in peoples work patterns.

108.15 The Medical Director commented in his discussion with senior clinicians he had stressed to them they were best placed to advise on how to run the service and it was his firm intention to engage with frontline staff without imposing solutions upon them.

108.16 The Chairman commented he felt further consideration was needed around overall developments, staffing, culture and values and their impact on individual areas including service redesign. He asked for a future iteration of the Board paper to provide feedback on how to improve focus in these areas.

108.17 The Chief Executive commented reports to the Board still focussed on silos and referred back to the need to be aware of inter relationships and interdependencies as referred to in the Chairman’s opening remarks. He commented the key priorities for the Board to address were around patient safety and experience; access to emergency care; access to elective care and meeting the treatment time guarantee; improving the culture and reinforcing values as well as meeting financial targets.

108.18 The Chief Executive advised a recent visit to the acute receiving ward at the Western General Hospital had highlighted to him issues around inter relationships and interdependencies and the fact changes in one area impacted elsewhere and this demonstrated the need for a multifactorial approach. He commented along with the Chairman and the Corporate Management Team he was considering how to address and report issues to the Board in a more holistic manner. He commented it was clear staff at the front door of the service were working under huge pressures and this potentially compromised the organisations values.

108.19 The Director of Unscheduled Care advised workforce redesign would develop through the clinical strategy and agreed with the need for this to be multi-factorial. The Director of Finance commented in future the focus of efficiency and productivity would be around service redesign and this would be picked up in the workshop seminar to be held following the Board meeting.

108.20 Dr Williams commented he was pleased to see reference to primary care although he felt there was a need to be cautious about the data as it only represented a percentage of practices. He commented primary care was experiencing the same demands and pressures as the acute sector and commented changes in pension
arrangements and seniority payments would mean a number of more senior
general practitioners would leave the service and this required to be factored into
workforce planning. The Board noted Dr Williams and Dr Bryce would be
participating in a pilot patient safety walk around in a GP practice later in the week
and it was hoped to roll out this approach.

108.21 Mr Ash commented he felt it was equally important to ensure a primary care
strategy was developed in conjunction with Community Health Partnerships
(CHPs). The Medical Director advised the development of the primary care
strategy would feature in the February Board paper and would also discuss issues
around CHP engagement.

108.22 The Board agreed the recommendations contained in the Medical Workforce Risk
Assessment Report.

109. Waiting Times Performance, Progress and Elective Capacity Investment

109.1 The Medical Director advised the Board report compared the current position in
respect of waiting times with that experienced 18 months previously. He advised in
respect of inpatients and day cases good progress was being maintained. The
Board noted the Director of Scheduled Care would be presenting NHS Lothian’s
plan to the Scottish Government Health Directorates in January and he would be
responsible for presenting the Waiting Times Report to the Board in future.

109.2 The Medical Director advised the position in respect of outpatient waiting times was
not showing the same positive reduction as for inpatients and day cases. He
commented however significant and remarkable reductions had been made in
neurology. The Board noted the recommendations of a previous internal audit
report had been implemented and a significant number of staff had been trained in
Standing Operating Procedures around waiting times.

109.3 The Board noted there had been improvements in diagnostic performance with
further improvements expected in November in respect of surveillance endoscopy.
It was noted provisional information suggested the reducing trend which was
absent in the previous month had recommenced and would continue.

109.4 The Board noted in respect of Child and Adolescent Mental Health Services
(CAMHS) and psychological therapies there continued to be challenges around
CAMHS services which were not yet on target. In respect of psychological
therapies there was a need for further work to be undertaken in respect of
producing full data. A progress report on this would be provided to the February
Board meeting.

109.5 The Director of Scheduled Care commented in terms of performance delivery it
was clear to him people needed to work smarter and in a more focussed way. He
advised he had a vision of what a sustainable recovery plan would look like with
this being delivered on a phased basis to give assurance to both the Board and the
Scottish Government Health Directorate about its sustainability.
109.6 Dr Bryce welcomed the comprehensive paper and noted the further advice around progress being made to improve psychological therapies and looked forward to the further update in the New Year. The Vice Chair commented she had noted the increase in referrals to the CAMHS service and commented the situation was deteriorating. She felt the February timeline was a long way off if people were waiting for referral to the service. She of was of the view the solution needed to be joined up with Medical Workforce and should also recognise pressures on GPs.

109.7 The Chief Executive commented for a number of years CAMHS and psychological therapy services had not had the same status as acute targets. He commented now the national target was in play it would be important to take a holistic approach to meeting the requirements which would include working with primary care to manage referrals as history proved when capacity became available then demand increased. It was noted the Director of West Lothian Community Health and Care Partnership was undertaking work around psychological therapies with a policy decision having been taken to treat long waiters in the first instance and this might have an adverse impact on the 18 week target until the tail of waiters had been addressed. It was noted primary care referral management and priorities would be important moving forward. It was noted once the initial tranche of work had been undertaken acute psychiatry and emergency admission patients would then become the priority.

109.8 The Director of West Lothian Community Health and Care Partnership provided the Board with a detailed explanation of the work he was undertaking in this important area. He commented he continued to meet with service leads on a monthly basis in order to ensure they were fully engaged in discussion around how best to redesign the service. He commented the most recent data which had not been available in time for inclusion in the Board paper showed performance improvement. He advised he would welcome raising the profile of this service within primary and community care.

109.9 The Board received the update on performance and progress on inpatient, outpatient and other waiting times.

110. Quality Report

110.1 The Medical Director reminded the Board of recent adverse media attention around theatre incidents and safety in theatres. He reassured the Board this issue had already been discussed at the Health Care Governance Committee. He commented this was a serious and major concern although he commented the system had demonstrated a willingness to escalate incidents and have these fully investigated. He advised 1200 theatre staff would be involved in Human Factors based training.

110.2 The Chairman commented he had been impressed at a meeting he had attended the previous week where one of the consultants involved had given a candid overview of his involvement in the incident referred to by the Medical Director and had openly shared his personal responsibility, distress and suffering around the incident. The consultant had fully endorsed rolling out training and for the issue to be discussed openly with colleagues.
110.3 Dr Mackenzie commented there had been considerable interest around Hospital Standardised Mortality Ratios (HSMR) data and more information would be included on this in the next Board report and at the Board Development Session in January.

110.4 The Board noted the Quality Report focussed on diabetes and this was a major health issue in respect of managing new cases as well as reducing the incidents of rates of rise of diabetes moving forward in conjunction with public health. The current performance in respect of managing blood pressure and blood glucose was explained to the Board although it was stressed this approach was not the best for everyone. It was noted NHS Lothian was behind trajectory in respect of meeting Scottish Intercollegiate Guidelines Network (SIGN Guidelines) which it was stressed were aspirational. Dr Mackenzie advised diabetologists were holding a national conference in order to discuss how better to manage the condition.

110.5 The Director of Public Health and Health Protection advised consideration of preventative spend was also important as was addressing societal issues. Dr Bryce commented this was a really important point and commented the links with obesity and type 2 diabetes were well known. The Director of Finance advised around £140m of resources was spent on people with a diabetes diagnosis.

110.6 Mr Brettell commented he was not sure what the take away message from the report was particularly in respect to references that although Lothian was not meeting targets it was no worse than elsewhere in Scotland. Dr Mackenzie commented whilst it was correct to state NHS Lothians performance was typical of the Scotland wide position the report did not intend to suggest this was a satisfactory position and it would be important not to be complacent. He commented however if more detailed analysis of the data was undertaken then there were a number of areas where Lothian performed well. Mr Brettell commented the current report suggested to him that diabetes was a red flag performance area.

110.7 The Director of Public Health and Health Policy commented almost all of the drivers of type 2 diabetes were preventable and were currently moving in the wrong direction from a societal perspective. She commented whilst maintaining the current position in the short term might be acceptable this would not be the case moving forward. She suggested this was an issue that might be addressed further through the finance seminar to be held later in the day.

110.8 Mr Walker welcomed the introduction of an inpatients survey to capture patient experience and requested this included a free text box where additional comments could be recorded. Dr Mackenzie advised this would be possible.

110.9 Professor Iredale commented he would like to reinforce the points raised by Mr Brettell. He felt it was vital the NHS Lothian approach remained highly aspirational and the challenge would be to benchmark against the best European and UK wide performance. He was of the opinion there was a need for a firm and immediate focus on prevention in respect of diabetes. The Director of Strategic Planning, Performance Reporting and Information advised a community planning seminar would be held the following week and diabetes featured as a significant agenda.
item. He commented there was a need to ensure strategic thinking was aligned to include the diabetes agenda.

110.10 Dr Mackenzie provided the Board with details of HSMR data figures which had been released the previous day as well as information around trend over time based on a 2006/07 baseline. He advised whilst none of the values were statistically significantly different from the Scottish average this was again not a reason for complacency. He commented work was underway in respect of one particular trend which was not comparable and the outcome of this would be reported back to the Board once the full facts were known.

110.11 Dr Mackenzie commented whilst there was current publicity around HSMR it was important to be mindful this was just one measure and it should be regarded as a part of a suite of performance data.

110.12 The Chief Executive commented the Board development session in January would be led by Dr Mackenzie and others and would take Board members through how best to interpret and interrogate data systems. It was noted a report on Lanarkshire HSMR issues would publish in the near future. The Chief Executive commented Board papers would in future require to become more action focussed.

110.13 The Board agreed the recommendations contained in the Quality Report.

111. Financial Position to 31 October 2013

111.1 The Chairman reminded the Board further work was being undertaken to get behind the detail of recent National Resource Allocation Committee (NRAC) and other allocation changes. The Board development session on finance to be held following the Board meeting would also consider in further detail.

111.2 The Director of Finance acknowledged Board members would be concerned to see the significant in-month adverse movement which was largely due to supplies, equipment and facilities. There had also been a reduction in the rate of the pay underspend as a consequence of more people becoming live on the payroll.

111.3 The Director of Finance advised she was not as was her normal practice specifically predicting a breakeven position at the end of the financial year until she understood the reason for the change in trend in month. She commented increasing activity levels and bed numbers would be part of the problem with the appendix to the paper showing increases in activity resource both externally and internally. The early onset of winter and increases in delayed discharges meant that 100 extra beds were now open and this had not been anticipated at this point.

111.4 The Board noted it was anticipated the prescribing overspend would level out albeit not as quickly as desired. The Director of Finance commented in respect of the facilities overspend a significant part of this related to increasing energy costs which would need to be reflected in the financial plan. The Board were advised the energy contract was negotiated and procured through national procurement. The Chief Executive commented there was a need for an energy awareness campaign in order to remind staff about the importance of basic housekeeping measures like
switching off lights and computers when not in use. The Board noted the Communications Team had recently won an award for their Power Pact Initiative. Dr Williams suggested lessons could also be learned from the Royal College of General Practitioners Scheme around environmentally friendly practices.

111.5 The Director of Public Health and Health Policy reported on national work to reduce carbon emissions and preliminary work looking at efficiency and productivity. It was noted the Director of West Lothian Community Health and Care Partnership was undertaking work from a community dental service perspective. Lessons would also be learned from Fife pilot work which had suggested that new buildings were not necessarily the most energy efficient. The Director of Finance commented in some instances spend to save schemes would be the way forward.

111.6 The Board noted there had been a slight improvement on LRP delivery with the year end forecast improving slightly in respect of slippage. The Director of Finance advised that finance managers were working with staff to look at opportunities to pull back spend whilst still supporting the service. A further update report would be discussed at the Finance and Resources Committee in December with finance being a major topic for discussion at the December Joint Management Team meeting.

111.7 Mr Wilson questioned whether it was intended to impose any recruitment constraints and whether there were opportunities to vire between capital and revenue. The Director of Finance advised the system was loosening up the recruitment process for existing posts. New posts however needed to come through an appropriate authority level. The Director of Finance felt there might be a need to have a more rigid approach around corporate posts. The Board noted there was potential for some virement around capital and consideration was being given to looking at planned maintenance spend although this work had yet to conclude and the benefit was not anticipated to be material.

111.8 The Board noted the Director of Finance’s report on the financial position and the further work that was being undertaken to understand the reasons for the in-month variation in trend.

112. Corporate Objectives Update

112.1 The Director of Strategic Planning, Performance Reporting and Information advised the paper reflected the mid year position against the corporate objectives. He commented 16 of the objectives were red with many of the issues having been discussed earlier in the meeting. It was noted in respect of the green achievements there was an element of subjectivity given the paper did not report on amber status objectives.

112.2 The Board noted the Corporate Management Team considered the corporate objectives on a monthly basis and ensured actions were in place to mitigate performance where necessary. It was noted the corporate objectives were considered at the Risk Management Steering Group chaired by the Chief Executive and where appropriate featured in the Corporate Risk Register.
112.3 Mrs Meiklejohn commented in respect of the reduction in staff assaults improvements were behind trajectory and she was aware of a recent Health and Safety Enforcement Notice. The Director of Human Resources and Organisational Development provided detailed background to the reasons for the enforcement notice having been issued advising that following an agreed 1 month extension to the timescale it had been confirmed back to the Health and Safety Executive that all actions had been completed. It was anticipated a follow up inspection would be made.

112.4 The Director of Human Resources and Organisational Development in respect of violence and aggression towards staff in general advised this was one of the main health and safety issues. It was noted in conjunction with the Director of Occupational Health revamped arrangements had been put in place to reduce such incidents and this was appropriate given one of the Boards corporate objectives was to reduce harm to staff.

112.5 The Nurse Director commended the work of the Violence and Aggression Team and their efforts and support in organising training on a flexible and often bespoke basis.

112.6 The Vice Chair reminded the Board of the importance of recognising the many examples of good practice already in place. She advised the Cabinet Secretary at a recent discussion around the 2020 vision had referenced the positive work undertaken by Lothian around the development of the toolkit.

112.7 The Board agreed the recommendations in the circulated report.

113. Any Other Competent Business

113.1 Celebrating Success – The Chairman commented had been an excellent event and it had been a privilege to spend time with the nominees and winners. He advised it had struck him how significant an impact event such as this had and he felt there would be benefit in considering further similar events.

113.2 It was noted a primary care practice in Muirieston, West Lothian had received a Royal College of General Practitioners award and it would be important to recognise such achievements and other examples of best practice.

113.3 The Director of Human Resources and Organisational Development commended the team who had arranged the Celebrating Awards event and advised he along with colleagues was looking at ways of augmenting such recognition events and details of this would be brought back to the Staff Governance Committee.

114. Date and Time and Next Meeting

114.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 5 February 2014 in the Boardroom, Waverley Gate, 2-4 Waterloo Place Edinburgh.
115. **Invoking Standing Order 15.2**

115.1 The Chairman sought permission to invoke Standing Order 15.2 to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke Standing Order 15.2.
SUMMARY PAPER - WORKFORCE RISK ASSESSMENT

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The focus of the paper has been widened to include other areas of the workforce in response to the request from board members.</td>
</tr>
<tr>
<td>3.21</td>
<td>Obstetrics &amp; Gynaecology – The recruitment process for two further consultant posts and two further specialty doctor posts (all with resident out of hours shifts in the job plans) for RIE is now complete, with the appointment of only one consultant. The second consultant post is being re-advertised and options for alternative solutions for the specialty doctor posts are being considered.</td>
</tr>
<tr>
<td>3.22</td>
<td>Paediatrics – One of the three new consultant posts at St John’s Hospital left in November and the recruitment process for a replacement has received no suitable applicants. Out of hours cover at St John’s Hospital remains fragile with a heavy reliance on small number of people doing additional night and weekend shifts.</td>
</tr>
<tr>
<td>3.24</td>
<td>The areas of Anaesthetics, Medicine of the Elderly, and Ophthalmology highlighted in last months paper are actively recruiting to vacancies. An update will be provided once these processes are completed.</td>
</tr>
<tr>
<td>3.25</td>
<td>An update on National planning to increase attractiveness of trainee posts is underway at a national level.</td>
</tr>
<tr>
<td>3.3</td>
<td>A Workforce risk assessment of Radiotherapy Medical Physics highlighted a lack of national planning and coordination of training. There is a high risk of being unable to recruit to specialised clinical scientist roles that are integral to service provision. The opening of the West of Scotland Satellite Cancer Unit, which will be recruiting new additional staff in 2014 represents a risk. Risks have been considered at a national Radiotherapy Event in September, a response from the Scottish Government is anticipated.</td>
</tr>
<tr>
<td>3.4</td>
<td>The nationally mandated nursing workload speciality and professional judgement tools were completed in September 2013 for all in patient areas. The initial work has demonstrated that midwifery services and in patient continuing care are of the most significant risk to the organisation.</td>
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</table>

Nick McAlister
Head of Workforce Planning
23 January 2014
WORKFORCE RISK ASSESSMENT

1 Purpose of the Report

The purpose of this report is to update the Board on the actions currently underway to ameliorate risks to service sustainability within specialties where high levels of risk have been identified. Whilst previous Board papers have focussed on medical workforce risks this and future papers will also consider workforce risk within the wider workforce.

2 Recommendations

2.1 Note that recruitment for 2 Consultants and 2 Specialty Doctors within O&G across St John’s and the RIE to help address acute staffing shortages at the RIE has resulted in only 1 Consultant level post being filled. The other Consultant post is being re-advertised and options for alternative solutions for replacement of the specialty doctor vacancies are being developed.

2.2 The staffing situation for the combined paediatric and neonatal service remains fragile, heavily reliant on a small number of people doing additional night and weekend shifts.

2.3 The areas of medical workforce risk identified within the Anaesthetic, Older People and Ophthalmology services in October are currently recruiting to trained doctor posts and further updates will be provided in the next Board paper once current recruitment exercises have been completed.

2.4 We await the Scottish Government response to the output of the National Radiotherapy Workforce Event in September which should set out a co-ordinated pan-Scotland approach to addressing radiotherapy workforce issues to avoid the potential destabilisation of services. NHS Lothian service leads need to be actively involved in this work.

2.5 The Board should be informed where the application of the mandated national nursing and midwifery workload and workforce planning tools highlight any particular areas of concern, including detail of how these are being addressed.

3 Discussion of Key Issues

3.1 Background

Since June 2013 a Medical Workforce Risk Assessment paper has been taken to the NHS Lothian Board to highlight the areas of high risk and the actions underway to reduce the level of risk. Over this time there have been on-going updates around Emergency Medicine, Paediatrics and O&G as these were identified as key areas of risk as part of the medical workforce risk assessment process.

Emergency Medicine(EM) are now no longer covered as an area of high risk following successful recruitment of additional trained doctors, the creation and recruitment of
clinical development fellow posts to support out of hours cover and the implementation of an updated model of care at St John’s Hospital (SJH). EM is no longer included as an area of high risk.

There has also been detail provided around other areas of significant risk in relation to recruiting significant staff to provide additional capacity and improve patient flow; Anaesthetics, Medicine of the Elderly (MoE) and Ophthalmology.

In November detail was also provided of the findings from the 2013 National Primary Care Workforce Survey and the workforce risks within the Lothian Unscheduled Care Service.

At the November 2013 Board meeting members asked for a widening in the focus of future papers to include workforce risks within the wider workforce also, reflecting the inter relationships and inter dependencies that exist. Consequently this paper will provide for the first time some initial background information of areas of workforce risk and challenge within Nursing, Health & Social Care Partnerships and small specialist areas within Healthcare Sciences.

3.2 Progress in addressing key medical workforce risks

3.2.1 Obstetrics & Gynaecology

The South East Scotland O&G training programme experiences a high level of gaps due to trainees going Out of Programme (OOP) for research/experience, maternity leave and less than full time working. This has resulted in increased internal locum usage and consultants covering resident middle grade OOH shifts several times a month with a consequent impact on day time availability. The numbers of gaps varies on a month by month basis and at the RIE it can be difficult to find competent external locums to provide cover.

Following expansion of the trained medical workforce in 2012 a further three consultant posts were recruited at the RIE in 2013 (these posts include out of hours resident shifts to compensate for loss of experienced trainees). Other recent appointments include a consultant gynaecologist at the RIE who will take up post in March 2014 and a further consultant gynaecologist working between SJH and RIE who will also commence in March 2014.

Within Obstetrics two further consultant posts and two further specialty doctor posts (all with resident out of hours shifts in the job plans) have also been under recruitment for the RIE. The outcome of which was that one consultant was appointed, however the second post was not filled and has been re-advertised. The specialty doctor recruitment has been unsuccessful, with only one individual recruited who subsequently withdrew. These results reflect a very competitive recruitment situation in obstetrics and gynaecology and the inherent undesirability of career grade posts with resident out of hours middle grade shifts in the job plan.

Given the importance of sustaining services at the SCRH for both Edinburgh and the South-East region as a whole a short life working group has been established to examine ways in which a regional approach could be taken to expand the trained workforce across the region considering sources in addition to local CCT holders and avoiding competition between Boards for a limited group of specialists. The initial meeting of the working group took place in early October and has identified a number of options to be taken forward. This was followed up at a SEAT Regional Demand
and Capacity Event where O&G was agreed as a key regional priority. Further information will be detailed in future papers.

Following a period of stability SJH now faces two maternity leave gaps in the middle grade registrar rota from early 2014 and two gaps in the GPST cohort. Plans for the recruitment of locums to cover the registrar gaps have been unsuccessful. One gap will be covered by extending a current LAS appointment and a second with an external agency locum. There will therefore be a continuing requirement for internal and external locum usage to sustain the two rotas.

3.2.2 Paediatrics

Gaps in middle grade registrar rotas caused by maternity leave, less than full time training and out of programme research continue to affect all paediatric and neonatal rotas in Lothian. To address these pressures there has been recruitment of an additional consultant and specialty doctor at SJH in addition to two new consultants appointed in 2012, two senior Clinical Fellows and two advanced neonatal nurse practitioners in neonatology at RIE, two junior Clinical Fellows shared between RHSC and RIE, a Clinical Fellow in Paediatric Intensive Care at RHSC and the consolidation into clinical practice of two advanced nurse practitioners in the paediatric intensive care unit at RHSC. An advanced nurse practitioner in paediatric and an advanced neonatal nurse practitioner are now established in the middle grade rota at SJH.

However one of the three new consultant paediatricians based at SJH resigned in November 2013 and there were no suitable applications as part of a recent recruitment exercise. Again this reflects the inherent unattractiveness of consultant posts with resident middle grade shifts in the job plan. There will however be continued efforts to recruit to this post.

From February there will be only four of the nine out of hours slots at SJH filled on a substantive basis. The staffing situation for the combined paediatric and neonatal service remains very difficult, heavily reliant on a small number of people doing additional night and weekend shifts and prone to short notice collapse because of sickness or other unplanned events.

Recent successful recruitment to medical and nursing posts in neonatology has significantly mitigated the risk to the neonatal service at SJH. Although one of the three consultant neonatologists resigned last year he was successfully replaced. These neonatologists are able to support the neonatal service but cannot contribute to the out of hours paediatric service. Two fixed term Clinical Fellows in neonatology were also recruited in 2013 and can make a similar contribution to neonatology but not paediatrics. The Board has also drawn up a specification for an Advanced Paediatric Nurse Practitioner post which they hope to recruit shortly due to the success of the two Advanced Neonatal Nurse Practitioners recruited last year who are based at RIE but who could contribute to cover of neonatology at SJH.

A key medium term action that has been identified at a local and national level has been the development of advanced nurse practitioners. Five members of the nursing staff at RHSC are now enrolled on the nationally sponsored Paediatric advanced nurse paediatric course, which commenced in September, which will take between two and three years to complete depending on whether study is full or part time. These roles will not therefore support service sustainability in the short term.
3.2.3 **Community Paediatrics**

The Community Child Health Service had also been facing impending staffing shortages mostly due to sickness, retirements and difficulties in recruiting. However the service has successfully recruited three consultants in late 2013 and consequently medical staffing there is now more robust.

3.2.4 **Other areas of the medical workforce that have been identified with high levels of risk.**

The October and November Board papers highlighted that Anaesthetics, Medicine of the Elderly and Ophthalmology are also facing significant challenges in attracting and sustaining the required numbers of trained medical staff to meet treatment time guarantees and achieve improved patients flow. Whilst there are some issues in relation to trainees the areas of highest risk relate to the trained workforce. Within each of these areas there is significant recruitment is underway for trained doctors and it is anticipated that the outcome will not be known until late February 2014. A further update will be provided to the Board at this stage.

3.2.5 **National planning to increase attractiveness of medical trainee posts**

The risk assessment process has however flagged up a difficulty in filling posts that arise out with the annual recruitment process either as a result of trainee withdrawal, maternity leave and trainees going out of programme to undertake research PhDs. As detailed previously these gaps can be very difficult to fill other by using agency or bank locums, as posts may be less than full time and for a relatively short period.

The November board paper provided detail on the national StART Alliance whose remit is around reviewing 2012 and 2013 recruitment outcomes and establishing improved recruitment. The outcomes of the initiative to date are included in Appendix 1. Further updates will be provided to the Board on this important initiative when they become available.

3.3 **Radiotherapy Medical Physics**

Following the introduction of Medical Workforce Risks Assessment it has become clear that other areas where there are workforce pressures and challenges that would benefit from a similar systematic approach. In conjunction with the Scottish Government lead for Healthcare Sciences a version has been developed for use where there are concerns about workforce sustainability in small occupational groups.

The risks that are included cover:

- The trainee workforce in relation to the availability of training programmes in Scotland and the UK and the link between training numbers and national workforce planning.
- The trained workforce in relation to recruitment, retention, productivity and demography
- The cross specialty workforce in relation to the existence of alternative workforce solutions from outwith the specialty. In the case of Radiotherapy/Oncology Medical Physics this was not considered applicable.

The detailed risks used as part of the assessment are included in Appendix 2.
Background

The growth in radiotherapy activity and demand for radiotherapy workforce has created shortages of experienced staff with specialist skill sets. There are concerns that the training ‘pipeline’ and the external labour markets may not be able to meet future workforce demand.

The development of a radiotherapy satellite centre in the West of Scotland is anticipated to increase future demand for medical, radiotherapy medical physics and therapeutic radiography staff. The West region has prepared an outline business case, including detailed breakdown of the staffing requirement. This was submitted to Scottish Government Capital Investment Group on 8th July 2013. There is concern that the recruitment of the additional workforce required to staff the satellite unit will attract staff from existing units across Scotland thus creating further shortages in key roles.

Recruitment difficulties are also an issue for other centres in Scotland, particularly smaller centres. For example medical staff shortages in the North of Scotland mean that neuro-oncology, head and neck and paediatric patients are currently travelling to ECC for treatment which places additional demand upon the ECC workforce. Staff shortages in any one region will therefore lead to additional demand on the other regions. Regional planning will therefore need to take account of the wider Scottish context.

The growth in radiotherapy activity and demand for radiotherapy workforce has created shortages of experienced staff with specialist skill sets. For example, the Edinburgh Cancer Centre (ECC) has found it increasingly difficult to recruit to senior clinical scientist posts within the radiotherapy medical physics team, despite advertising at a UK and international level. There are concerns that the training ‘pipeline’ and the external labour markets may not be able to meet future workforce demand.

Given the current staffing issues and the lead in times for training and developing the workforce it is essential to try and forecast future workforce demand in order to establish the ‘supply pipelines’ for the skilled workforce required in the future.

Risk assessment findings

Trainee Workforce

- There is capacity locally to support trainees within Clinical Scientist, Clinical Technologists and Engineering however there is only a national training programme for Clinical Scientists.
- There is training available locally however a national programme is required to ensure consistency to ensure that there are consistent standards applied and qualifications are transferable.
- There is no link between national workforce planning and training numbers, therefore there is a very high risk of undersupply as each board trains the number it believes it needs in isolation.

Trained Workforce

- There is a very high risk of being unable to recruit to Clinical Scientist posts, with the required level of skills. Approximately 40% of posts filled in the last
three years have been below the grade advertised as the individuals do not have the required level of skills and require a significant period of training. There have been occasions where recruitment to specialised posts has been unsuccessful despite local, national and international recruitment. These risks also apply to Clinical Technologists and Engineers where there is no ready supply of trained individuals.

- Out of hours commitments for Clinical Scientists staff can be intense as complex treatments require for equipment to be checked out of hours to avoid loss of capacity during day time. There has been a very heavy out of hours commitment for engineers to service and install equipment which is close to non compliance with European Working Time regulations.

- 2 out of the 5 most senior Clinical Scientists are almost certain to retire within the next 3 years, including the Head of Oncology Physics and it is highly unlikely that these individuals will be replaced with individuals with similar skill sets and experience. Both of these posts are ‘single handed’ specialist posts and the inability to successfully recruit on a like for like basis will have a direct impact on service provision.

These risks relate to the service as it currently provided, there will however be a requirement to expand cancer services within Lothian and across Scotland to provide additional capacity for treating both increased incidences of cancer and patients living longer with Cancer as detailed in the following figure.

These projections set out in section have been utilised to develop a model to predict the effect on radiotherapy activity in the South East over the next 8 years. The model predicts that there will be an approximate increase in demand for radiotherapy fractions (attendances for treatment) of 2% year-on-year, from c54,300 in 2013 to c62,400 in 2021.

This growth will require either the extension of the working day or an additional Linear Accelerator both of which are being considered as part of the Cancer Services Strategy which is being developed as part of the Clinical Strategy, which will come to the Board by the end of March. When taken in conjunction with the commissioning of the new satellite centre in the West of Scotland the current workforce supply pressures there considerable risks ensuring there are the required numbers and levels of staff to sustain and grow the service.
A specific risk to the ECC is the establishment of the satellite unit in the West region. There are two components; firstly it will create short-term workforce risks during 2014-15 as staff are recruited to the unit with the potential to destabilise existing centres and secondly it will increase the recurring demand for staffing within Scotland.

The workforce issues identified above have been fed into the Scottish Government Radiotherapy Programme Board in greater detail by SEAT as part of a National Radiotherapy Workforce Event in September 2013. There has not yet been a formal response and action plan issued by the Scottish Government, it is hoped that this will happen soon given the importance of the issues raised. There is however already work underway to try and set out the detail of a national clinical technology training programme being led locally, further detail of which will be provided once confirmed.

3.4 Application of nursing and midwifery workload and workforce planning tools

Rollout Approach

The Assistant Director (Nursing Workforce & Business Support) is the nominated lead for all work around the NMWWPP project and is responsible for ensuring that each area is scheduled to complete the relevant speciality tool and Professional Judgement tool on an annual basis. Chief Nurses are responsible for delivery of this within their clinical area. Reports within the SSTS / BOXI environment will be used to evidence use of the tools.

NHS Lothian has a well established Nursing and Midwifery Workforce Group led by the Assistant Director (Nursing Workforce & Business Support). The Workforce Planning team and partnership colleagues have representation on this group. This group have a remit to co-ordinate Board wide runs of the Nursing and Midwifery Workload and Workforce Planning tools. Governance around the delivery of the CEL is via this group and the findings / evaluation of Board wide runs of the tool will be reported through professional lines and to the Joint Management Team. There is a regular update on the nurse and midwifery staffing position and the use of the national tools via a quarterly Department of Nursing update that is available to all staff via the intranet. Professional approval of all nursing and midwifery establishments rests with the Nurse Director.

A master class for Charge Nurses and Clinical Nurse Managers was held in 2012 to ensure that a wide group of senior nurses have a detailed understanding of the workload and workforce tools. All Senior Charge Nurses have access to the relevant workforce tools via SSTS for their roster location(s). The recent release of reporting functionality to access the data will be rolled out to the Chief Nurses and Clinical Nurse Managers to enable local analysis. In September 2013 a Board wide run of the speciality tools and professional judgement was completed for all in patient areas. Going forward Board wide runs will be scheduled across a speciality on an annual basis. Additionally all new developments and service redesign include a ratification process against the agreed Board position.

NHS Lothian has a system (MIDAS) to record a range of quality indicators. The data from this system and the feeder systems for areas not linked to MIDAS is being used as part of the triangulation process, together with financial data and the local context. Chief Nurses and Clinical Nurse Managers have been involved in agreeing Board wide principles around nursing and midwifery staffing. In addition any incidents reported relating to staffing levels are reported on a weekly basis to the Nurse Director and Medical Director and Chief Nurses.
Application of tools

The following tools have been applied across all in-patient areas (as appropriate to the roster location) as part of the skill mix review.

- Professional Judgement (2 week run September 2013)
- Adult Acute (2 week run September 2013)
- Small Wards (2 week run September 2013)
- Mental Health/Learning Disability (2 week run September 2013)
- SCAMPS™ (being used twice daily)
- Neonatal (being used twice daily)

Additionally the following tools have been used to inform local staffing debate and/or to comply with national testing of tools.

- Maternity
- Perioperative (national run)
- Emergency Department / Emergency Medicine (national run)
- Community Nursing Workload Assessment (national run)

The following tools have not been run during 2013, it however anticipated that they will be run in 2014-15.

- Clinical Nurse Specialist
- Community Nursing Benchmarking Profile
- Community Children’s and Specialist Nurse

A paper taken to JMT in November 2013 detailed the initial findings of a skill mix and staffing levels review across all in patient facilities. The initial work has demonstrated that midwifery services and in patient continuing care are of the most significant risk to the organisation.

Funding has been awarded to midwifery services to increase the midwife staffing within Labour Ward by 5 wte, which will enable the service to assure 1:1 care during birth on 90% of days.

The Strategic Planning Committee have agreed to take forward a review of the options for provision of in patient continuing care across Lothian.

Further work is being taken forward to determine specific areas of priority to be included in the financial plan. The analysis is taking account of the outcome of professional judgement, speciality specific nationally mandated nursing and midwifery workload and workforce tools, quality indicators and the local context, including the current financial envelope.

3.5 Future papers

This paper has for the first time set out detail on the workforce risks and challenges are for the wider workforce. Work will be undertaken with Nursing Director to consider whether it would be beneficial to develop a risk assessment process to pull together the wide range of indicators that have been developed as part of the nursing and midwifery workload and workforce planning tools work.
Community Partnerships have also been asked to provide a summary of how they are approaching the development of social care capacity. Given the wider scope of this Board paper consideration will be given as to how best to provide breadth of coverage whilst also providing a meaningful level of detail.

4 Risk Register

4.1 The NHS Lothian risk register contains a ‘Medical Workforce Sustainability’ risk, which relates the risk that workforce supply pressures in conjunction with activity pressures will impact on service sustainability and/or NHS Lothian’s ability to achieve its corporate objectives. The multi-factorial risk assessments that have been carried out will be reviewed and updated where necessary on a 6 monthly basis or where there are significant changes.

5 Impact on Inequality, Including Health Inequalities

The introduction of the medical workforce risk assessment process has been subject to a recent rapid impact assessment for which a draft report has been prepared. Once this report is finalised the findings will be detailed in future papers.

6 Involving People

Before any changes in service provision across any site in NHS Lothian are made, there would need to be engagement and consultation with appropriate audiences with the guidance of the Scottish Health Council.

7 Resource Implications

7.1 There are potential resource implications, which are identified as part of the planning process within specialties to reduce the level of workforce risk. These will be progressed through the appropriate local management structures to secure necessary support. Emergency Medicine, Paediatrics and Obstetrics & Gynaecology have all been supported financially at both a local and national level to enable recruitment to additional trained doctors to reduce workforce risks as detailed within the report.

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23 January 2014

List of Appendices

Appendix 1: Outcomes of the initiative to date
Appendix 2: Detailed risks used as part of the assessment
Appendix 3: Radiotherapy Medical Physics Workforce
Understanding push-pull factors in medical careers decision making.

The following section details the findings of research (Final report Clelland J et al) into the push/pull factors for trainees:

- The greatest influence on medical students’ decision making is lifestyle, including location – with proximity to friends and family, and familiarity with the local and work environments impacting mostly on decision making.
- Career decision making among doctors in training is more complex, but overall the greatest influencers are cited to be work-related factors, specifically good working conditions, desirable location, good reputation for quality training and availability of linked training positions (linked with their partners’ appointment).
- While some factors that have been identified are personal and are not amenable to intervention – improving the quality of the working and training experience may increase the attractiveness of posts and locations.
- Early positive experiences are very important to careers decision making.
- Overseas doctors are more tolerant of less desirable options including poorer working conditions and departments with lesser reputation.

Improved branding of Scotland focusing on its reputation for medical excellence

Our participation in the 2012 BMJ Careers Fair in London in 2012 contributed to our awareness of the need for an initiative such as StART; the aims in participating in this year’s event were as follows:

- To increase the impact of NES and NHS Scotland presence compared to 2012 when it was clear other Deaneries’ stands & scale of with marketing recruitment opportunities eclipsed that of NES.
- To increase applications to training programmes in Scotland for Aug 2014.
- To inform plans for a future Scottish Careers Fair from an understanding of the format, seminar topics & exhibitors at this fair.
- To assess the role of technology in the fair and to evaluate accessibility of content in the new ScotMT website by trainee users.

Development of social media programme

StART is developing a social media campaign to connect potential recruits to our ‘training ambassadors’ through Twitter Hours and webinars. Initially run in conjunction with Bright Signals, it is intended to take the learning and embed these approaches fully into our programme of activities to maximise access to insights around what training in Scotland – ‘the home of medical excellence’ - has to offer.
StART – the next phase

- Planning for a Scottish Careers Fair in 2014.

- ‘Make me want to train in Scotland’ - there is a need to recruit a group of trainers from around Scotland – to add to the rank of trainees who have committed to working with StART as ‘training ambassadors’. Their role is to be accessible to prospective applicants to help address trainees’ queries, but also to participate in Careers Fairs within Scotland.

- Engagement of the Territorial Boards - One of the highest priorities for trainees in influencing their choice of programme is work environment. NES will work with Directors of Medical Education (DMEs) and Medical Directors in the Boards to ensure they are aware of trainee concerns and to support them in improving workplace environments where necessary, as well as spreading examples of good practice.

- Engagement of Scottish Medical Schools in StART’s ambitions – there is a clear need for StART to engage with the Medical Schools more fully with Scottish Medical Schools to promote Scotland to school pupils and undergraduates as the place to train and work.

- Development of StART website - the growth of interest in StART necessitates improved access to information about this initiative and related activities. In 2014 NES will develop the linking site for StART showing what StART is doing through a) its Core Group activities, b) the StART Alliance c) our cohort of Training Ambassadors and d) events such as careers fairs. This site will host a specially designed interactive career pathway directing students, prospective and current trainees as well as trained doctors looking for career opportunities and information. It will provide links web sites such as Scottish Medical Careers to provide a single gateway to information about being a doctor in Scotland.

- Development of the Trainee Ambassadors – Commence the development process of ambassadors to harness the enthusiasm and focus that our trainees have expressed both to be ambassadors for their programme and Scottish training. They will also reflect back ways to improve the quality of training and ideas on how to improve how we communicate and support the trainee at every stage but crucially at transition points

- Rural-track training - In line with NES policy on supporting remote and rural healthcare StART includes a focus on rural-track training and incorporates learning from the Northern Peripheries Project “Recruit and Retain Healthcare Workers”.
Small occupation workforce risks

Trainees

- Ability of service to support trainees
- Availability of accredited training in Scotland; suitability of training in rest of UK
- Link between training numbers and National workforce planning
- Disproportionate effect of research breaks, maternity leave, etc due to small numbers of trainees

Trained Workforce

- Difficulties in recruitment of trained workforce
- Inconsistency of grading within Scotland and UK affecting retention.
- Gaps in trained workforce resulting from absence sickness, maternity, study leave, etc.
- OOH commitments and impact upon morale/retention, etc
- Staff shortages resulting in lack of capacity as evidenced by waiting times/lists, etc
- Productivity does not meet planned or benchmarked levels expected
- Demographic issues such as aging workforce or increased feminisation that are anticipated to lead to staffing issues over next 1-3 years
- Single handed specialist or skills shortage within the team
- Financial impact of additional payments to cover Waiting List payments/OOH resident working, etc

Cross Specialty Workforce

- Availability of appropriately trained staff i.e. within existing workforce, able to be recruited?
- Can they be trained within required timescale?
- Is there funding available to train an alternative workforce
- Is the cross specialty workforce as productive as the workforce for which it substitutes?
- Turnover/Retention of cross specialty workforce
- Gaps in cross specialty workforce resulting from absence (sickness, maternity, study leave, etc)
Radiotherapy Medical Physics Workforce

All medical physics staff are graduates in physics or a related degree subject, with the possible exception of some engineering roles.

Clinical Scientists:

Upon employment as trainees (band 6) individuals will follow a NHS Education Scotland (NES) supported 3½ year training programme which combines a mix of workplace and academic study. NHS Lothian currently takes one trainee Clinical Scientist per year which alternates annually between Medical Physics and Radiotherapy Medical Physics, i.e. one trainee is taken on in Radiotherapy Physics every two years. Completion rate is high; since the programme started in 2006 only one radiotherapy trainee has dropped out and the majority of these trainees have been employed within NHS Lothian. With an establishment of 4 WTE band 7 Clinical Scientist posts the one trainee every two years is sufficient to cover turnover in radiotherapy.

England has started to implement a ‘Modernising Scientific Careers’ (MSC) initiative which will reduce training time to 3 years and this might prove to be more attractive to prospective trainees, although the ability to achieve state registration in this timeframe is yet to be evidenced.

Once state registered, individuals will continue to pursue research-based qualifications and other specialist training as part of the new Higher Specialist Training Scheme from MSC in order to support career progression. For posts in band 8 there is no separate supply pool and appointments are made either through internal development or recruiting from other departments – “robbing Peter to pay Paul”. Generally, only staff at band 8 have sufficient experienced competence to lead on service developments and, in a time of rapid expansion of new techniques in radiotherapy within the UK, people with these skills are in short supply.

Clinical Technologists/Engineers:

Clinical Technologists/Engineers are currently not required to be state registered to practice but there is a professional body voluntary registration scheme. NHS Lothian participates in the IPEM training scheme for Radiotherapy Medical Physics and Radiation Engineering Technologists. There is no current national programme for clinical technologist trainees so training is provided as required within departments and this can increase the training burden on senior Clinical Scientist staff significantly. A central Scottish training scheme for clinical technologists/engineers would be beneficial. As there are some similarities with other Healthcare Scientist roles, combining common core training, such as anatomy and physiology, with the Life and Physiological Healthcare Scientists would be desirable and NHS Lothian is considering establishing a Healthcare Science Academy.

In a similar way to Clinical Scientists, for senior Clinical Technologist posts there is no separate supply pool and appointments are made either through internal development or “robbing Peter-to-pay-Paul”. With engineers there is some opportunity to recruit from private industry, e.g. the armed forces supplemented by in-house training schemes.
This paper aims to summarise the key points.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work to produce the Local Delivery Plan (LDP) for 2014/15 is now underway. This is due to be submitted to Scottish Government by 14 February 2014, with final plans submitted by 14 March 2014.</td>
<td>2.1</td>
</tr>
<tr>
<td>• Antenatal Care: NHS Lothian continues to exceed the target of 80% of pregnant women in each SIMD quintile booked for antenatal care by the 12th week of gestation.</td>
<td>4.1.2</td>
</tr>
<tr>
<td>• Child Fluoride varnishing: The latest ISD figures (30 June 2013) show a dip in performance from 8.18% to 5.46% in the worst performing quintile in Lothian</td>
<td>4.1.4</td>
</tr>
<tr>
<td>• Dementia Diagnosis: a Data Sharing Partnership has been developed to establish robust systems to record diagnosis within the patient’s electronic record.</td>
<td>4.1.5</td>
</tr>
</tbody>
</table>

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20 January 2014
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1 Purpose of the Report

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

2 Recommendations

2.1 Receive this update on the current performance against those HEAT targets and standards that the Board has agreed to receive in this performance paper as set out in Appendix 1.

2.2 Note that work to produce the Local Delivery Plan (LDP) for 2014/15 is now underway. The LDP is the delivery contract between Scottish Government and NHS Boards in Scotland, and sets out how Boards will meet HEAT targets and other national priorities.

2.3 This year the LDP has 3 elements:
   • Improvement & Co-production Plan
   • NHS Board Contribution to Community Planning Partnership Plan
   • HEAT risk management plans and delivery trajectories

2.4 Draft plans are to be submitted to Scottish Government by 14 February 2014, with final plans submitted by 14 March 2014.

3 Discussion of Key Issues

3.1 Of the 10 items monitored within Appendix 1, the most recent data indicates NHS Lothian is off trajectory / does not meet the overall target on 6 occasions. These are highlighted in red in the appendix.

4 Key Risks and areas to highlight:

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

The latest ISD HEAT Data shows that NHS Lothian has delivered 1441 child healthy weight interventions to date however this does not reflect the significant drive that NHS Lothian has made towards achieving the target during the period September – December 2013. During this timeframe NHS Lothian has completed a significant number of interventions and can confirm that we have now achieved and
exceeded the national target, having completed 2503 interventions. We are still waiting for ISD and Scottish Government to validate these figures however it is likely that this figure will continue to rise considerably until end March 2014, when it is expected that we will exceed 2600 interventions.

4.1.2 Early Access to Antenatal Care (Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

NHS Lothian continues to exceed the target of 80% of pregnant women in each SIMD quintile booked for antenatal care by the 12th week of gestation, and is above trajectory to meet the target by March 2015. Particular focus is now being placed on supporting those women in more deprived communities to have access and support. Latest data published in January for the period to 30th June 2012 by ISD reports that NHS Lothian is ahead of the Scotland position and one of the better performing Boards.

4.1.3 Energy and Carbon Emissions (Responsible Director: Director of Human Resources and Organisational Development)

Whilst progress is being made in respect of reducing carbon emissions, current indicators suggest that the HEAT Target will not be met for technical reasons. The HEAT target is under review by SG due to limitations in scope and accuracy. The achievement of HEAT target will require major investment in infrastructure and although new initiatives such as Green Investment Bank funding are being explored there is no new money being allocated. Smaller capital development programmes are in place to help continue the downward trend but these cannot meet the ambitious long term objective.

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

The latest ISD figures for the year to end of June 2013 show a dip in performance from 8.18% to 5.5% in the worst performing quintile in Lothian. Similar reductions in performance were noted across Scotland. There was a serious supply problem with fluoride varnish for the first few months of 2013 due to a manufacturing problem and it is likely that this is the reason for the fall. The worst performing quintile is the most affluent according to SIMD, and is where oral health is likely to be best. In the most deprived quintile 32% of three year olds and 44% of four year olds received two varnish applications. The Public Dental Service Childsmile Programme operates in the nurseries located in the most deprived SIMD quintile.

4.1.5 Dementia Diagnosis (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

To ensure that we are providing person centred care, recognising the different supports that a person may require during the post diagnostic period, this is a target that needs to be owned and delivered upon in partnership between NHS Lothian, the four Local Authorities and 3rd sector partners. The first step is to ensure that we have robust systems in place to record diagnosis with the patient’s electronic record. This will then enable the patient to be tracked across the local system of care and support. A Data Sharing Partnership has been developed which will
enable to safe and appropriate transfer of data. Formal reporting against the target will commence in February 2014.

4.1.6 Detect Cancer Early (Responsible Director: Director of Public Health and Health Policy)

To note that work on this continues. The latest campaign is targeted at getting those that may be at risk of lung cancer to seek early diagnosis. The second round of campaigning in respect of breast cancer awareness is due to commence in April. We are making preparations now in relation to the impact that this may have as during the first campaign there was a significant increase in demand as a result of the campaign.

4.1.7 Suicide prevention (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

Note that the Scottish Government issued a revised suicide strategy in December 2013. NHS Lothian and its key partners are reviewing this revised strategy and will consider any additional actions that need to be taken through the Mental Health and Well-Being Programme 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 i.e. delayed discharges.

6 Impact on Inequality, Including Health Inequalities

6.1 As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall.

7 Involving People

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

8 Resource Implications

8.1 There are no resource implications relating directly to the provision of this report. Financial implications are reported as appropriately to the Board, JMT and other committees.

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List of Appendices

Appendix 1: Performance Management Scorecard
### Performance Management for Board

**Appendix 1**

**Owner:** Alex McMahon, Director of Strategic Planning, Performance Reporting & Information

**Period:** 2013-14

**Note:** Where Target includes breakdown by quintiles, Trend uses bottom cell to calculate analysis.

### 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>Trend</th>
<th>Status</th>
<th>Lead Dtr.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Healthy Weight - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (add, requirement that at least 45% of child healthy weight interventions are delivered to children/families in the two most deprived SIMD quintiles by local SIMD deciles to be reported annually)</td>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr-11 - Mar-13 1193</td>
<td>Apr-11 - Sept-13 1441</td>
<td>1740</td>
<td>↑</td>
<td>AWM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Reduction - % of suicides per yr per 100,000 population</td>
<td>2013</td>
<td>20%</td>
<td>2008-11 13.7%</td>
<td>2008-2012 14.1%</td>
<td>20%</td>
<td>↑</td>
<td>JF</td>
<td></td>
<td>The 2012 figures for suicide in Scotland were released on the 27th August 2013</td>
</tr>
<tr>
<td>Smoking Cessation - deliver universal smoking cessation services to achieve at least 11,686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-board SIMD areas over the period 2011/12 to 2013/14</td>
<td>Mar-14</td>
<td>11,686</td>
<td>Aug-13 12,335</td>
<td>Sep-13 12,842</td>
<td>9,680</td>
<td>↑</td>
<td>JF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Fluoride Varnishing Aged 3 - achieve at least 60 per cent of 3 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td>Mar-14</td>
<td></td>
<td>01/04/2012 - 31/03/2013 28.10%</td>
<td>01/04/2012 - 31/03/2013 31.18%</td>
<td>35%</td>
<td>↓</td>
<td>AWM</td>
<td></td>
<td>Performance has reduced across all quintiles. Performance is highest in the most deprived quintile.</td>
</tr>
<tr>
<td>Child Fluoride Varnishing Aged 4 - achieve at least 60 per cent of 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td>Mar-14</td>
<td></td>
<td>01/04/2012 - 31/03/2013 28.10%</td>
<td>01/04/2012 - 31/03/2013 31.18%</td>
<td>35%</td>
<td>↓</td>
<td>AWM</td>
<td></td>
<td>Performance has reduced across all quintiles. Performance is highest in the most deprived quintile.</td>
</tr>
<tr>
<td>Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 80% are to be diagnosed while in the first stage of the disease</td>
<td>Mar-15</td>
<td>29%</td>
<td>Oct-13 83.24%</td>
<td>Nov-13 83.98%</td>
<td>80%</td>
<td>↑</td>
<td>AWM</td>
<td></td>
<td>Baseline 2010/11 for NHS Lothian has now been agreed at 82.6% and trajectory for 2013/2014 at 85.6%</td>
</tr>
<tr>
<td>Early Access to Antenatal Care - at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation by March 2015 in the worst performing quintile</td>
<td>Mar-15</td>
<td></td>
<td>Oct-13 83.24%</td>
<td>Nov-13 83.98%</td>
<td>80%</td>
<td>↑</td>
<td>JF</td>
<td></td>
<td>Local trajectories still to be agreed with the Scottish Government</td>
</tr>
</tbody>
</table>

### Efficiency

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Dtr.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Carbon Emissions - % reduction year-on-year (Tonnes of CO2)</td>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 4 12/13 8.56%</td>
<td>Qtr 2 13/14 1.90%</td>
<td>5.61</td>
<td>↓</td>
<td>AB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Energy Consumption - % reduction year-on-year (Energy GJ)</td>
<td>Mar-15</td>
<td>-2.97%</td>
<td>Qtr 4 12/13 1.34%</td>
<td>Qtr 2 13/14 1.13%</td>
<td>1.86</td>
<td>↓</td>
<td>AB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Access to Services

<table>
<thead>
<tr>
<th>Access to Services</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Dtr.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Appropriate for Patient</td>
<td>Oct-15</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>JF</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trend named cells - do not adjust**

- ↑ for increase on previous reporting period
- ↓ for decrease on previous reporting period
- ↔ for no change from previous reporting period

Children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14, requirement that at least 45% of child healthy weight interventions are delivered to children/families in the two most deprived SIMD quintiles by local SIMD deciles to be reported annually.
<table>
<thead>
<tr>
<th>Treatment Appropriate for Patient</th>
<th>Reported in Waiting Times Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faster access to CAMHS - deliver 18 wks Referral to Treatment</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td><strong>A&amp;E Attendances</strong> - rate of A&amp;E attendances per 100,000 population</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>MRSA / MSSA Reductions - achieve a reduction in the infection rate of <em>Staphylococcus aureus</em> bacteraemia (including MRSA) (cases to 0.24 or less per 1,000 acute occupied bed days)</td>
<td>Reported in HAI Report</td>
</tr>
<tr>
<td>C-diff infections - achieve a reduction of the rate of <em>Clostridium difficile</em> infections in patients aged 15 and over to 0.25 cases or less per 1,000 total occupied bed days</td>
<td>Reported in HAI Report</td>
</tr>
<tr>
<td>Reduction in emergency bed day rates for patients aged 75+</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>Delayed Discharges: no people wait more than 28 days from April 2013; followed by a 14 day maximum wait from April 2015.</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>IVF - Eligible patients will commence IVF treatment within 12 months by 31 March 2015</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>4-hour A&amp;E - 95% of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&amp;E treatment as a minimum and NHS Boards should pursue further sustainable improvement towards the 98% 4 hour A&amp;E standard</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>Drug and Alcohol waiting times - 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>Cancer Waiting Times - 62 day referral to treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 62 days of urgent referred with a suspicion of cancer, referred through A&amp;E, or referred from one of the national cancer screening programmes</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>Cancer Waiting Times - 31-day decision to treat to first treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat, irrespective of the source or urgency of the referral.</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>Stroke Unit - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
</tbody>
</table>
SUMMARY PAPER – HEALTHCARE ASSOCIATED INFECTION

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress against Health Efficiency Access Treatment Targets</td>
<td>3.1</td>
</tr>
<tr>
<td><em>Staphylococcus aureus</em> Bacteraemia (SAB): there were 21 episodes of <em>Staphylococcus aureus</em> Bacteraemia during December 2013 giving a current rate of 0.31 per 1000 bed days, and that this reflects performance outwith projected aim of 0.24 per 1000 bed days by March 2015.</td>
<td>3.2</td>
</tr>
<tr>
<td><em>Clostridium difficile</em> Infection (CDI): there were 33 episodes of <em>Clostridium difficile</em> Infection during December 2013 giving a current rate of 0.55 per 1000 bed days, and that this reflects performance outwith projected aim of 0.32 per 1000 bed days by March 2015.</td>
<td>3.3</td>
</tr>
<tr>
<td>Norovirus outbreaks: since 1/11/2013 there have been 128 patients identified as norovirus positive in acute sites, with 8 patients identified as norovirus positive within community hospitals.</td>
<td>3.4</td>
</tr>
<tr>
<td>Mandatory Surgical Site Infection Surveillance: NHS Lothian Surgical Site Infection rate for the period July to September 2013 was 1.9%, in comparison the rate for the period April to June 2013 was 1.8%.</td>
<td>3.5</td>
</tr>
<tr>
<td>MRSA Screening Programme: recent quarterly Health Protection Scotland (HPS) review noted NHS Lothian’s current compliance is 61% compared to the previous quarter 45% compliance</td>
<td>3.6</td>
</tr>
<tr>
<td>Healthcare Environmental Inspectorate (HEI): the report from the unannounced inspection at the Royal Infirmary of Edinburgh was published with 4 requirements and the announced inspection at Liberton with 5 requirements and 3 recommendations. NHS Lothian has been advised there will be an announced community inspection at Astley Ainslie Hospital on 28/29 January 2014.</td>
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Fiona Cameron
Head of Infection Prevention and Control Services
22 January 2014
fiona.cameron@nhslothian.scot.nhs.uk
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 (HAI) across NHS Lothian. Any member wishing additional information should contact the Nurse Director in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to:
- acknowledge receipt of the HAI Reporting Template for December 2013.
- note NHS Lothian’s *Staphylococcus aureus* Bacteraemia target by March 2015 is to achieve a rate of 0.24 per 1000 bed days. The current rate is 0.31. NHS Lothian is currently off trajectory as projected rate for December 2013 was 0.27 and multidisciplinary effort is required if target is to be achieved.
- support staff to improve the clinical management of invasive devices in accordance with NHS Lothian and Patient Safety Standards.
- note NHS Lothian’s *Clostridium difficile* Infection target by March 2015 is to achieve a rate of 0.32 per 1000 bed days. The current rate is 0.55. NHS Lothian is currently off trajectory as projected rate for December 2013 was 0.38. A multidisciplinary effort is essential if target is to be achieved.
- support the Antimicrobial Team activities in relation to Antimicrobial Prescribing Review and reduction of antimicrobials associated with *Clostridium difficile*.
- encourage General Practitioners to share information associated with investigations of Community Healthcare associated *Clostridium difficile*.

3 Discussion of Key Issues

3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2015

![Figure 1: No. of CDI Episodes 2013-14](image1)

![Figure 2: No. of SAB Episodes 2013-14](image2)

![Figure 3: Hand Hygiene Compliance Rate – January 2014](image3)
3.2 *Staphylococcus aureus* Bacteraemia: NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days by March 2015 with a current rate of 0.31. There were 21 episodes of *Staphylococcus aureus* Bacteraemia in December 2013 (4 Meticillin Resistant *Staphylococcus aureus*, 17 Meticillin Sensitive *Staphylococcus aureus*), compared to 24 in November 2013 (0 Meticillin Resistant *Staphylococcus aureus*, 24 Meticillin Sensitive *Staphylococcus aureus*).

3.2.1 Key actions to assist NHS Lothian to reduce *Staphylococcus aureus* Bacteraemia includes

a. Continued collaboration with Health Protection Scotland to review all new cases and identify focus for quality improvement support.

b. Utilisation of Scottish Government funding to support Practice Education Facilitators delivery of education to Accident and Emergency Department, aseptic / non touch technique for areas with greater than 4% blood culture contamination rate and cannulation where invasive devices may have contributed to acquisition

c. Testing of different approaches to investigation, comparative results from RIE and WGH will be discussed at March Infection Control Committee to see if outcomes / learning can be improved.

3.3 *Clostridium difficile* Infection: NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days by March 2015 in patients aged 15 and over, with a current rate of 0.55. There were 33 episodes of *Clostridium difficile* Infection in patients aged 15 or over in December 2013, compared to 35 in November 2013.

3.3.1 Key Actions to assist NHS Lothian to reduce *Clostridium difficile* includes

a. on going work with antimicrobial team to review the contribution of antimicrobial use to the acquisition including a business case to provide addition clinical pharmacist support

b. focus on enquires to General Practitioners to support investigations in to risk factors for new cases

c. Notification to General Practitioners informing of patient’s vulnerability to further antimicrobial linked *Clostridium difficile* Infection post discharge.

d. Support from Health Protection Scotland to analysis community CDI incidence has been sought

e. consideration of alternative diagnosis of Norovirus causing symptoms with *Clostridium difficile* as a secondary finding with possible additional virology testing for all samples submitted from General Practitioner services testing positive for *Clostridium difficile*

3.4 Norovirus: NHS Lothian Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to service. Health Protection Scotland notified boards that Norovirus season commenced on the 9th of December 2013 based on the number of boards affected. NHS Lothian noted gradual increase in the incidence of Norovirus from October 2013. To date Norovirus season 2013 has comparatively less incidences of outbreaks and patients affected compared to the same time period in 2012. The resulting lower incidences have also reduced the impact of bed days lost.

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3.5 The Meticillin Resistant *Staphylococcus aureus* (MRSA) Screening Programme: compliance with completion of MRSA Clinical Risk Assessments and swabbing continues to be monitored. The most recent quarterly report by Health Protection Scotland noted a compliance with MRSA screening of 61% within NHS Lothian. This was improved from the previous quarter compliance of 45%.

3.6 Healthcare Environmental Inspectorate: The report from the unannounced inspection at the Royal Infirmary of Edinburgh on 2 October 2013 was published on 25 November 2013 with 4 requirements. The report from announced inspection at Liberton on 23/24 of October 2013 was published on the 17 December 2013 with 5 requirements and 3 recommendations. NHS Lothian has been advised there will be an announced community inspection at Astley Ainslie Hospital on 28/29 January 2014.

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Based on current trend for *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection NHS Lothian is not on target to achieve the set Health Efficiency Access Treatment Target.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register is currently graded medium. The risk register covers norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation. This will be re-assessed at the beginning of December depending on the trends identified in November’s data.

6 Impact on Inequality, Including Health Inequalities

6.1 Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. Accordingly, changes made are reducing the burden of Healthcare Associated Infection.

7 Involving People

7.1 Patient public representatives are actively involved during the Healthcare Environment Inspectorate inspections, with one member sitting on the Healthcare Environment Inspectorate Steering Group. Other patient public representatives sit on the Infection Control Committees (Lothian Infection Control Advisory Committee, Acute and Community).

8 Resource Implications

8.1 Infection Prevention and Control is an invest to save service. The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile*
Infection is variable, depending on increased length of stay and additional treatment requirements.

8.1.1 NHS Lothian has increased funding to provide an additional 3 Infection Prevention & Control Nurses to support the ongoing work to reduce healthcare associated infection

8.1.2 In addition NHS Lothian have resourced an Infection Prevention and Control Nurse for to support the HAI Scribe demands as result of the investment programmes in new building works and ongoing maintenance programmes across NHS Lothian. HAI Scribe is a three key stages process in infection prevention and control in the built environment:
   1. Identify the hazard;
   2. Assess the risk from the identified hazard;
   3. Manage the risk to eliminate or minimise its impact

The 3 stages of HAI scribe are applied to development and maintenance of the healthcare facilities as follows;

- proposed site for development;
- design and planning;
- construction and refurbishment;
- ongoing maintenance.

Fiona Cameron
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21 January 2014
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List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
**Healthcare Associated Infection Reporting Template (HAIRT)**

**Section 1 – Board Wide Issues**

**NHS LOTHIAN**

### Staphylococcus aureus bacteraemia monthly case numbers

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## WESTERN GENERAL HOSPITAL

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**ST JOHNS HOSPITAL**

**Staphylococcus aureus** bacteraemia monthly case numbers

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**Clostridium difficile** infection monthly case numbers

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LIBERTON HOSPITAL

**Staphylococcus aureus** bacteraemia monthly case numbers

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**Clostridium difficile** infection monthly case numbers

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**Cleaning Compliance (%)**

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ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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Cleaning Compliance (%)

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COMMUNITY HOSPITALS

The community hospitals covered in this report card include:

- Astley Ainslie Hospital
- Corstorphine Hospital
- Ellen's Glen House
- Ferryfield House
- Findlay House
- St Columba's Hospice
- Fairmile Marie Curie Centre
- Loanhead Hospital
- Midlothian Community Hospital
- Roodlands Hospital
- Royal Edinburgh Hospital
- Royal Victoria Hospital
- St Michaels Hospital
- Tippethill Hospital

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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OUT OF HOSPITAL INFECTIONS

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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SUMMARY PAPER - CORPORATE RISK REGISTER

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

| • The Risk Management Steering Group undertook a formal review of the corporate risks using a set of principles set out under para 3.2 | 3.2 |
| • The review resulted in 16 risks being confirmed as strategic risks in December 2013. Three risks were removed and the rational is set out under 3.2.4.1 | 3.2.4 |
| • Additional changes have been made by the December 2013 Audit & Risk Committee and RMSG, which includes an increase in risk for HAI and Achieving Financial Targets, a decrease in the risk concerning Preparedness for Emergency Planning and an additional risk on Health & Social Care Integration Plans | 3.2.5 |
| • There is minimal movement in risk grading over the last 4 quarters by the Board | 3.3.1 |
| • A draft risk appetite is set out for comment to inform further discussions to be taken forward by the Audit & Risk Committee | 3.4.1 |

Jo Bennett
Clinical Governance & Risk Manager
20 January 2014
Jo.bennett@nhslothian.scot.nhs.uk
CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to provide assurance on the management of risks at a corporate level.

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

2 Recommendations

2.1 Agree the current updated NHS Lothian Corporate Risk Register, highlights of which are contained in section 3.2 and summarised in Appendix 1.

2.2 Comment on the draft Risk Appetite and further work being undertaken by the Audit & Risk Committee.

3 Discussion of Key Issues

3.1 The Corporate Risk Register was last submitted to the Board in September 2013 and set out Quarter 3, April to June 2013 corporate risks. This report sets out the Quarter 4 position plus a range of additional changes not reflected in Table 1, agreed through the Risk Management Steering Group (RMSG) and Audit & Risk Committee in December 2013, which are set out below.

3.2 The RMSG has agreed principles for submitting risks on the Corporate Risk Register which are set out below:-

3.2.1 Risks that executive management cannot manage

3.2.2 Risks that are defined in a manner that it is clear to the Board what the contributing factors are, and what items require a decision of the Board

3.2.3 The score of the residual risks can range from very high or very low. The above two factors should be what determines whether or not something is on the Corporate Risk Register. It is likely however that items that meet those criteria will have higher scores.

3.2.4 A review of the current risks on the Corporate Risk Register reported to the Board in Quarter 3 (2013) was undertaken by the RMSG against the above principles and following 16 were confirmed as strategic risks:-

- Lack of Management Capacity
Medical Workforce Sustainability
• Patient Safety
• Public Protection
• Health & Safety
• Patient Experience
• Achieving Waiting Times Targets
• Unscheduled Care
• Healthcare Associated Infection
• Achieving Financial Balance on sustainable basis
• Maintenance Backlog
• Data Quality
• Roadway & Traffic Management
• Board’s Capital Plan
• Preparedness in Emergency Planning
• Data Protection Compliance

3.2.4.1 Three risks were removed from the Corporate Risk Register through this review and the rationale is set out below, leaving a total at December 2013 of 16 corporate risks.

- Litigation Exposure was removed as it is a consequence of not continuously improving patient and staff safety. Patient Safety and Staff Safety are currently on the Corporate Risk Register. There was also a risk associated with internal audit recommendations which have now been met in full
- Equal Pay Claims was removed and put onto the Director of Human Resources Risk Register as NHS Lothian’s current assessed exposure is limited based on NHS Scotland experience. This risk can be escalated by the Director of Human Resources should this exposure change
- Non-Compliance with Statutory Duties was removed and put onto the Director of Human Resources Risk Register as there has been sustained improvement relating to compliance with NHS Lothian’s policy on undertaking impact assessments as reported through the Healthcare Governance Committee.

3.2.5 Additional Changes – The risk registers are updated on a quarterly basis (Quarter 4 in January 2014) along with changes agreed at the RMSG and Audit & Risk Committee. The following changes have also taken place in addition to those outlined above:-

- The risk concerning Preparedness in Emergency Planning (1966) has been reduced from Medium 8 to Medium 4, following a review by the new resilience lead in Lothian in Quarter 3

- The Audit & Risk Committee in December, following a review of the Corporate Risk Register and Very High/High Risks across the organisation, identified the need to have in place a risk concerning Health & Social Care integration. This risk has been added to the Corporate Risk Register and focuses on delivery of the integration plans to agreed timescales in order to meet Scottish Government requirements and legislative duties as set out in the Public Bodies Joint Working Act (3567). This risk required further refinement and has been set at High 16 as there is still guidance to be issued by Scottish Government and the impact of not delivering this risk is significant both in terms of legal duties and delivery of improvement outcomes for patients/clients
• The risk concerning Healthcare Associated Infection (1076) has been increased from Medium 9 to High 12 in December 2013 by the RMSG and is reflected in the Corporate Risk Register.

• The risk concerning achieving financial targets in year on a sustainable basis has been increased through discussions at the December RMSG from Medium 9 to High 10 which will be reflected in Quarter 3 reporting and has been updated on the Corporate Risk Register.

3.3 Table 1 below provides a summary of the corporate risks and movement in risk grading over last 4 quarters. Appendix 1 provides additional details of each individual risk, October updates and the changes set out above. The next quarterly update took place during January 2014.

3.3.1 If you have an electronic version of this report, links to each risk in the appendix have been embedded in the table below (please click on individual Datix risk number in the table). This table illustrates that there has been minimal movement in risk grading over the last year.

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<tbody>
<tr>
<td>Healthcare Governance Committee Risks</td>
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<tr>
<td>3480</td>
<td>Patient Safety (Safety Outcome Measures in Quality Report and October 2013 HCG agenda item)</td>
<td>High 16</td>
<td>Date opened 13/02/2013</td>
<td>High 16</td>
<td>High 16</td>
<td>High 16</td>
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<tr>
<td>1085</td>
<td>Public Protection (Child, Adult, MAPPA) (Standing item on HCG)</td>
<td>High 16</td>
<td>High 15</td>
<td>High 15</td>
<td>High 15</td>
<td>High 16</td>
</tr>
<tr>
<td>3454</td>
<td>Patient Experience (Patient experience data and Complaints reporting – in Quality Report )</td>
<td>High 12</td>
<td>Date opened 13/02/2013</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>3486</td>
<td>Data Quality</td>
<td>High 12</td>
<td>Date opened 24/05/2013</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>1076</td>
<td>Healthcare Associated Infection (Standing item on Board Agenda)</td>
<td>Medium 16</td>
<td>Medium 9</td>
<td>Medium 9</td>
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<tr>
<td>2612</td>
<td>Data Protection Act 1998 Compliance (Reported to HCG Committee and to Board via Minutes)</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
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<tr>
<td>1966</td>
<td>Preparedness in Emergency Planning (Reported at Dec HCG)</td>
<td>Medium 12</td>
<td>Medium 8</td>
<td>Medium 8</td>
<td>Medium 8</td>
<td>Medium 4</td>
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<tr>
<td>Staff Governance Committee Risks</td>
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<tr>
<td>3527</td>
<td>Medical Workforce Sustainability - which replaces/incorporates: ID 1103 Paediatric Services at St John’s Hospital, now closed</td>
<td>High 16</td>
<td>Date opened 26/07/2013</td>
<td>High 16</td>
<td>High 16</td>
<td>High 16</td>
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<tr>
<td>3455</td>
<td>Health &amp; Safety (Reported at H&amp;S Committee, via Staff Governance Committee Minutes)</td>
<td>Medium 9</td>
<td>High 15</td>
<td>High 15</td>
<td>High 15</td>
<td>High 16</td>
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### 3.4 Risk Appetite

#### 3.4.1 Following the Board Risk Appetite Workshop in May 2013, a draft risk appetite statement has been drawn up for consideration. The Audit & Risk Committee in December 2013 considered the statement set out below which has been developed in response to feedback from both Executives and Non-Executives in a range of forums. The Audit & Risk Committee agreed it warranted further discussion however it was also agreed it would be useful for the Board to see the draft risk appetite below and to inform these discussions.

**Risk Appetite Statement**

“NHS Lothian operates within a low overall risk appetite range. The Board’s lowest risk appetite relates to patient and staff safety, experience and delivery of effective care. The Board tolerates a marginally higher risk appetite towards delivery of corporate objectives including clinical strategies, finance and health improvement.”

This risk appetite statement seeks to reflect the Board’s appetite / tolerance towards risk and the extent to which it is prepared to tolerate or accept risk in delivering its strategy and associated corporate objectives.

- This overarching appetite reflects the nature of the services NHS Lothian provides
- The “statement of Risk Appetite” aims to set a good overall “tone / sentiment” for how the Board views Risk, which overall is low for delivery of corporate
objectives set within a scale of “None, Low, Medium, High”, which has been simplified based on feedback.

- This risk appetite statement can also be graphically illustrated, as set out in Figure 1 below within the context of NHS Lothian’s core corporate objectives; represents how these objectives fit within the overall goals and informs judgement on risks, priorities and challenges.

Figure 1

3.4.2 The next stage once the risk appetite statement is agreed is to set targets which represent the Board Risk Appetite and in addition Tolerance is agreed. This work will take place through the RMSG and will be discussed by the Audit & Risk Committee prior to submission to the Board.

4 Key Risks

4.1 The risk register process fails to identify, control or escalate risks that could have a significant impact on NHS Lothian

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of the Corporate Risk Register updates, do not have any direct impact on health inequalities, each of the component risk areas within the document contain elements of the processes established to deliver NHS Lothian’s corporate objectives in this area.
7 Resource Implications

7.1 The resource implications are directly related to the actions required against each risk.

Jo Bennett
Clinical Governance & Risk Manager
20 January 2014
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Summary of Corporate Risk Register
# NHS Lothian Corporate Risk Register

<table>
<thead>
<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
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</table>
| 3480 | 6: Improve Staff and Patient Safety - Low Risk Appetite | Patient Safety | There is a risk that patient safety is compromised due to unreliable care and sub-optimal incident management leading to potential patient harm. | - The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety.  
- Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response.  
- The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring.  
- Quality Improvement Strategy (2011-14) sets out a range of improvement programmes to improve safety and outcomes of care.  
- Quality of care which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. | Risk reviewed Oct 2013: SPSP updated to October HCG issues of % compliance with 10 safety essentials highlighted. The new additional workstreams also highlighted the infrastructure may not support the pace of change required. As such the Risk remains high.  
Risk grade/rating remains unchanged High/16 | Uncertain; impact of controls not known at this time and more work required to identify current situation | | Dr David Farquharson | Healthcare Governance Committee |
<table>
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<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
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<th>Adequacy of controls</th>
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<th>Assurance</th>
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<tbody>
<tr>
<td>3189</td>
<td>8: Financial Resources and Plans - Medium Risk Appetite</td>
<td>Maintenance Backlog</td>
<td>Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk.</td>
<td>• The backlog maintenance sum has been reported at circa. £140 million. The Property Asset Management Strategy (PAMS) 2013-2020 describes how this figure will be reduced by disposals and Reprovision Programme. • F&amp;R have agreed to fund an initial £10 million expenditure on the high and significant risks over the next 18 months. A further £5m will be allocated until 2017/18 from the Board’s Capital Allocation to address backlog maintenance works. • A programme of works has commenced to undertake high and significant risks. The programme will continue into the financial year 2013/14. Within the Boards Capital Investment Plan a commitment of £5m has been allowed to continue the programme of works over a five year period. • An update of the PAMS for next year will log the affect upon the backlog maintenance and compliance figure • A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance. • A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years. • Rationalisation of the estate through planned disposals and termination of leases</td>
<td>Risk reviewed Oct 2013: The allocation for 2013/14 is £4.8m of which circa £2.2m has been committed this financial year. Emphasises this year is once again addressing high and significant risk items. Offers received for Morningside Properties being considered. Continuing marketing of Mill Lane and Polbeth. Offer being explored with preferred bidder for Rosslynlee</td>
<td>Adequate but ineffective; control is properly designed but not being implemented properly</td>
<td>High 16</td>
<td>Medium 4</td>
<td>Alan Boyter</td>
<td>Finance &amp; Resources Committee</td>
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<tr>
<td>3657</td>
<td>4: Develop a Cohesive Strategic Plan for NHS Lothian - Medium Risk Appetite</td>
<td>Health &amp; Social Care Integration</td>
<td>There is a risk that the Board and its Partners fail to submit agreed integration plans that satisfy the Scottish Government requirements to agreed timescales resulting in a failure to meet its legal responsibilities (Public Bodies Joint Working Act)</td>
<td>• Timescale for development and approval of the Integration Plan to be agreed at February 2014 Board acknowledging changes in SG timescales and requirement to consult on regulations and guidance to support the Bill. Update to go to Audit and Risk Committee in March 2014 • Plans will be open to consideration by the three governance committees of NHS Lothian and the process will be managed by the Integration Lothian Leadership Group</td>
<td>Risk reviewed Oct 2013:</td>
<td>Adequate but ineffective; control is properly designed but not being implemented properly</td>
<td>High 16</td>
<td>Low 3</td>
<td>Alex McMahon</td>
<td>tbc</td>
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<tr>
<td>3567</td>
<td>4: Develop a Cohesive Strategic Plan for NHS Lothian - Medium Risk Appetite</td>
<td>Medical</td>
<td>There is a risk that</td>
<td>• In response to a request from the SEAT Planning Board, a medical</td>
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| 1065 | 6. Improve Staff and Patient Safety - Low Risk Appetite | Public Protection (Child, Adult, MAPPA) | There is a risk of harm to individuals and to the Organisation’s reputation because of increasing complexity of cases, reduced capacity of medical and nursing specialist services including the vacancy for the Designated Doctor for Child Protection and the limitations of the existing | • A revised structure for Public Protection following a review in 2011 is now firmly embedded across NHS Lothian.  
• Designated leads for child and adult protection as well as the Multiagency Arrangements for Public Protection (MAPPA) are in place reporting directly by the Assistant Director for Public Protection to the Executive Director for Public Protection (Public Protection Framework attached).  
• The Public Protection arrangements are supported by range of robust policies, procedures and guidelines both interagency and health.  
• A comprehensive Public Protection training strategy is in place.  
• The governance arrangements for public protection are monitored by the Executive Lead through the relevant public protection action | The regional medical workforce group has recently reviewed its membership and terms of reference and now includes the NHSL Chief Executive. A local medical workforce group has not as yet been established.  
A regional short life O&G working group has been established to identify regional approaches to expanding the trained workforce through developing new workforce supply channels. Initial meeting took place in October and has identified initial priority workstreams. These will be developed into proposals for the Regional Medical Workforce Group to consider and approve.  
Risk Grade/Rating remains as High/16 | Risk reviewed Oct 2013. Progress has been made in relation to the vacancy for the Designated Doctor for Child Protection. One of the Lead Paediatricians for Child Protection has agreed to take on this role. It is anticipated this will commence by December 2013.  
The role requirements for a Designated Doctor for Adult support and Protection have been | "Uncertain, impact of controls not known at this time and more work" | High 15 | Melanie Johnson | Healthcare Governance Committee |
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<th>NHS Lothian Corporate Objective</th>
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<th>Risk Owner</th>
<th>Assurance</th>
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</table>
| 3455 | Improve Staff and Patient Safety - Low Risk Appetite | Health & Safety | There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being. | • Closed loop Health & safety management system in place.  
• Robust H&S Committee structure.  
• H&S policies and procedures in place (attached document).  
• Competent specialist H&S advice in place. Robust Occupational Health Services. Learning lessons through incident investigation.  
• Director of Occupational Health & Safety/Occupational Physician delivers an annual report to the NHSL H&S Committee with specific actions within these reports. | Risk reviewed. Oct 2013: NHS Lothian have been prosecuted and fined £32K for breaches of H&S Legislation  
Risk grade/rating remains unchanged - High/15 | Adequate but ineffective; control is properly designed but not being implemented properly | High 15 | Medium 6 | Alan Boyter  
Staff Governance Committee |
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<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
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</table>
| 3531 | Transform the management culture of the organisation | Lack of Management Capacity | There is a risk that management capacity, particularly in the acute sector and at executive level, will impact on developing and implementing robust plans to deliver key strategic objectives, or that operational management will be stretched to the extent that objectives are not met. | • Board reports on delivery of organisational objectives, risks and response.  
• Annual appraisals and mid-year reviews.  
• Review of organisational development needs including visible leadership at points of care.  
• Articulate organisational priorities to focus management efforts and identify areas of risk the organisation can tolerate in areas, particularly around internal audit recommendations.  
• Audit & Risk Committee commission internal audits and monitor recommendations and management actions.  
• Staff Governance Committee to lead on management capacity and capability from a governance perspective. | Risk reviewed Oct 2013. Controls/actions updated:  
• Additional senior management capacity and workforce planning approved.  
• Fourth Director of Health & Social Care appointed and started  
• Action and backfill in place for Executive Nurse Director duties.  
• Temporary management arrangements in acute division put in place (Aug/Sept 2013) – completed.  
• Management capability issues and layers of management will be undertaken when Director of Schedule Care commences duties.  
• Report to go to September 2013 Audit & Risk Committee on achievements/ non-achievements of management actions against internal audit reports – Regular reports will be presented to Audit Committee.  
• Consideration being given to additional compliance monitoring, (Director of Finance – Internal Audit), (Director of HR&OD – OH&S) – need to clarify what this process should be.  
Director of Scheduled Care commences 11 Nov 2013. | Adequate but ineffective; control is properly designed but not being implemented properly | High 15 | Low 3 | Tim Davison | Staff Governance Committee |
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<th>Risk Owner</th>
<th>Assurance</th>
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<tbody>
<tr>
<td>3486</td>
<td>Improve Staff and Patient Safety - Low Risk Appetite</td>
<td>Data Quality</td>
<td>There is a risk that poor data quality impacts upon patient safety. Poorly entered data could lead to the incorrect information being extracted for patient management or performance reporting. • A Data Quality Steering Group has been established to identify and address risks associated with poor data quality. The actions being taken forward are: Induction training for all new staff. • Undergraduate training for Nurse and Drs, training for Bank Staff. TRAK refresher courses linked with SOP training for waiting times. Reduce DNA for TRAK refresher courses. Address issues in Medical Coding. Communicate the importance of Data Quality to all staff.</td>
<td>Risk reviewed Oct 2013: A Data Quality Steering Group has been established to identify and address risks associated with poor data quality. The actions being taken forward are: Induction training for all new staff. Undergraduate training for Nurse and Drs, training for Bank Staff. TRAK refresher courses linked with SOP training for waiting times. Reduce DNA for TRAK refresher courses. Address issues in Medical Coding. Communicate the importance of Data Quality to all staff.</td>
<td>Uncertain; impact of controls not known at this time and more work required to identify current situation</td>
<td>High 12</td>
<td>Medium 9</td>
<td>Alex McMahon</td>
<td>Healthcare Governance Committee</td>
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Risk grade/rating remains unchanged High/12
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<th>Updates</th>
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| 3328 | 6. Improve Staff and Patient Safety - Low Risk Appetite | Roadways/ Traffic Management | There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites | • Traffic surveys have been conducted across all hospital sites, and action plans have been prepared. High risk actions have been completed where funding has permitted  
• Actions include:  
  o segregation of vehicle and pedestrian traffic;  
  o walk ways;  
  o drop-off areas and disabled spaces;  
  o additional parking attendants.  
• Interim measures have been put in place to prevent illegal parking including temporary barriers and bollards  
• RIE Site Campus Group has been put in place to co-ordinate the reprovision of DCN & RHSC, including impact on activity on traffic management  
• Action plans have been revisited on a number of hospital sites and has resulted in additional high risk works being undertaken | Risk reviewed Oct 2013. Proposals have been developed and estimated costs provided for traffic improvements at St John’s hospital. A business case is required to be completed and submitted through governance for funding to undertake the works.  
Recommendations and costs now received for improvements at St John’s Hospital. A business case is required to be developed.  
Risk grade/rating remains unchanged - High/12 |
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<th>Risk Owner</th>
<th>Assurance</th>
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<tr>
<td>3454</td>
<td>7. Implementation of the Patent Centred Collaborative - Low Risk Appetite</td>
<td>Patient Experience</td>
<td>There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.</td>
<td>• The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care. • Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response. • Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care. • Delivering Better Care structures in place to deliver Older People’s Action Plan and Vulnerable People’s Quality Improvement Framework, reported to the Board through the executive lead. These plans are informed by inspection reports produced by Healthcare Improvement Scotland and local audit and regular checklists i.e. PQI and mock OPAH. • The Delivering Better Care Hub has been established as a primary resource for nursing staff and where appropriate, other disciplines. • As part of the improving care to vulnerable people the rollout of a support manual with detailed information inclusive of a rapid patient essential care check sheet has been implemented within acute areas and planning now in place to roll out to community settings. • Quality of care is subject to internal Audits and compliance with audit recommendations reported via Audit &amp; Risk Committee and Healthcare Governance Committee. • A new national Person Centred Programme has been launched which NHS Lothian is taking part in, with the aim of capturing and responding to patient experience of care, including enhancing active involvement of patients in their care and co-production. This will be reported via governance committees of the Board.</td>
<td>Risk reviewed Oct 2013: DBC Hub resource now established WGH site. Open days were held in August with over 80 people visiting. Vulnerable People’s Quality Improvement Framework was refreshed and recirculated at the start of September updated and now includes PCC reference. A Critical Friend Review was conducted and feedback in July formal report received in September and a report will be taken to HCG in Nov/Dec. Progress is now being made on determining local measures for this work, with first pilot of ‘test question’ to take place during October.</td>
<td>Uncertain; impact of controls not known at this time and more work required to identify current situation</td>
<td>High 12</td>
<td>Medium 6</td>
<td>Melanie Johnson</td>
<td>Healthcare Governance Committee</td>
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<td>6: Improve Staff and Patient Safety - Low Risk Appetite</td>
<td>Healthcare Associated Infection</td>
<td>Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment.</td>
<td>• NHS Lothian has an Infection Prevention &amp; Control Service to provide access to specialist knowledge. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid &amp; East and West Lothian) established to cover both acute and community settings. • The UHS and CHP Infection Prevention and Control Committees are in place and report to board through LICAC. • IT based system in place to facilitate IPCN to monitor incidences of HAI within their clinical remits and to monitor for trends and patterns. SPSP have provided a collection of tools to support good practice to minimise potential for patient. IPCNs work collaboratively with clinical teams and bed management to provide advice and guidance on isolation and restriction of patient movements to balance the risk of transmission and impact on patient flow. • IPCNs communicate directly with clinical services, escalating as appropriate. SAB and CDI rates reported weekly and monthly through IPCT reports which are sent by email and available on intranet. At senior management level there is CMG/CMT and board papers. All incidences of SAB &amp; CDI investigated, clusters of 2 or more investigated for links SBARs are provided. Systems are in place to escalate investigation. HAI Matrix utilised to identify reporting level HAIIRT. Communications provide support to manage public release of information as required. • Packages of audits are in place to monitor standards and are linked to the National Standard Infection Control Precautions Chapter. • HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro and the Education Strategy is available on line. • There is a Decontamination Strategy Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment.</td>
<td>17 Jan 2014: Risk regraded to reflect outwith trajectory risking achievement of HEAT targets and the potential risk to service associated with ratio of trainees to experienced staff [17/01/2014 12:17:02 Fiona Cameron] 17 Jan 2014. Update on actions undertaken. Addition of actions associated with HEAT targets added as currently off trajectory to achieve these for CDI and SAB by March 2015 Staffing added as a risk due to ratio of trainees to qualified staff. Risk grade/rating upgraded to High12</td>
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<tr>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Risk Owner</th>
<th>Assurance</th>
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<tbody>
<tr>
<td>Satisfactory controls adequately designed to manage risk and working as intended</td>
<td>High 12</td>
<td>Medium 6</td>
<td>Melanie Johnson</td>
<td>Healthcare Governance Committee</td>
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<tr>
<td>ID</td>
<td>NHS Lothian Corporate Objective</td>
<td>Title</td>
<td>Description</td>
<td>Controls in place</td>
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<tr>
<td>211</td>
<td>2: Plan and Deliver Waiting Times Recovery Plan - Low Risk Appetite</td>
<td>Achievement of National Waiting Times Targets</td>
<td>There is a risk of: Not achieving national waiting times targets (stages within the 18 weeks RTT pathway; 31/62 Cancer waiting times; treatment time guarantee;) for a number of reasons: Lack of core capacity in a number of specialties; Internal capacity not being utilised effectively; Risk of overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; risk of not achieving Value for Money. Lack of robust management process and staff capability to deliver consistent management of waiting lists. Risk of adverse publicity relating to failure to meet waiting times targets.</td>
<td>• Waiting Time Recovery and Sustainability Group meets weekly chaired by the Medical Director to ensure the delivery of in-patient/day case and out-patient activity to reduce the backlog. There is monitoring of the financial impact of the recovery plans. The performance against the Treatment Time Guarantee is monitored. • Development and implementation of a consistent approach to capacity planning is progressing with QuEST support. • Development of skills for demand and capacity planning and management across various staff groups in the organisation. • Development and implementation of booking processes which supports good waiting list management; and use of the 6-4-2-1 theatre scheduling system to make better use of theatre capacity. • Commissioned support for purchase of external capacity to ensure Value for Money. • Action plan with agreed timescales in place to address internal audit recommendations relating to the management of waiting times in NHS Lothian, supported by a delivery group chaired by the Director of Finance. This includes single management system for waiting time’s management, development of SOPs and a staff training programme to ensure consistency of approach. Progress report - Audit &amp; Risk Committee, September 2013.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Risk Owner</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory, controls adequately designed to manage risk and working as intended</td>
<td>High 12</td>
<td>Low 1</td>
<td>Jim Crombie</td>
<td>Finance &amp; Resources Committee</td>
</tr>
<tr>
<td>ID</td>
<td>NHS Lothian Corporate Objective</td>
<td>Title</td>
<td>Description</td>
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<tr>
<td>3203</td>
<td>3: Improve Unscheduled Care Performance - Low Risk Appetite</td>
<td>Unscheduled Care</td>
<td>Performance against the delivery of Unscheduled Care is primarily measured by the 4 hour Emergency Care Standard. Performance against this standard is a measure of the effectiveness of performance against the whole healthcare system. It reflects the effectiveness of patient flow through the system. Poor performance is evidenced by the number of breaches of the 4 hour standard, levels of overcrowding within Emergency Departments, the number of patients boarding (including the use of day surgery beds as over night capacity), the need for elective cancellations due to capacity pressures, the number of delayed transfers of care (either from critical care and recovery to acute, acute to sub-acute or to non-hospital). It is understood that poor performance against these measures will have a direct and adverse impact on patient care. Whole system working involves GP’s, SAS, Local Authorities, NHS24, LUCS, primary care and secondary care.</td>
<td>The Unscheduled Care Group is responsible for developing and implementing the unscheduled care strategy. The Group is co-chaired by the Director of Nursing and the Director of Health &amp; Social Care. The Group has developed a range of proposals which are being implemented including: • The development of new medical assessment models to improve senior consultant presence in the evening and weekends. • The development of models of care for older people to support admission avoidance and earlier discharge from hospital. • The development of increased capacity in social care services to reduce the number of patients with a delayed transfer of care for social reasons (including an additional 4,610 hours per week care at home for older people in the first nine months, a 12% increase) The weekly discharge target has now increased from 63 people per week to 72 people per week. • Effective Joint Working with Councils to progress the Integration agenda. • Investment in additional bed capacity (RIE ward 104, WGH ward 25, re-opening of RVH ward 1 and 2, Corstorphine) • Planned development of additional capacity on RIE site for assessment and ward bed capacity in line with demand. • Work on redesign to improve processes (e.g. admission avoidance with OPAT, development of ambulatory care pathways, more rapid pull of patients to wards) • Investment in senior supervisory nursing staff to support improved discharge planning including earlier in the day discharges to support patient flow. • Investment in staffing within Emergency Departments. • Focus on those patients waiting for packages of care of less than 14 hours; care at home as well as those on the rehabilitation list who could be supported at home. In addition we continue to focus on the reduction in the length of time to process complex cases, including guardianship applications. • The performance metrics in place through the Change Fund plans will be used to determine the impact and effectiveness of the interventions and will be reported through JMT and CH(C)P Sub-committees. The Delayed Discharge team within NHS Lothian will closely monitor delays over 2012/13 to ensure they remain on trajectory and provide analysis to support any proposed changes required to address performance through JMT and the Board. January Elective plan - Reviews of 2013 performance will focus on potential for increased reduction in planned elective activity in the first two weeks of January to support unscheduled care flows. Norovirus impact on Liberton - Development of an alternative plan for repriorisation of the rehabilitation flow/surge plan in alternatives models of care when affected by Norovirus (e.g. all wards shut during Feb2013)</td>
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<tr>
<td>ID</td>
<td>NHS Corporate Objective</td>
<td>Corporate Objective</td>
<td>Title</td>
<td>Description</td>
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<tr>
<td>2964</td>
<td>Financial Resources and Plans</td>
<td>- Medium Risk Appetite</td>
<td>The Board does not achieve its financial targets each year on a sustainable basis.</td>
<td>8: Financial Resources and Plans - Medium Risk Appetite</td>
</tr>
<tr>
<td>ID</td>
<td>NHS Lothian Corporate Objective</td>
<td>Title</td>
<td>Description</td>
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<tr>
<td>1267</td>
<td>6: Financial Resources/Plans</td>
<td>The Board's Capital Plan cannot be delivered</td>
<td>There is a UK-wide reduction in public sector budgets, which in turn has significantly reduced the level of available capital funding. Revised national arrangements have been introduced through CEL 32 (2010): Arrangements for the Management of NHS Scotland Capital Resources after 2010/11. Amongst other things, the Board's delegated limit has been reduced from £10m to £5m. The Board therefore has less capital funding, and less delegated authority.</td>
<td>• The Lothian Capital Investment Group, Joint Management Team and Finance &amp; Resources Committee of the Board regularly review progress with major capital projects and the property &amp; asset management programme overall. • The Director of Finance is the executive lead for the Property &amp; Asset Management Strategy, which encompasses all aspects of the estate and infrastructure, and sets priority areas for investment. The PAMS has been presented to the F&amp;R Committee for discussion, it remains an area of ongoing dialogue and aims to ensure connections with the Clinical Strategy</td>
</tr>
<tr>
<td>2812</td>
<td>6: Improve Staff and Patient Safety</td>
<td>Data Protection Act 1998 Compliance</td>
<td>There is a risk that NHS Lothian breaches the Data Protection Act 1998 by accidental or unauthorised disclosure to third parties, of identifiable sensitive data relating to patients or staff. Disclosure of manual or electronic identifiable data could occur by accidental loss such as theft, or by failure to implement policy or appropriate control and security of, use and disclosure of personal data. Consequences of inappropriate disclosure</td>
<td>• Staff training (induction and refresher). • Staff awareness (letter to all staff, team brief articles and roadshows). • Policy and Procedures including security and confidentiality. • Monitoring of potential inappropriate access to patient systems. • Monitoring of potential inappropriate use of eHealth tools including email and encrypted USB devices. • Audit and Incident review. • Procedure for subject access to records in line with Data Protection Act. • Transport of records policy ratified by Information Assurance Group in last period.</td>
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<td>ID</td>
<td>NHS Lothian Corporate Objective</td>
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<td>20</td>
<td></td>
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<td>are; distress to individuals, reputational damage to organisation, legal action or financial penalty up to £500,000.</td>
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<td>ID</td>
<td>NHS Lothian Corporate Objective</td>
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<td>1966</td>
<td>9. Protect Health, Improve Health Status &amp; Health Inequalities - Medium Risk Appetite</td>
<td>Preparedness in Emergency Planning</td>
<td>We are a Category 1 responder under the Civil Contingencies Act 2004 and the associated Contingency Planning (Scotland) Regulations 2005. There is a risk that insufficient preparedness for major incidents and other events, as detailed in the National Community Risk Register and mandated by the legislation, would mean that the Board would not meet the expectations of South East Scotland Emergency Planning Strategic Coordinating Group, partner agencies nor Scottish Government. We are always reviewing emergency preparedness and an internal audit is currently underway (October 2013) to ensure consistency of approach with Preparing for Emergencies – Guidance for Health Boards in Scotland (published Oct 2013) and to ensure full compliance with The Civil Contingencies Act 2004, etc.</td>
<td>1. NHS Lothian major incident plans, outbreak plans and Public Health SOPs and guidance on the management of incidents indicate management structures and accountability. 2. Internally, when appropriate, Emergency Planning matters are reported at several key meetings, including JMT, HG&amp;RM and EPSAG. Additionally, HG&amp;RM receives an annual report from the Emergency Planning Officer. Externally, through the Director of Public Health and Health Policy and the Emergency Planning Officer, NHS Lothian is represented at all Lothian and Borders Emergency Planning Strategic Coordinating Group (SCG) meetings at strategic, tactical and operational levels and the NHS Scotland Resilience Forum at Scottish Government. 3. Incidents are reported to the above groups as required in some cases following multi-agency structured debriefing. The Emergency Planning Officer is a member of the SCG’s Risk Group which oversees the Community Risk Register. 4. Structured debriefs are held of major and other significant incidents with a view to capturing issues and learning points. Where required they will inform amendments to plans, policies and procedures. 5. NHS Lothian staff participate in emergency planning training and exercises at local, regional and national levels on a regular basis. The Emergency Planning Officer chairs the SCG’s Training and Exercising Working Group. 6. Under the NHS Lothian Scheme of Delegation the Director of Public Health and Health Policy is given the role of responsibility for and oversight of emergency planning functions. 7. NHS Lothian Corporate Communications has co-opted membership of the Emergency Planning Strategic Advisory Group where they can be kept up to date with local, regional and national emergency planning issues. 8. The next internal audit of Emergency Planning is programmed for 2014/15. 9.As a means of mitigating SCC reform risks, it is probable that existing SCC arrangements would be capable of extension for a period of time if required to ensure a continued robust response at strategic SCC level, in which NHS Lothian participates through the Chief Executive and the Director of Public Health and Health Policy. However, the importance of maintaining effective communications and dialogue on the changes and impact upon Health Boards – NHS Lothian, Borders, Forth Valley and Fife -, as Category 1 responders across the East hub can not be underestimated in resolving issues. The provision of early clarity on future SCC resourcing from Scottish Government will also assist in this regard. The Joint Management Team has been asked to consider proposals for an executive led Resilience Committee to provide integrated strategic leadership in this area, in line with specific Scottish Government recommendations. This would be chaired jointly by the Director of Public Health and Health Policy and the Director of Strategic Planning. A detailed work-plan is being developed which will consider the requirements of G2014 planning and exercising and the recommendations of the internal audit of emergency preparedness. This is in addition to major ongoing commitments arising from risk based, generic emergency preparedness arrangements and more specific infectious disease and environmental health arrangement.</td>
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SUMMARY PAPER- CORPORATE OBJECTIVES

This paper aims to summarise the key points in full paper.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>• To note the progress made at the end of the third quarter of 2013/14 in delivering NHS Lothian’s Corporate Objectives. The paper also highlights those objectives where our performance is off trajectory or not on target and where we require further work to be done.</th>
<th>1.1</th>
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<tbody>
<tr>
<td>• NHS Lothian's Corporate Objectives for 2013-14 comprise 74 actions, including the revised HEAT targets and standards within the 2013-14 Local Delivery Plan</td>
<td>2.3</td>
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<tr>
<td>• Of the 74 actions, 54 are identified as green and 20 as red.</td>
<td>3.2</td>
</tr>
<tr>
<td>• Actions to address objectives identified as red are included within the comments sections of the appendix and have been highlighted within the paper, as well as reported in the appropriate performance reports to the Board.</td>
<td>3.2</td>
</tr>
</tbody>
</table>

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24 January 2014  
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Alex McMahon  
Director of Strategic Planning  
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1 Purpose of the Report

1.1 To recommend that the Board notes the progress made at the end of the third quarter of 2013/14 in delivering NHS Lothian’s Corporate Objectives. The paper also highlights those objectives where our performance is off trajectory or not on target and where we require further work to be done.

1.2 It was agreed at the end of 12/13 that performance against Corporate Objectives should be recorded as either ‘Green’, on target/trajectory or ‘Red’ off target/trajectory and that a report would come to the Board on a quarterly basis.

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

2 Recommendations

2.1 Note progress towards NHS Lothian’s Corporate Objectives for 2013-14.

2.2 Note that the corporate objectives are aligned to the six key aims of the current Clinical Strategy Framework and the 2020 Vision Route Map as well as the content of our Local Delivery Plan.

2.3 Note that of the 74 actions within the Corporate Objectives we are reporting a position of ‘Green’ for 54 and Red for 20 in this latest quarter. This is against the last quarter position reported to the Board in November of 58 being reported at ‘Green’ and ‘Red’ for 16.

2.4 To note that those actions that have moved from Green to Red are ‘preparing NHS Lothian to deliver high impact interventions that will support the delivery of the acute Scottish Patient Safety programme outcome measures to reduce mortality by 20% and achieve 95% harm free care by the end of 2015’. As well as ‘ensuring the current Safe Care patient Safety Programme measures are met and reported’. ‘Deliver faster access to mental health services for CAMHS and psychological therapies’ as well as ‘Further reduce healthcare associated infections’ and the current performance related 95% of patients being seen within 4 hours.

2.5 For the 2014/15 Corporate Objectives we will bring a set of propositions forward to the April Board. These will be set against the Strategic Plan and the 2014/15 LDP which will also be presented at the April Board. In doing so we will attempt to reduce the overall number of actions but there is a requirement to ensure that those we do agree are better articulated in terms of measurability.
3 Discussion of Key Issues

3.1 NHS Lothian’s Corporate Objectives for 2013-14 comprise 74 actions, including the revised HEAT targets and standards within the 2013-14 Local Delivery Plan. Appendix 1 details progress against each objective and the actions that sit within them.

3.2 Significant progress has been made across the range of objectives set during the first three quarters of 2013/14 and these are highlight within the report. Of the 74 actions, 54 are identified as ‘Green’ and 20 as ‘Red’. Actions to address objectives identified as red are also included within the comments sections of the appendix and have been highlighted below within this paper.

3.3 Performance overall against the Corporate Objectives is in a positive balance. Many of those that are green relate to our strategic planning and strategy development and implementation but also the work in relation to transforming the culture of the organisation and the development and now implementation of the work on our ‘Values’. We have also reported positive progress in respect of developing capacity plans for addressing our acute capacity; business continuity; driving forward our children’s agenda and the work to develop the OBC for the Royal Edinburgh Hospital re-provision. Work has also started in respect of site master planning and playing this into the development of the Strategic Plan.

3.4 As mentioned in the last report to the Board in November 2013 a significant focus has been given to patient safety and quality of care as evidenced through our work in the national acute patient safety programme; the mental health and maternity patient safety programmes and the primary care patient safety programme as well as the Early Years Collaborative. Although we are reporting progress against these actions as Red in this period work is emerging from these programmes and is being reported to the Board either through the Healthcare Governance Committee or the actual Board through the Quality report. For example NHS Lothian has implemented the ‘10 safety essentials (CEL 19)’ to all appropriate areas in the acute service. Further work in and around the patient safety and quality agenda is being taken forward with the Directors of Scheduled and Unscheduled Care supported by senior medical colleagues. Further work will also be undertaken during 2014 to learn from the recent review of NHS Lanarkshire. The development of a quality board and quality hub is also being explored and being taken forward by the Medical Director. Narrative providing an update on actual actions to progress our performance is included in the appendix to this paper. More detailed actions are contained within the narrative in the appendix of this report.

3.5 We want to support our staff, and ensure that they are safe at work. Our work on developing the ‘Values’ has engaged over 3000 members of NHS Lothian staff. It has been agreed by the Staff Governance committee to review the work that had been done initially by the Management Culture Steering group. A refreshed Leadership Framework is being developed as is NHS Lothian’s Learning Plan. The first meeting of the group who will be responsible for the action plan is scheduled for the 30th January. Membership includes the Joint Chairs from each of the re-formatted Local Partnership Forums The group will report back progress to the Staff Governance Committee. Further work on staff safety is required as we are still reporting this as ‘red’ in the attached report. The Director of HR/OD and Workforce will be able to update colleagues on further work that is being undertaken.
3.6 With regards to those actions which are marked as Red, the majority (12) are within Objective 10, ‘To have robust system of performance management and reporting aligned to delivery of HEAT targets. Our position within this objective has gone from 8 actions being reported as Red.

3.7 The targets that we are not delivering against are reported routinely within CMT and to the Board through papers on performance, waiting times, unscheduled care and quality as well as the HAI report. An important context for a number of these targets and our performance is that within the national position as reported through the Information and Statistics Division (ISD). There are challenges for many Boards i.e. the 4 hour accident and emergency target; reducing the rate of attendance at accident and emergency departments; the reducing suicide rates; reduction in energy consumption; delayed discharges; Healthcare Associated Infection a well as child healthy weight and fluoride tooth varnishing.

3.8 Targets where we are doing well and indeed are performing better than the all Scotland position are in respect of staff sickness absence; smoking cessation and access to antenatal services. In addition we are reporting a positive position in relation to delivery of the number of IVF treatments. We are also positively engaging in the work around detect cancer early and the Board should note the current lung cancer awareness campaign and that a further awareness on breast screening will run nationally later this spring.

3.9 In relation to the 4 hour A&E standard, NHS Lothian’s performance has dipped over the winter months. There has been a number of very challenging weeks and the Western General Site in particular has struggled with its performance. During December performance across the four sites averaged 92.5% within 4 hours and there were 17 patients who waited longer than 12 hours. Various sites i.e. the RIE and the WGH have had challenges over the last few weeks in respect of volume; age and complexity of care needs being presented with and the timing of presentation i.e. later in the day. We have developed the Lothian Unscheduled Care Plan and we have also developed our Winter Plan which was presented to the Board in October.

3.10 At the same time the number of delays in our system continues to prove challenging. This is having a direct effect on our 4 and 12 hour performance as well as boarding in to beds which then cannot be used for their original purpose. This is then having an effect on our elective capacity. Work is underway with the City of Edinburgh Council and NHS Lothian, led by the Chief Executive’s and supported by the Board Chairman and the Council Leader to look at what additional capacity can be developed within the community to better support flow through the acute and primary care system to increase the number of discharges on a daily and an ongoing basis. We are exploring a ‘blended’ approach in respect of options around a care village model and this is being developed as a proposition within the Strategic Plan; further step down and step up beds; care at home and packages of care. At the same time we are also exploring options with East Lothian Council as well as they are also experiencing some difficulty in supporting adequate rates of discharge from hospital and in to appropriate care facilities or back home with support. Current levels of delays are being reported in the Unscheduled Care report to the Board. At the same time we are progressing further work around the number of people boarding into our acute and primary care beds and this work is now being
implemented across the system lead by the Site Director for SJH. We are also scoping a review of our inpatient continuing care beds and looking at our re-admissions and what further work can be done to minimise the need for re-admission where clinically appropriate and possible. Aspects this work will be brought back to the Board within the context of our Strategic Plan.

3.11 Additional emergency medicine consultants have been appointed with support from emergency nurse practitioners at St John’s. There is consultant cover in the Emergency Department until 11.00pm. Six Clinical Development Fellows are in place to support the out of hours service in the Emergency Department at St John’s. Additional Emergency Medicine consultants have been recruited to Lothian and another cohort of Clinical Development Fellows will be recruited for August 2014.

3.12 In addition to these targets we are also behind where we would want to be in relation to our performance on 90% of elective patients commencing treatment within 18 weeks and also 12 weeks from referral to first outpatient appointment. Again significant focus has been given to our performance around elective waiting times through routine, monthly Board reports and this will continue. The Board is well sighted on the financial investments that have been made in recruiting more staff to increase our capacity and work in developing robust plans for key service areas such as orthopaedics; ophthalmology; ENT, dermatology etc. which continues. The Director of Scheduled Care has started the process of pulling together a recovering plan for those services identified above but is also exploring what activity could be better placed on alternative sites to maximise capacity and clinical time and expertise. Plans are being formulated and will be aligned to the Strategic Plan and will also be brought to the Board in due course having been considered by the Acute Care Committee of the Board which is being proposed.

3.13 We have also reported separately to the Board on our performance against the Stroke Standard and Board members recently received an update from the Director of Unscheduled Care. Further work is being done to look at the best model of care for those who have had a stroke and this will be developed and brought back to the Board in April as part of the Strategic Plan.

3.14 Our performance in relation to meeting the targets against CAMHS and psychological therapies requires more work to be done. We have briefed the Board on a number of occasions in respect of the way in which we have taken this work forward, which has involved services being migrated across over a period of time. This has resulted in our performance, particularly around psychological therapies appearing to fluctuate dramatically at times. Additional staff have been recruited through using the additional £700,000 provided this year. A review of whether or not continued support and funding is required going forward is being taken forward with the lead Director and the Director of Finance. Further update on this target is included within the Board’s Waiting Times paper.

3.15 Out with the immediate HEAT targets and standards we have reported a “Red” status against our action on cash efficiency savings and also our capital investment plan. The Director of Finance has given assurances that the position should be in balance for 13/14 and that we should hit the agreed trajectory. These two actions are also closely monitored through the Boards Finance and Resources Committee and the CMT. Additional updates will be provided through the Director of Finance at the February Board meeting.
3.16 For the 2014/15 Corporate Objectives we will bring a set of propositions forward to the April Board. These will be set against the Strategic Plan which will also come to the Board as well as the 2014/15 LDP which will also be presented at that Board meeting.

4 Key Risks

4.1 Risks associated with the delivery of HEAT targets and standards are detailed within the Local Delivery Plan Risk Management Plan which was accepted at the February Board.

5 Risk Register

5.1 The Corporate Objectives for 2013-14 are linked directly to and where appropriate placed on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 All HEAT Targets and standards have been fully impact assessed as have where appropriate, many of the other targets and actions within the set of corporate objectives.

7 Involving People

7.1 Issues are highlighted within the Local Delivery Plan Risk Management Plan.

8 Resource Implications

8.1 Resource implications are highlighted within the Local Delivery Plan, Risk Management Plan and also within the financial plan that accompanies the plan.

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List of Appendices

Appendix 1: NHS Lothian Corporate Objectives 2013-14 Update Q3 Dec 2013
### OBJECTIVE 1
TO TRANSFORM THE MANAGEMENT CULTURE OF THE ORGANISATION

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>Ongoing, by March 14</td>
<td>All</td>
<td>Waiting times challenges continue to be addressed. Tranche 2 investments in elective and unscheduled care are being made. Specific areas of challenge in elective care are in urology, ophthalmology, orthopaedics as well as residual challenges around specialist spinal work. The Director of Scheduled Care is developing a recovery and longer term strategic plan.</td>
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# NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

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<th>RELATES TO AIM 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</th>
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<th>COMMENTS</th>
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<tbody>
<tr>
<td>OBJECTIVE 1 TO TRANSFORM THE MANAGEMENT CULTURE OF THE ORGANISATION</td>
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<tr>
<td>Implement the specific Organisational Development Action Plan which flows from the work of the Management Culture Steering Group including specific Board Development and Senior Manager Development programmes.</td>
<td>March 14</td>
<td>AB</td>
<td>It was agreed by the Staff Governance committee that we would transfer the work of the Management Culture Steering group. A refreshed Leadership Framework is being developed as is NHS Lothian’s Learning Plan. The first meeting of the group that will be responsible for the action plan is scheduled for the 30th January. Membership includes the Joint Chairs from each of the re formatted Local Partnership Forums The group will report back progress to the Staff Governance Committee</td>
<td><img src="Image" alt="Green" /></td>
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<tr>
<td>Develop the team coaching methodology for Corporate Management Team members and their direct reports to reinforce exemplar behaviours.</td>
<td>March 14</td>
<td>All</td>
<td>Team development sessions have taken place. Values work, as well as corporate and individual objectives now set and agreed.</td>
<td><img src="Image" alt="Green" /></td>
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<tr>
<td>Endorse and further develop the work on vision and values as part of the Management Culture review.</td>
<td>June 13</td>
<td>AB</td>
<td>Final version of values were linked to NHS Scotland values, and approved at the Board in July 2013. These have now been published and circulate to staff across the organisation. Engagement has commenced with each of the Local Partnership Forums and a draft plan will come to the Staff Governance Committee at the End Of March 2104.</td>
<td><img src="Image" alt="Green" /></td>
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## NHS Lothian – Corporate Objectives 2013/14 – Update end Dec 2013

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<tr>
<td><strong>OBJECTIVE 2:</strong> TO PLAN AND DELIVER THE WAITING TIMES RECOVERY PLAN TO CLEAR THE BACKLOG OF PATIENTS AND DEVELOP RECURRING DEMAND/CAPACITY EQUILIBRIUM</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
<td>STATUS</td>
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<td>Ensure the implementation of the revised Standing Operating Procedures, the required training programme for staff and the phased centralisation of the management of waiting times staff.</td>
<td>JUNE 13</td>
<td>JC</td>
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<tr>
<td>Training to identified staff undertaken during 2013 and is ongoing. SOPs will require revision in light of revised access policy which will go to the Board in February 2014. Single system Waiting Times staffing remains on track.</td>
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<table>
<thead>
<tr>
<th>Ensure comprehensive monthly performance monitoring to the NHS Board on performance against targets, recovery plan and waiting times management compliance</th>
<th>MARCH 14</th>
<th>AMCM</th>
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<table>
<thead>
<tr>
<th>Ensure the delivery of a sustainable financial framework to support recovery and maintain performance thereafter.</th>
<th>ONGOING</th>
<th>SG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring investment plans agreed in principle at Jun-13 board subject to F&amp;RC review and agreement of business cases for areas of major service development. Provision made for investment decisions not yet approved. Initial resource requirements for non-recurring support to recovery trajectory agreed at June board, with further work required to confirm independent sector requirements for Q3/Q4.</td>
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### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

<table>
<thead>
<tr>
<th>Objective</th>
<th>Date</th>
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<th>Notes</th>
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<tbody>
<tr>
<td>Ensure delivery of the comprehensive system of compliance monitoring of waiting times systems including real-time scrutiny of changes made on TRAK.</td>
<td>JUNE 13</td>
<td>AMCM</td>
<td>Weekly Forensic Dashboard in place for unusual changes affecting waiting time clock. SOP dashboard to assess other aspects of compliance with guidance in development. Weekly Outpatient Forecast and development of DCAQ dashboard as well as information in External Provider Activity provided. Internal Audit report update taken to Audit and Risk Committee in December 2013 updating on progress against all identified actions.</td>
</tr>
<tr>
<td>Develop and implement costed capacity plans by specialty to ensure recurring demand/capacity equilibrium, including specific clinical workforce plans, leading to the phased reduction in reliance on external capacity.</td>
<td>JUNE 13</td>
<td>JC</td>
<td>There has been a review of the management capacity to complete this work and this will mean an extended timescale. With support from the Scottish Government, plans have been developed for three of the high risk specialities - ophthalmology, orthopaedics and colorectal surgery, which will be discussed in detail.</td>
</tr>
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</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

<table>
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<tr>
<th>OBJECTIVE 3: TO IMPROVE UNSCHEDULED CARE PERFORMANCE</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Develop and implement a costed capacity plan to reach demand/capacity equilibrium for unscheduled care across primary, secondary and social care.</td>
<td>June 13</td>
<td>MJ</td>
<td>Lothian Unscheduled Care Action Plan (LUCAP) produced. Ongoing financial review and programme of evaluation of schemes. Capita modelling undertaken for social care to be considered by Change Fund and Unscheduled Care Group. LUCAP update submitted to Scottish Government (Dec 2013). Further evaluation of plan required due to projected financial pressures in 2014/15. Work in progress to address whole system capacity issues across Health and Social Care. Further workforce requirements emerging as service improvement work continues.</td>
<td><img src="green.png" alt="Progress" /></td>
</tr>
<tr>
<td>Create effective surge capacity for mixed economy of home care, care home and NHS beds able to be deployed rapidly to respond to peaks in demand for specialist health and/or social care through the work of the Unscheduled Care Group</td>
<td>June 13</td>
<td>PG/MJ/AMcM</td>
<td>Surge capacity created and used across winter period. Will be reviewed in terms of longer term sustainability. Proposal for SJH medical workforce to replicate weekend and evening extended consultant presence at RIE/WGH submitted to address HSNR and flow concerns. To be considered as part of the financial plan.</td>
<td><img src="green.png" alt="Progress" /></td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

#### OBJECTIVE 3: TO IMPROVE UNSCHEDULED CARE PERFORMANCE

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<td>Step-down beds jointly commissioned and on stream from November 2013 in phased approach.</td>
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<td>7 day working event held with action plan developed and incorporated into Lothian Unscheduled Care Action Plan</td>
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<td>Hospital at Weekend implemented from December 2013 at St John's Hospital to support 7 day weekend working.</td>
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<td>Work is underway to improve flow through preventing admissions, service redesign and increases in capacity. Examples include:</td>
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<td><strong>Prevention:</strong> Edinburgh CHP Long Term Conditions Programme. Change Fund investments of £8.6m in 2013/14, including £1.2m in building community capacity.</td>
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<td><strong>Acute Service redesign:</strong> Creation of a mobile medicine of the elderly service at the Western General</td>
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<td><strong>Acute Staffing capacity:</strong> Additional investment in consultants, specialty doctors and Advanced Nurse</td>
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<tr>
<td>RELATES TO AIMS 2 AND 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</td>
<td>TIMING</td>
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<tr>
<td>OBJECTIVE 3: TO IMPROVE UNSCHEDULED CARE PERFORMANCE</td>
<td></td>
<td>Practitioners</td>
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<td><strong>Acute increases in physical capacity:</strong> Additional beds have been opened, with further 31 additional beds being commissioned in February for RIE.</td>
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<td><strong>Increases in Social Care Capacity:</strong> Council capacity for Care at Home and Home Care increased by 14% at an additional cost of c. £2.5m during 2012/13. In the first half of 2013/14 an additional 5% has been provided.</td>
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<td>Hospital at Weekend pilot service started at St John’s in November.</td>
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<td>Mobile MoE service now up and fully staffed at WGH; 78 beds now available at RVH for delayed discharges; additional 14 oncology beds and 28 medicine beds now open at WGH.</td>
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<td>Dec 13</td>
<td>PG/MJ/ALL</td>
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</table>
### OBJECTIVE 3:
**TO IMPROVE UNSCHEDULED CARE PERFORMANCE**

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<tr>
<td></td>
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<td>The Boarding trend is up on this time last year</td>
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<td>The number of 8 hour breaches increased from 130 in November to 146 in December. (YtD Av. 145)</td>
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<td>The number of 12 hour breaches decreased from 20 in November to 17 in December (YtD Av 15). LUCAP describes planned actions.</td>
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<td>Delayed discharge targets in place – achieve 0 over 4 weeks, reduce average delay to 20 days but not being met.</td>
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<td><strong>Change Fund</strong> investments in community services have helped to reduce delayed discharges</td>
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<td><strong>Step Down</strong> – 43 step down beds will be developed within independent care homes in Edinburgh by December 2013 (not October 2013 as originally planned). It is intended to increase this to 60. St Michael's Hospital (West Lothian) being utilised for step down beds in conjunction with REACT team.</td>
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<td>Additional beds now identified for RVH to ensure</td>
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<tr>
<td>Develop and implement costed clinical workforce plans to sustain vulnerable 24/7 front door clinical services, ensuring that contingency plans are in place to mitigate the impact of staffing vacancies that may arise.</td>
<td>June 13</td>
<td>MJ/DF/AB/JC</td>
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## RELATES TO AIMS 1, 2, 3, 4, 5 AND 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK

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<tr>
<th>OBJECTIVE 4: To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements.</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>Develop a strategic planning process to integrate existing and emerging clinical strategies with workforce, finance, capital investment and property strategies, incorporating a refreshed Vision and Values Framework.</td>
<td>June 13</td>
<td>AMcM</td>
<td>Strategic Planning Committee now established. Directors have a monthly Strategic Programme Board. Process agreed, and staff have been recruited to the Strategic Planning Programme Office. On track to take a strategic plan to the NHS Board on the 2nd April.</td>
<td></td>
</tr>
<tr>
<td>To develop a site master-planning process for the four main inpatient sites of RIE, WGH, SJH and REH to support the implementation of existing and emerging clinical strategies for unscheduled care, elective care, laboratory medicine, children’s services, cancer services, mental health services and learning disability services.</td>
<td>May 13 and ongoing</td>
<td>AMcM/SG</td>
<td>Master planning activity has commenced across all 4 main acute sites with a campus development approach being undertaken. The REH and RIE are primarily being addressed through project teams that have been established. The WGH and SJH have established master planning groups that are currently establishing the current capability and conditions of these sites and also assessing the feasibility for future developments. Several scenarios for the optimisation and development of services across these two sites have been developed. Technical expertise has been procured to assist in the definition and initial costing of these proposals. These master planning activities will be governed</td>
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### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

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<thead>
<tr>
<th>Objective</th>
<th>Date</th>
<th>Implementation Details</th>
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<tbody>
<tr>
<td>Ensure implementation of integration plans with our 4 Council partners to</td>
<td>March 14</td>
<td>Provided evidence to the Parliamentary Process regarding the draft Bill. Four Directors now in post. Shadow Partnerships (Boards) are in place. Two Board workshops on Integration held in September 2013 and two further planned for Jan 2014.</td>
</tr>
<tr>
<td>secure the integration of primary, secondary and social care to drive</td>
<td></td>
<td>Integration Plans and Strategic Commissioning Plans are now being worked on and aligned to the NHS L Strategic Plan. Timescales for going live are being reviewed in light of the parliamentary process and the publication of regulations.</td>
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<tr>
<td>performance improvement across health and social care.</td>
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<tr>
<td>Continue to promote the clinical pathways model to secure management of</td>
<td>March 14</td>
<td>The Strategic Plan will have content that focuses on patient pathways and this work, focusing initially on four major patients/ pathways will be taken forward during 2014 aligned to the Strategic Plan going to the April Board.</td>
</tr>
<tr>
<td>patients’ journeys across service boundaries through our systems wide</td>
<td></td>
<td>Respiratory MCN supporting COPD Invest to Save project to develop integrated pathways across secondary and primary care with aim of reducing readmission rates. In addition, work is being taken forward in pulmonary rehabilitation.</td>
</tr>
<tr>
<td>managed clinical networks</td>
<td></td>
<td>Diabetes pathway scoping work being undertaken in association with the Diabetes MCN and Efficiency and Productivity Group with aim of shifting the balance of care to release secondary care.</td>
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<table>
<thead>
<tr>
<th>Objective</th>
<th>Action Taken</th>
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<tbody>
<tr>
<td>Increase care capacity to manage the increasing prevalence of diabetes.</td>
<td>Myalgic Encephalopathy Chronic Fatigue Syndrome (ME - CFS) Rehabilitation pilot began in November 2012, 6 monthly reporting on activity / outcomes to be submitted to SGHD.</td>
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<td></td>
<td>Service improvement manager for Chronic Pain Services has been recruited to support pathway development and service integration.</td>
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<td></td>
<td>REH re-provision is developing new models of care and community responses. This will form part of the outline business case.</td>
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<td></td>
<td>Physical and Complex Care – work on epilepsy, Huntington’s Chorea and also sensory impairment is being taken forward.</td>
</tr>
<tr>
<td>Review and refresh the maternity strategy and capacity plan</td>
<td>March 14 AMcM Agree that reducing maternal inequalities should be incorporated within Children and Young People Strategy. Consultation taking place between 8 Oct and 17 January 2014.</td>
</tr>
<tr>
<td></td>
<td>Progress made on the Refreshed Maternity Framework which focuses on the three key areas of workforce development, information and data, and pathways of care. Contingency plan for managing the refresh of the SJH maternity unit is in place and discussed at the December 13 Finance and resources Committee.</td>
</tr>
<tr>
<td>RELATES TO AIM 1, 5 AND 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</td>
<td>TIMING</td>
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<tr>
<td>OBJECTIVE 5: EFFECTIVE INTERNAL AND EXTERNAL COMMUNICATIONS</td>
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<tr>
<td>Implement NHS Lothian’s Communications Strategy.</td>
<td>December 2013</td>
</tr>
<tr>
<td>Develop and Implement Communications Plan for Strategic Clinical Framework.</td>
<td>May 2013</td>
</tr>
<tr>
<td>Supporting the communication is relation to ‘Our Values Into Action’</td>
<td>On-going</td>
</tr>
<tr>
<td>RELATES TO AIM 1, 2, 3, 4 AND 5 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</td>
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<tr>
<td>OBJECTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY</td>
<td>TIMING</td>
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### OBJECTIVE 6:
CORPORATE TEAM OBJECTIVE
TO IMPROVE PATIENT AND STAFF SAFETY

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<tbody>
<tr>
<td>March 14</td>
<td>DF/All</td>
<td>None of the three Lothian Adult Acute Hospitals has been an outlier on HSMR. The HSMR has reduced by 11% on two of the three sites since start of the programme and work to understand the trajectory on the other site is underway. Harm Free Care – Healthcare Improvement Scotland has consulted with key groups about the SPSI and short-life working groups are being set up for each indicator to develop the definitions and measurement framework in preparation for the launch at the next Learning Session in Glasgow on 28th &amp; 29th August 2013. Harm Free Care – Healthcare Improvement Scotland has consulted with key groups about the SPSI and short-life working groups were set up for each indicator to develop the definitions and measurement framework in preparation for the launch on 28th &amp; 29th August 2013. NHS Lothian is a test site for measuring Harm Free Care. The SPS indicator- previously harm free care, has been published and consists of Pressure ulcers, falls with harm, active cardiac resuscitation, and CAUTI. Lothian have offered to pilot the measurement of this over the next few months to test the process and identify the level</td>
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</table>

Prepare NHS Lothian to deliver high impact interventions that will support the delivery of the acute Scottish Patient Safety Programme outcome measures to reduce mortality by 20% and achieve 95% harm free care by the end of 2015.
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

#### OBJECTIVE 6:
**CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY**

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<td>DF/SBS/All</td>
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- Ensure the current Safe Care Patient Safety Programme measures are met and reported

- Of harm this measures. Harm Free Care includes:
  - Falls – NHS Lothian has achieved a 20% reduction in falls harm reported via the Quality Report
  - Cauti bundle being tested in primary care
  - Pressure ulcer reduction programme in place in Lothian led by Nurse Director
  - Patient safety non-executive walkrounds re-launched and taking place weekly

- A review of compliance against SPSP essentials conducted. Plans being put in place to improve compliance in key areas

- HSMR plan approved by the January 2013 Board and is the focus for patient safety on three acute sites.

- Board development session in June focused on patient safety and patient experience. A need to review Board meetings and structure to better support focus on both. Human Factors Training Day August 2013 and revised Quality Report agreed by Board September 2013.

- HCG received a SPSP presentation for Acute and Primary Care programme in October 2013
### Objective 6: Corporate Team Objective to Improve Patient and Staff Safety

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<td></td>
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<td><strong>Self-Assessment around CEL19(2013) conducted the 10 essentials in place across NHS Lothian as part of the pre-list briefing. However the reliability of these essentials is on average about 60% so actions have been identified to achieve &gt;95% reliability in all areas.</strong>&lt;br&gt;&lt;br&gt;There are 9 safety priorities, which, apart from Heart Failure, are part of our active programme and on the HSMR action plan. The greatest challenge is the safer medicines work stream and the Safer Use of Medicines CMO Letter requires Boards to be able to demonstrate compliance in discharging their clinical; governance responsibility around medicines reconciliation by ensuring implementation and monitoring of this guidance.&lt;br&gt;&lt;br&gt;Although much has been done in the deteriorating patient work stream, to recognise deterioration there is still a long way to go to ensure a reliable escalation and response in order to reduce cardiac arrest. The implementation of the heart failure bundle will require additional capacity.**</td>
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# OBJEKTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY

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<td>March 14</td>
<td>DF/All</td>
<td>A new process of Walk-Rounds has been established to include Non-executive Directors. The process is still being tested and adapted to meet the needs of all the stakeholders. Venous thromboembolic prevention in testing phase. Following initial testing implementation and spread of sepsis prevention programme is under way. Consultant and midwifery leads have been appointed as Maternity Champions to lead the safety and improvement work over the next two years in NHS Lothian. The NHS Lothian Consultant Lead has also been appointed as the national Maternity Clinical Lead for Obstetrics for this collaborative. The aim this year for the programme is to: o Test the elective induction care bundle o Develop the Scottish Perinatal Trigger Tool o Develop measures and operational definitions</td>
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</table>
| OBJECTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY | | | Mental Health – working group set up and initial data submitted to extranet. Safety Culture Survey completed. Focus 2013/14:  
  o Improving Pass Plan procedures  
  o To initiate patient culture survey  
  o Medicines Management including Med Rec, PRN medication including the Forensic Unit  
  o Introduce Walk-rounds which include patients  
  o Development of Rapid Tranquilisation Bundle  
  o Safety briefs and debriefs post restraint in place  
 See below for Scottish Patient Safety Programme (SPSP) in General Practice. | | | |
### OBJECTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY

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<tr>
<td>To ensure participation and benefit from involvement in the new Maternity Safety programme.</td>
<td>March 14</td>
<td>AMcM/DF</td>
<td>Please see above.</td>
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| Ensure that GP practices across NHS Lothian as well as NHS Lothian as an employer benefits from full participation in the primary care patient safety programme | March 14 | DF/DS | Patient safety programme in primary care was launched in March 2013. 11 QOF points to fund practice engagement in the key features of the programme. NHS Lothian continues to fund patient safety (£300,000) through the Patient Safety Scottish Enhanced Services Programme contract.  

Warfarin: 2012/2013 – 71% (n=89) of practices signed up to the Local Enhanced Service  

Compliance for sites 2012/13:  
- 100% completed clinical surveys  
- 100% completed monthly data collection with 24% now fully compliant  
- 100% completed Global Trigger Tool  
- 100% undertaken patient involvement  

Learning Set taken place for 2013/14 and compliance monitored through Quality Improvement Database. Total of 386 staff trained so far in Lothian (mix of GPs, Practice Nurses and Practice Managers).  

Positive HIS visit - awaiting report. |
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<tr>
<td>Undertaken safety walk-around in Primary Care with Board members.</td>
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<td>Complete the Year 1 action plan for the Equality Outcomes Framework 2013-17, and publish a mainstreaming report and equal pay statement in order to meet legal requirements and ensure that the patient experience is as equitable and safe as possible for all individuals.</td>
<td>March 14</td>
<td>AB/All</td>
<td>Public Health has been involved in the action plan work using international equity standards to help develop effective processes to gather evidence and data about equality, poverty and all protected characteristics.</td>
<td>☑️</td>
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<tr>
<td>Work towards a reduction in the number of staff assaults</td>
<td>March 14</td>
<td>All</td>
<td>On the back of the Improvement Notice that the Board received from the Health and Safety Executive re Violence and Aggression, a significant amount of training has taken place. Using the Purple Pack, this has been delivered to the 11 areas originally inspected. A plan is in place to extend this training to all areas by the end of March 2014. This work has already raised the profile of this issue. As a result, we are likely to see an increase in the number of incidents reported, followed by an actual reduction over time.</td>
<td>☑️</td>
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<tr>
<td>Ensure robust arrangements are in place within NHS Lothian’s Business Continuity Management programme to support business resilience of the organisation.</td>
<td>On-going</td>
<td>All</td>
<td>Formal reassurance has been received from NHS Lothian Executive Directors and Joint Health and Social Care Directors as part of NHS Lothian’s Business Continuity Management Programme (BCM) compliance reporting. Key elements of</td>
<td>☑️</td>
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<tr>
<td>OBJECTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY</td>
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<td>focus have been:</td>
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<tr>
<td>January - March 2013: Cascading of the key document Generic Principles, Guidelines and Control Documents for NHSL Business Continuity Programme, Plans &amp; Arrangements, within local Business Continuity fora and communication channels</td>
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<td>April – June 2013: Annual confirmation that business areas Empower Essential Workers Module records have been maintained Business areas who participated in NHS Lothian’s Strategic Business Continuity Management annual Exercise 2013 took part and contribute to the cold debrief process. That Business Continuity 6 monthly communication tests have been conducted.</td>
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<td>July – Sept 2013: Additional reassurance from Business Areas that any local exercises had been captured within the central civil contingencies folder Programme matrix, for audit purposes.</td>
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<td>Oct – December 2013: All business areas have confirmed that arrangements have been put in place to take forward the new Business Continuity</td>
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<td>Management (BCM), Advanced eLearning Module (mandatory for staff who have BCM duties as part of their roles and responsibilities) 290 staff have completed in the first 12 weeks of the module launch</td>
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<td>Annual Compliance Programme</td>
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<td>Annual Compliance of Business Continuity Management (BCM) Arrangements for 2013 have been provided by all Business Areas for both Testing &amp; Exercising and Plan Maintenance.</td>
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<tr>
<td>Complete the Corporate ROSPA Quality Safety Audit of NHS Lothian’s Health and Safety management system.</td>
<td>March 2014</td>
<td>AB</td>
<td>RoSPA QSA is now complete. A key action is the development of a Strategic Health and Safety Plan, with KPI's in place along with Performance Management System and relative performance standards. The Draft Strategic Plan has been distributed for comment prior to submission to the NHSL H&amp;S Committee. The Audit outcome will be presented at the November H&amp;S Committee meeting.</td>
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<td>OBJECTIVE 7: CORPORATE TEAM OBJECTIVE</td>
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<td>Implementation of Patient / Person Centred Care</td>
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NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013
### OBJECTIVE 7: CORPORATE TEAM OBJECTIVE

**Implementation of Patient / Person Centred Care**

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<tr>
<td>March 14</td>
<td>SBS</td>
<td>Two local events have been held with partner organisations to discuss approach with this wide and complex agenda. Further events are planned for early 2014/15 looking at risk enablement and the personalisation agenda through the implementation of the Self Directed Support Legislation. NHS Lothian has jointly funded a Living Leadership programme with the Thistle Foundation and has stakeholder engagement from Health, the LAs and local third sector organisations. NHS Lothian is considering the offer from Healthcare Improvement Scotland (HIS) to hold a local stakeholder event in 2014/15 that builds on the workstreams of the national programme.</td>
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</table>

Ensure that NHS Lothian using the recommended methodology progresses work that will demonstrate the robust implementation of person centred care

| December 15 | MJ/SBS          | Scottish Government published in June 2013 a draft outcome measurement framework. Following correspondence from SG in 2013 HIS have revised this draft measurement plan. Based on the learning and feedback from the 11 |  |
### OBJECTIVE 7:
**CORPORATE TEAM OBJECTIVE**
Implementation of Patient / Person Centred Care

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<td></td>
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<td>test teams NHS Lothian is working with them to identify validated materials that they can adopt into clinical practice.</td>
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<td>Quantitative data has been obtained from 11 test teams and this feedback has demonstrated that patients have received a generally positive experience whilst receiving care and services from NHS Lothian.</td>
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<td>The PCH&amp;C Team are working with the CGST to explore how DATIX can be used to record patient &amp; staff feedback in the medium / longer term.</td>
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<td>Work is continuing to link this work with existing sources of patient / carer / staff feedback eg Tell us Ten Things &amp; CraFTeam</td>
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<td>The next national Learning Session is due to take place in May 2014.</td>
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<tr>
<td>Implementation of Patient / Person Centred Care</td>
<td>March 14</td>
<td>SBS/All</td>
<td>Implementation of the LCP across NHSL acute hospital and CHCP settings was completed in March 2013. Audit data and evaluation demonstrated improvements to care with positive feedback from staff whilst work progressed to capture bereaved carer feedback and Charge Nurse leadership in EOLC. The Care Homes EOLC project is underway and will complete 2015. In July, <em>More Care Less Pathway: Review of the LCP</em> recommended that the LCP is phased out in England. A review of the LCP in Scotland - NHSL data included - has been completed with draft recommendations currently under review by the National Advisory Group (NAG) for Living &amp; Dying Well. December 2013 these guidelines were published as interim with revised guidance expected in summer / autumn. The improvement work continues within the work streams of essential care delivery and will report on improvements for end of March. The process for setting quality ambitions for 2014/15 has started. Implementation of Care Rounding continues with tests of change around person centred qualitative</td>
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<td>Implementation of Patient / Person Centred Care</td>
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<td>questions being asked as part of the process “What matters to you”. The importance of having a conversation with patients about ‘what matters to me’ will be further strengthened by the care experience measures.</td>
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</table>
| Ensure that the NHS Lothian Board receives a regular report on the quality of care provided within NHS Lothian services | Monthly | DF/SBS | Through the Quality Report it has been agreed that the Board will receive regular data based on the 2 questions below  
- Overall, how would you rate your care  
- If a friend of family member needed the same care or treatment I would feel comfortable if they were admitted to this ward or unit  

The healthcare governance committee also regularly scrutinises wider aspects of clinical quality and patient care. |
<p>| Ensure that the key learning points are taken from the Francis report and are implemented locally | Ongoing | DF/SBS | Board development session on this at the 26th June Board. Outputs from that session will now be considered for Board and other committee functions. Best practice agreed by Board 25th September. Medical Director Quality Improvement to lead implementation. |</p>
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| Implementation of Patient / Person Centred Care | | | Workshops commenced in February targeting Band 3 and upwards in relation to delivering better care, specifically focusing on improvement and continual monitoring, reflecting on Francis. This remains a rolling programme.  
- As stated above, review of Quality Report against Francis recommendations  
- Executive Walkrounds re-launched as additional assurance mechanism (key Francis recommendation)  
- Lothian culture and values are being integrated into Quality Improvement Programmes from SPSP to Person-centred programme  
- A continued range of reports from unscheduled care to waiting times and external reviews reported to the Board  
- Non-Executive Walkrounds initiated to provide an additional assurance mechanism for quality of care provided in Lothian  
- Human Factors day attended by Board members and clinical staff, explored the importance of non-clinical skills and safety culture based on a positive climate for staff to raise concerns. | |
**Objective 7:**
**Corporate Team Objective**
Implementation of Patient / Person Centred Care

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<tr>
<td>March 14</td>
<td>AMcM</td>
<td>NHS Lothian actively leading, contributing to and monitoring progress of the 3 local EYCs in Lothian. Tests of change focusing on improving access to maternity and improving uptake of 27-30 month assessment. Preparing for introduction of new workstream focusing on 5-8 year olds.</td>
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<td>Draft Strategy presented to the Board in September, and currently out for public consultation (until 17 January 2014). Trained 34 staff across NHS, local authorities and voluntary sector to consult with children and young people prior to deadline.</td>
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<td>Exploring opportunities with local authority partners for integration of children’s services and implementation of Children’s Bill. Bill Requires NHS Boards to invest in Named Workers – Health Visitors for children aged 0-5. This is addressed in the Children’s Strategy.</td>
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<td>Evidenced delivery of positive outcomes within Edinburgh and Midlothian Children’s Partnership Inspections. East Lothian being reviewed.</td>
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<tr>
<td>OBJECTIVE 8: TO LIVE WITHIN AVAILABLE FINANCIAL RESOURCES, DEVELOP A SUSTAINABLE FINANCIAL PLAN AND DELIVER THE CAPITAL INVESTMENT PLAN</td>
<td>TIMING</td>
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<tr>
<td>To achieve a break-even position for 2013/14 to live within the Revenue Resource limit.</td>
<td>March 14</td>
<td>SG/All</td>
</tr>
<tr>
<td>To deliver a cash efficiency savings programme to secure the resourcing of the local reinvestment plan for 2013/14</td>
<td>March 14</td>
<td>SG/All</td>
</tr>
<tr>
<td>Achieve the implementation of the Board’s Capital Investment Plan with the Capital Resource Limit.</td>
<td>March 14</td>
<td>SG/All</td>
</tr>
<tr>
<td>Proceed with the development of the new RHSC/DCN facilities</td>
<td>March 14, ongoing</td>
<td>SG/DF</td>
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<tr>
<td>Proceed with the first phase of the new REH re-provision programme</td>
<td>March 14</td>
<td>DS/SG</td>
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### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

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<tr>
<td>senior user. The Outline Business Case and the Masterplan was submitted to F&amp;R Committee on 9th October. And to the Scottish Government on 5th November. A detailed planning application has been submitted to City of Edinburgh Council Planners for approval w/c 7th October and this will be accompanied by a planning in principle application for the Masterplan.</td>
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<tr>
<td>Take forward the redesign of the front door and bed model within the RIE to support delivery of improved patient experience and safety</td>
<td>Nov 13</td>
<td>MJ</td>
<td>The redesign of workforce and patient flow pathways continues in ED &amp; AMU. The additional 31 beds on the infirmary are due to be commissioned in February 2014. In line with this ward re-configuration to take place to enhance pathways across the site, with a further 10 beds being aligned to General Medicine.</td>
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<tr>
<td>Improve performance management of the Consort RIE contract</td>
<td>Ongoing</td>
<td>SG</td>
<td>PFI Contract manager has been appointed and will take forward the performance of the RHSC/DCN and RIE Contracts performance</td>
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<tr>
<td>To develop a savings programme for implementation in 2014/15 and beyond.</td>
<td>Ongoing</td>
<td>SG/All</td>
<td>Longer terms plans are in development. An Efficiency and Productivity session is planned for 12th February 2014.</td>
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**OBJECTIVE 9:**

**TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES**

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<tr>
<td>March 14</td>
<td>AKM/All</td>
<td>Health Inequalities: All areas have finalised SOAs including indicators relating to health improvement and health inequalities. Tobacco: We continue to target cessation services at areas of inequalities. We are also working in partnership with Local Authorities and the voluntary sector to support local alliances to deliver a range of cessation, prevention and protection activities in support of SG Tobacco Strategy. Alcohol: Work continues with Alcohol Licensing boards in Lothian following new licensing policies adopted in November 2013. Keep Well: Verified figures from ISD confirm we delivered 5,717 health checks in 2012/13; exceeding the Scottish Government annual target of 4,800 checks for Lothian. The target for this year is the same as last year and, having completed 1,524 initial health checks, 701 five year review checks and increased the number of participating GP practices to 46 by August 2013, we are on trajectory. Health Promoting Health Service –action plan to implement CEL 01 (2012) for 2013/14 has been agreed and is in line with the SG objectives. Challenges all 13 sites- must have HLA plus by 2015 -only 3 do; 6 sites have recorded no progress (3 not registered), 4 sites have until</td>
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## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

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<tr>
<td>Strengthen ill-health prevention and early intervention by ensuring population screening and immunisation programmes, achieve prescribed standards for uptake, coverage, waiting times, quality and outcomes</td>
<td>March 14</td>
<td>AKM/All</td>
<td>2014 to achieve HLA plus. Achievements re cultural competence, welfare rights, health literacy, Health Works (back into employment) and Working Health Services (maintain in employment) etc commended. Finding resources, including for smoke free grounds by 2015, will be challenging. Breast and Cervical cancer screening: uptake rates for 2012/13 are likely to be static or will have slightly declined compared to last year as recall is cyclical on a 3 -5 yearly timescale. Work is ongoing to introduce new policy for the age range and frequency of cervical screening. Work has commenced to consider a redesign of screening and symptomatic breast pathways but discussions have now been caught up in the wider cancer reprovision discussions. Bowel screening: uptake is at 52.4% and is slowly increasing with prospects for an acceleration with DCE programme. DCE Pilot project – this has progressed over the Summer. The participating practices identified a range of initiatives to support breast and bowel screening, covering health information, IT, training and engagement. Outreach work - as part of DCE we are keen to develop the expertise of our nurse colposcopists.</td>
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<td>Protect the public health by assuring emergency preparedness, identifying and implementing appropriate interactions that protect health and limit risk to our communities from communicable diseases and environmental hazards</td>
<td>Ongoing</td>
<td>AKM</td>
<td>We are reviewing emergency preparedness to ensure consistency of approach with Preparing for Emergencies – Guidance for Health Boards in Scotland (published Oct 2013) and to ensure full compliance with The Civil Contingencies Act 2004 and regulations, Public Health etc. (Scotland) Act 2008, and other relevant legislation. Executive led Resilience Committee to provide integrated strategic leadership in this area, in line with specific Scottish Government recommendations to provide integrated strategic leadership in this area, the Executive led Resilience Committee met (in shadow form) in November 2013 and approved a workplan to deliver the necessary updates and associated audit recommendations.</td>
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<td>Ensure that NHS Lothian meets the demand for increase immunization across children, adults and housebound patients during 13/14.</td>
<td>Summer 13</td>
<td>AKM</td>
<td>The expanded Immunisation programme has been rolled out across Lothian during 2013-14. Funding agreed.</td>
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<tr>
<td>Ensure the review of our children and young people’s strategy is commenced and consulted on during 2013</td>
<td>Summer 13</td>
<td>AMcM</td>
<td>Draft Strategy taken to the Board in September, and is now out for 3 month consultation.</td>
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<td>Commence the review of the learning disabilities strategy, in line with the review milestones and the REAS re-development</td>
<td>Summer 13</td>
<td>AMcM</td>
<td>Underway and being aligned to the new national policy ‘The Keys of Life’. Early draft of revised strategy in 2014. LD in-patient beds are part of phase 2 of the REAS redevelopment and wider developments around community, out of areas and specialist needs are underway.</td>
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<td>Continue to strengthen Public Protection arrangements by delivery of the 2013/14 action plan</td>
<td>March 14</td>
<td>SBS</td>
<td>Development &amp; strengthening of the Public Protection Team continues. Recruitment to the</td>
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<td>Adult Support &amp; Protection Advisor is underway. The Operational Post for MAPPA has been progressed and the successful candidate commenced on 2.9.13</td>
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<td>The Lead Paediatrician for Child Protection in Midlothian has been appointed to the Designated Doctor role and commenced post at the end of November 2013.</td>
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<td>Paediatric Consultant cover for Child Protection has been reviewed across Lothian and a lead paediatricians has been identified for Edinburgh and West Lothian. The pressure on Paediatric Consultant cover remains, however two new consultant Paediatricians have been appointed. However it will be a number of months before they can support the child protection work fully. There remains sickness absence in West Lothian. This is being managed by Consultant Paediatricians from Edinburgh, East and Midlothian.</td>
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<td>The Looked After Children’s Nurses Team and CAMHS has been strengthened with additional resources from the Board to implement CEL 16. There has been successful recruitment to the Band 6 nursing posts with a further three Band 7 posts currently being recruited.</td>
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<td>RELATES TO AIMS 1, 2, 4 AND 5 OF THE STRATEGIC CLINICAL FRAMEWORK</td>
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### OBJECTIVE 10: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS

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<tr>
<td>March 14</td>
<td>AKM</td>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015. The national target was released in May 2013. It is anticipated that we will reach the Lothian Target of an additional 113 Stage 1 cancers per annum. A nationwide Detect Cancer Early media campaign will run until at least March 2014.</td>
<td>green</td>
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<tr>
<td>March 14</td>
<td>AMcM</td>
<td>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours. Currently exceeding target – Central Booking Call System had significant positive impact and created efficiencies in pathway. Focus is now on targeting vulnerable women within 10% not seen within 12 weeks. Worked with NHS Health Scotland to ensure that new campaign promoting access is locally relevant.</td>
<td>green</td>
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<tr>
<td>March 14</td>
<td>AKM</td>
<td>At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014. The latest ISD figures (July / August 2013) show a dip in performance from 10.41% to 8.18% in the worst performing quintile in Lothian. This is the most affluent quintile with lowest measured level of need. There was a serious supply problem with fluoride varnish for the first few months of 2013. There is only one product approved for the FV programme and the manufacturer has had problems sourcing a key ingredient so the product was unavailable for some months. As ISD stats report on two applications within one year, the improvements we have made locally will not begin to show through in the ISD stats for at least another year.</td>
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## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

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<tr>
<td>To achieve 2268 completed child healthy weight interventions over the three years ending March 2014.</td>
<td>March 14</td>
<td>AKM</td>
<td>Additional schools recruited for 2013/14 school year, expect to be submitting returns for more than 1,000 children by end December 2013 (between 4,000-5,000 children participating, 24.1% of which will be overweight / obese on the basis of Scottish Health Survey data) allowing us to meet the HEAT target ahead of schedule.</td>
<td>🟥</td>
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<td>Universal smoking cessation services to achieve at least 11686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.</td>
<td>March 14</td>
<td>JF/AKM</td>
<td>We have achieved April 2011 to March 2014 HEAT target early, having already delivered 12,250 successful outcomes including 7,440 in most deprived within Board SIMD areas.</td>
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**OBJECTIVE 10:**
TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS

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<td>March 14</td>
<td>JF</td>
<td>NHS Lothian and partners have contributed to the SG’ draft document on Preventing Suicide and Selfharm. We now await publication of the document which will set out future priorities. In the meantime we continue to implement local actions. All four partnerships participated in the recent national Suicide Prevention week. The rolling education and training programme continues to be delivered to members of the public and staff. Scottish Government published a revised strategy in December 2013 and this is being reviewed for NHS L and its four partnerships.</td>
</tr>
<tr>
<td>March 14</td>
<td>AB</td>
<td>Whilst progress is being made in respect of reducing carbon emissions, current indicators suggest that the HEAT Target will not be met for technical reasons. The HEAT target is under review by SG due to limitations in scope and accuracy. The achievement of HEAT target will require major investment in infrastructure. The trajectory is set by Health Facilities Scotland. They intend to change the methodology behind the target however this cannot be changed until 2015.</td>
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## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

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<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.</td>
<td>March 14</td>
<td>JF</td>
<td>CAMHS: The performance against the current 26 week RTT target reduced to 75% in November and 74% in December. Overall the service has recruited additional staff on fixed term contracts and has increased the number of patients starting treatment each month and reduced the average (median) wait to treatment (12 weeks in Sept 2012 compared to 7 weeks in Sept 2013, Source: ISD). However, there continues to be pressures through a continued increase in referrals to the service. Psychological Therapies: In December 2013 75% of patients were seen within 18 weeks. At the end of December 2013 there were 2787 patients waiting to be seen with 986 having waited more than 18 weeks. Patients waiting for assessment and treatment from East, Mid and West Lothian Adult psychology account for 44% of all patients waiting and 52% of all patients waiting over 18 weeks.</td>
<td>![Red Circle]</td>
</tr>
<tr>
<td>No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete by April 2015.</td>
<td>March 14</td>
<td>All</td>
<td>NHS Lothian and partners are currently not meeting this target. This item is reported in the Unscheduled Care paper to the Board.</td>
<td>![Red Circle]</td>
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### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

<table>
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<tr>
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<tr>
<td>To support 2% shift in the balance of care in the rates of attendance at A&amp;E between 2009/10 and 2013/14.</td>
<td>March 14</td>
<td>MJ/PG/DS/JF</td>
<td>We are still not meeting the target. We are close to trajectory. As at Nov ’13 our performance was 1966 against a trajectory of 1937.</td>
<td></td>
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</table>
| To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan. | March 14 | JF | The Lothian Dementia Implementation Group has wide stakeholder involvement and is focused on learning and sharing practice cross Lothian, and across agencies. This includes:  
- Defining the role of link worker and ensuring that people understand that it is a role that staff and workers from a wide of professions and agencies can take on  
- Learning from data models in place which ensure that all sectors’ activities can be collated e.g the A11 target  
- Use learning from pilots and evidence base to inform new service models  
- Recognise and plan service provision accordingly – i.e. not all people will require or want the same degree and intensity of support  
- Ensure there is understanding across all service of how all staff members can contribute to post diagnostic support including fulfilling the role of link-worker | |
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<tr>
<td>Eligible patients will commence IVF treatment within 12 months by 31 March 2015.</td>
<td>March 14</td>
<td>JC</td>
<td>We are currently exceeding the target of 12 months, and are well on course to deliver the target by 31 March 2015.</td>
<td>Green</td>
</tr>
<tr>
<td>Further reduce healthcare associated infections so that by March 2015 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days.</td>
<td>March 14</td>
<td>SBS/All</td>
<td>Current SAB rate (April-August 2013) – 0.28 Current CDI rate (April-August 2013) – 0.53 Interim SAB target by March 2014 – 0.28 Interim CDI target by March 2014 – 0.38 Working Group with HPS to review systems and processes for all SAB. This has included work on blood contamination rates and the development of policies on blood culture sampling. Tissue Viability Nurse referrals for soft tissue infections and continence nurse referrals for SABs related to urinary tract infections have been set up. Weekly CDI Ward rounds are carried out with</td>
<td>Red</td>
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**OBJECTIVE 10:**
**TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS**

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<tr>
<td></td>
<td>Consultant Microbiologist/Clinical Scientist and Infection Prevention and Control Nurse to review the application of the CDI toolkit and Standard Infection Prevention and Control Precautions in place providing guidance to the clinical teams on any issues identified at the point of delivery.</td>
<td></td>
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<td></td>
<td>Antimicrobial Ward-rounds which include CDI looking at general prescribing as well as the transition between IV and Oral switch.</td>
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<td></td>
<td>On-going education sessions with the Junior Doctor Induction Sessions.</td>
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<td></td>
<td>HPS collaboration on a monthly basis for both SABs and CDI.</td>
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<td></td>
<td>Current SAB rate (April-November 2013) - 0.30 The working group is on going. Investigations indicate vascular access devices account for approximately 14%, skin and soft tissue account for approximately 22%, blood culture contamination account for approximately 7% Current CDI rate (April-November 2013) - 0.56 As of November 2013 there have been 302 CDI which averages 38 per month. NHS Lothian will not achieve the Interim Target by March 2014.</td>
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**STATUS**
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<td></td>
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<td>Based on current data, the projected total number of CDI by March 2014 is 455 which represent 45% above the allowed target of 313. In total 41% are identified either in community or within front door area samples (27% cases are identified in GP practices). Incidence rates have increased in nine of the eleven mainland NHS boards. It is unknown what is driving the increase in numbers but consideration is being given that it is likely to be related to inappropriate prescribing and/or failure to implement and sustain infection prevention and control measures. Investigations continue to show that in many cases patients have history of antimicrobial therapy. Work is on going with the antimicrobial team to promote good prescribing practices. A trial of double testing CDI samples for norovirus Quality Improve Fund – 2 practice facilitators are focusing at RIE &amp; WGH on areas with +4% contaminated blood cultures and where there are issues with peripheral cannulae, aseptic technique. Additional support for Anti Microbial Team.</td>
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## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14 – Update end Dec 2013

### OBJECTIVE 10:
TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS

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| Monthly   | MJ/PG/All       | Increased community investigations.  
Trial of different approaches to investigation of SABs.  
Increase communication with GP once a patient who had had an episode of CDI has been discharged.                                                                                                                                                                                                                       |

95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

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| Monthly   | MJ/PG/All       | Scottish Government target is 95% for year between October 2013 and Sept 2014.  
Monthly performance against the 4 hour compliance target indicates the following:  
  - Nov ’13 – 93.7%  
  - Dec ’13 – 92.5%  
The average monthly 4 hour performance for this 4 month period was 93.4%. While falling short of the overall target, this represents an improvement on performance for the same period in 2012 where the av monthly performance was significantly lower at 90.1%. |

### HEAT STANDARDS

95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

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<tr>
<td>Monthly</td>
<td>MJ/JC/AMcM</td>
<td>Services continue to deliver at appropriate levels. Above 95% for both 31 and 62 day on most weeks but focus needs to be given to some pathways as small numbers of breaches also significantly affect performance against the</td>
</tr>
<tr>
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<tr>
<td>90% of planned / elective patients to commence treatment within 18 weeks of referral.</td>
<td>Monthly</td>
<td>JC</td>
</tr>
<tr>
<td>No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census)</td>
<td>Monthly</td>
<td>JC</td>
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</table>
| OBJECTIVE 10:  
TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS | TIMING | LEAD CMT MEMBER | COMMENTS | STATUS |
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<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
<td>Annual</td>
<td>DS</td>
<td>No national information available at point of reporting (data comes from annual national GP survey).</td>
<td>❓</td>
</tr>
<tr>
<td>90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>March 14</td>
<td>AMcM/PG</td>
<td>Sustained performance above 90% latest performance in Lothian 2013 was 95%.</td>
<td>❓</td>
</tr>
<tr>
<td>To achieve a sickness absence rate of 4% across NHS Lothian.</td>
<td>March 14</td>
<td>AB</td>
<td>We continue to offer support and monitor sickness levels, with Absence Review Panels organised for November. As at the end of November we continue to be below the Scottish NHS average at 4.52%</td>
<td>❓</td>
</tr>
<tr>
<td>NHS Lothian and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td>March 14</td>
<td>JF/PG/DS and AMcM</td>
<td>The ABI programme delivered 18,275 ABIs in 2013/14, almost twice the HEAT Standard target for NHS Lothian and ADPs. The LES for ABIs and the ABI training team will be funded in 2013/14 from the Scottish Government allocation for Alcohol Prevention, Treatment and Support. This financial commitment will ensure that the ABI programme continues to be delivered above the NHS Lothian HEAT Standard.</td>
<td>❓</td>
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<tr>
<td>March 14</td>
<td>MJ</td>
<td>Performance continues to improve steadily but significantly – 62% for Q1, 84% in Q4. Stroke exception monitoring now more reliably in place. Performance improving. Further work required on ensuring access and Swallow assessment as priority. Key actions identified – 1) Daily stroke huddle across centres – trialled, final version commences October 9th 2) Outreach nursing model to be implemented – December 2013. SJH require to identify additional consultant resource in order to achieve a reliable stroke pathway for patients and will be bring forward plans as part of business planning for 2013/14. Review of current stroke pathways is on-going with a view of creating a hyper-acute stroke unit at RIE.</td>
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SUMMARY PAPER - HEALTH AND SOCIAL CARE INTEGRATION IN EAST LOTHIAN
UPDATE ON SHADOW BOARD ARRANGEMENTS

This paper aims to summarise the key points in the full paper

The relevant paragraph in the full paper is referenced against each point

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<tr>
<td>• Note additional non voting membership of the shadow board</td>
<td>3.5</td>
</tr>
<tr>
<td>• Note development of a scheme of administration for the shadow board</td>
<td>3.8</td>
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David Small
Director of Health and Social Care
28 January 2014
HEALTH AND SOCIAL CARE INTEGRATION IN EAST LOTHIAN
UPDATE ON SHADOW BOARD ARRANGEMENTS

1 Purpose of the Report

1.1 The purpose of this report is to inform the Board of developments in the arrangements for the Shadow Board for health and social care integration in East Lothian.

2 Recommendations

2.1 Note the developments in the East Lothian shadow board arrangements.

3 Summary of the Issues

3.1 The main issues are.

3.2 NHS Lothian and East Lothian Council agreed to establish a shadow board to oversee the development of the East Lothian Health and Social Care Partnership.

3.3 The shadow board has met on five occasions since June 2013. The first four meetings were developmental and the first full meeting took place on 22nd January 2014.

3.4 During the developmental meetings the shadow board agreed and implemented a process to appoint five additional non-voting members.

3.5 The additional members are:

- Patient/User – Keith Maloney
- Third Sector – Eliot Stark
- Carers – Margaret McKay
- Independent Sector – Maureen Allan
- Independent Contractor – Dr Alastair Clubb

3.6 The additional members will serve for an initial period of six months.

3.7 The shadow board has noted that membership will be reviewed prior to establishment of the Integration Joint Board under the legislation.

3.8 The shadow board has also agreed a scheme of administration to manage its business during the shadow period. This has been drafted by NHS Lothian Secretariat and East Lothian Council Democratic Services and is attached.
4 Key Risks

4.1 None

5 Risk Register

5.1 There is no impact on the risk register.

6 Impact on Inequality Including Health Inequalities

6.1 There are no immediate implications for health inequalities of any of the issues covered.

7 Involving People

7.1 The appointment of additional members will strengthen involvement in health and social care integration in East Lothian.

8 Resource Implications

8.1 There are no new resource implications from the issues raised in this paper.

David Small  
Director of Health and Social Care  
28 January 2014

List of Appendices

Appendix 1: Scheme of Administration
EAST LOTHIAN SHADOW HEALTH AND SOCIAL CARE PARTNERSHIP

A Remit and Powers

The Shadow Partnership will focus on rethinking the model of health and social care services in East Lothian, taking account of the changing demographic profile of the area, financial restraint on the Council, the NHS and other partners, and opportunities to improve the health and wellbeing of the community.

Specifically, the Shadow Partnership will:

1. create a shared vision for the future model of health and social care in East Lothian
2. plan towards the formation of a Health and Social Care Partnership
3. approve a workplan containing the workstreams outlined below and seek updates from workstream leads at regular intervals
   - finance and IT
   - governance
   - outcomes
   - strategic commissioning
   - HR and workforce development
4. ensure that its plans for the establishment of a Health and Social Care Partnership are consistent with emerging legislation and guidance
5. create opportunities to work in partnership with families, carers, service users, communities and non-statutory partners to deliver the partners’ shared vision
6. create the climate for excellent service delivery building on best practice and feedback from service users
7. ensure that the Health and Social Care Partnership is founded upon a robust financial framework supported by first class service delivery and performance management systems
8. oversee the delivery of key aspects of East Lothian’s Single Outcome Agreement
9. ensure delivery of the national outcomes for health and social care integration.

B Membership

1. There shall be eight members of the Shadow Partnership, comprising four Non-Executive NHS Board Members (one of whom shall be the Partnership representative) and four Elected Members of East Lothian Council (three Councillors from the Administration and one Councillor from the Opposition). These eight members shall have full voting rights. All Council representatives shall operate in accordance with the Councillors’ Code of Conduct; all NHS representatives shall operate in accordance with the NHS Lothian Code of Conduct.
2. The Shadow Partnership shall appoint from amongst its members a Chairperson and Vice-Chairperson. If the Chairperson appointed is one of the NHS’s representatives, the Vice-Chairperson shall be one of the Council’s representatives, and vice versa. For the first two years, 2013-2015, the Chairperson shall be selected from the NHS Lothian Members, whilst the Vice-Chairperson shall be selected from the Council Elected Members. These positions will alternate annually thereafter, with a Member of the Council assuming the Chair in 2015.

3. All Members of the Shadow Board must behave respectfully at any meeting and should not behave in a manner that is improper or offensive or deliberately obstructs the business of the meeting. Members of the Shadow Board are bound by the decisions of the Shadow Board. Members can request that individual views are recorded in the minutes of the Shadow Board.

4. Any motion to remove a member of the Shadow Board may be carried by a simple majority of those members present and eligible to vote at the meeting at which the motion is put. In the event of an NHS representative being removed from the Shadow Board, the Health Board would be requested to nominate a replacement member; in the event of a Council representative being removed, the Council would be requested to nominate a replacement member; in the event of a non-voting member being removed, the Partnership will seek a replacement in the same way as the original appointment was made.

5. The Shadow Partnership shall also include membership from individuals covering NHS Independent Contractor, Third Sector, Independent Sector, Carer, service user/member of the public. These members shall have no voting rights. The non-voting members will be bound by the code of conduct for non-NHS members of the CHP Sub-Committee.

6. The Shadow Partnership shall be supported by the Chief Executive of NHS Lothian and the Chief Executive of East Lothian Council. The Chief Executives shall have no voting rights, but shall attend meetings and provide advice and oversight.

7. The following Officers will regularly attend meetings of the Shadow Board: the Chief Officer (Director of Health and Social Care Partnership), Head of Adult Wellbeing/Chief Social Work Officer, Head of Health/Chief Nurse, Clinical Director.

C Quorum

1. Half the voting membership + 1, with at least 2 members from among the Council representatives and 2 members from among the NHS representatives.

2. No business shall be carried out at a meeting unless a quorum is present. If, 10 minutes after the time appointed for a meeting, the quorum has not been met, the Chairperson shall postpone the meeting until a date and time determined at the time or afterwards. The minute of the meeting will record that no business was carried out due to the lack of a quorum.

D Substitutes

1. There shall be no substitutes.

E Meetings

1. Meetings of the Shadow Partnership shall be held in conjunction with meetings of the East Lothian Partnership, East Lothian Council and NHS Lothian.
F  Reporting Arrangements

1. During the period when the Shadow Partnership is chaired by the NHS (2013-2015), the NHS shall provide a clerk to take minutes of the meetings. When it is chaired by the Council, the Council shall provide a clerk.

2. Minutes of the Shadow Partnership shall be presented to the NHS and to the Council for noting.

G  Miscellaneous

1. Meetings of the Shadow Board will be held in private.

2. Decisions of the Shadow Board will normally be reached by consensus. Where consensus cannot be reached, the vote shall be taken by roll call. In the event of a tied vote, the Chairperson shall have the casting vote.
SUMMARY PAPER - COMMITTEE MEMBERSHIPS

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

- The Board is asked to agree the appointment of Dr Andreas Kelch to West Lothian Community Health & Care Partnership Sub-Committee, replacing Dr Annabel Ross.

- Dr Annabel Ross has stood down from the Sub-Committee and the relevant process has been gone through to select Dr Kelch.

Peter Reith
Secretariat Manager
27 January 2014
peter.reith@nhslothian.scot.nhs.uk
COMMITTEE MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the appointment of Dr Andreas Kelch to West Lothian Community Health & Care Partnership Sub-Committee, replacing Dr Annabel Ross.

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 Dr Andreas Kelch to West Lothian Community Health & Care Partnership Sub-Committee, replacing Dr Annabel Ross.

3 Key Risk

3.1 If Dr Kelch is not appointed, the West Lothian Community Health & Care Partnership Sub-Committee will not have a GP Representative.

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 Dr Annabel Ross has stood down from the Sub-Committee and the relevant process has been gone through to select Dr Kelch.

7 Resource Implications

7.1 There are no resource implications.

Peter Reith
Secretariat Manager
23 January 2014
peter.reith@nhslothian.scot.nhs.uk
AUDIT & RISK COMMITTEE

The draft minutes of the meeting held on 9 December 2013 are attached.

The Board is referred to the minutes of the meeting, but key items for noting by the Board in this report are:

General
- The meeting was quorate and well attended, including Internal Audit, Risk Management, Audit Scotland, CEO, CFO and the Board Chair
- The agenda and schedule of Committee business is now well established with excellent secretarial and governance support being received from Alan Payne.

Outstanding Management Actions
The Committee noted the ongoing efforts of Internal Audit working with Management, and the substantial improvement (i.e., reduction) in the position relating to Outstanding Management actions, now down to only 21 items outstanding with only 4 past agreed timescales.

Risk Register / Risk Appetite
Extensive discussion took place in respect of the Risk Register structure and reporting, and also the emerging Risk Appetite statements and reporting format. The Board should note that at the current time most measures are outside risk appetite, but the Committee has asked for a closed session workshop with the Committee, Risk Management Steering Group, and Risk Team, to review in depth the register and also reporting tolerances and metrics – this will take place early in the new year.

Internal Audit – Scopes and reporting
There was some detailed discussion regarding the scopes of Internal Audit, and the extent to which they focus on the “control frameworks” vs the actual outcomes. The Committee is keen to ensure Audits focus on the outcomes intended, and that these are key elements of the Audit. This matter has been escalated to the Board Chair and Director of Finance for discussions and resolution.

Jeremy Brettell
Committee Chairman
10 December 2013.
Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 9 December 2013 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr J Brettell (in the Chair); Mr M Ash; Ms K Blair; Dr M Bryce; Councillor D Grant and Councillor C Johnstone.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Mr T Davison (Chief Executive); Mrs S Goldsmith (Director of Finance); Ms D Howard (Head of Financial Control); Mr B Houston (Chairman); Mr P Lodge (Audit Scotland); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr C Marriott (Deputy Director of Finance); Mr D McConnell (Audit Scotland); Mr J Megaw (Strategic Programme Manager) (for item 7.1); Mr A Payne (Corporate Governance Manager); Mr A Perston (Audit Scotland); Mr D Proudfoot (Deputy Chief Internal Auditor); Mr D Woods (Chief Internal Auditor); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Councillor R Henderson and Mr Peacock.

The Board Chairman advised the Committee that Mr Peacock had now formally resigned as a non-executive Board member, and therefore as a member of this Committee.

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.

34 Minutes of the Previous Meeting

34.1 Minutes of the previous meeting held on 30 September 2013 – The Committee approved the circulated minutes as a correct record.

35 Matters Arising

35.1 Matters Arising from the Meeting of 30 September 2013 – the Committee received the paper detailing the matters arising from the Audit & Risk Committee meeting held on 30 September 2013, together with the action taken and the outcomes.

35.2 The Committee accepted that the actions detailed within the Running Action Note were complete or on track for completion by the intended target date. Dr Bryce advised that the Healthcare Governance Committee received a paper on the governance of independent sector providers at its December meeting and that the Committee was assured with the arrangements in place.
36 Risk Management

36.1 Risk Register Update

36.1.1 Ms Bennett gave a detailed overview of the report. She drew the Committee’s attention to work that assessed whether risks within the corporate risk register were fit for purpose, including specific changes in grading and the evidence that supported the decision to re-grade them.

36.1.2 The Committee reviewed the detail of the corporate risk register and the very high/ high risks identified in other risk registers, and the following matters were raised for management to consider:

- 3211 – Achievement of national waiting times targets. It was noted that whilst the risk had an overall grade of “high”, the underlying score had not moved over the last year and probably should be higher.
- 2964- The Board does not achieve its financial targets on a sustainable basis. The overall grade and score for this risk had been lowered, and this should be reviewed in the light of the financial position.
- The issue of integration does not feature on the corporate risk register, and only appears on the West Lothian CHCP risk register. Given the significance of the issue, it was agreed that it should at least be on the corporate risk register until the Scottish Ministers have approved the Integration Plans for the four local authority areas. Management should consider reflecting this issue in the CHP risk registers.
- 1763 – Delayed discharge of patients. This features on both the East & Midlothian CHP risk register as a high risk, however it was clarified that this is only an issue in East Lothian.
- The issue of productivity is not identified in the risk registers. Management should consider this issue, in addition to the existing focus on efficiency. If any risks are identified following that consideration then it should be reflected in the appropriate risk registers.
- There is a concern on mandatory training compliance and this should be clearly reflected in the operational risk registers where this is in fact an issue.
- The issue of medicines reconciliation should be considered.
- Determining what is actually happening on patient experience is entirely dependent on having robust data and information systems. It is not about performance against the standards for handling complaints. It is acknowledged that there is a generic “Data Quality” risk on the corporate risk register (3486), however management should consider defining this more specifically in the operational risk registers.

36.1.3 The Committee reviewed the draft reporting model for Risk Appetite. The Committee agreed that it was a good start, however agreed that further work was required to ensure there was a clear understanding of the terms being used, and to further refine some of the measures of risk tolerance. The Committee proposed a workshop with the Risk Management Steering Group early next year in order to progress this point and develop the Risk Appetite further, and to review in detail various aspects of the Register and risks.
The Chair confirmed that he would highlight to the Board that the initial results show that the Board is operating beyond its risk appetite. Ms Bennett confirmed that a paper shall be presented to the February Board meeting outlining the proposed reporting system for risk appetite, noting the action to be undertaken in 36.1.3 above.

The Committee thanked Ms Bennett for the report and acknowledged the progress had been made over the last year in developing the corporate risk register and the system of risk management.

37 Internal Audit & Counter Fraud Reports

37.1 Internal Audit – Progress Report December 2013

Mr Woods gave a brief overview of the report and highlighted that four audits had been completed since the September meeting. He highlighted that the review of Pharmacy Stores has been deferred into next year’s audit plan, and that internal audit have been asked to review controls associated with implementing the new pharmacy IT system (JAC).

The Committee noted the continued commitment to the reduction in outstanding management actions (now down to only 4 past their due dates), and the Chair thanked Mr Davison (management) and Mr Woods (internal Audit) for their efforts.

The Committee accepted the Internal Audit Progress Report – December 2013.

37.2 Reports with “Fully Satisfactory” or “Satisfactory” ratings - December 2013:

37.2.1 Hospital Catering

Mr Proudfoot advised that overall there was a good framework in place to provide patients with satisfactory food. He noted that though the report was given a satisfactory rating, issues had been raised about checking nutritional standards, recording food wastage and checking food temperatures. He advised that management are taking action to address the identified areas of concern.

Members debated whether the report’s overall “satisfactory” rating was appropriate, given the nature of the findings that had been reported in the presented summary. The Committee concluded that any assessment of the adequacy and effectiveness of a system of control has to consider what the actual outcomes or results have been. The Committee acknowledged that it had not seen the full report. It also recognised that the auditors had reviewed the framework of controls in place and were satisfied management were taking action to address the issues raised. However the Committee could not accept the “Satisfactory” opinion given the words and summary provided.
37.2.1.3 Mr Woods agreed to issue the full report for the Committee to review at its next meeting. The Chair also requested that the Head of Logistics and Catering provide a report to explain what action has been taken.  

37.2.1.4 Mr Houston advised the Committee of the forthcoming NHS Lothian Catering Strategy, lead by Ms Allen. He anticipated that proposals would be available in March 2014.

37.2.1.5 The Chair and Finance Director considered that the report could not be accepted as written and asked Internal Audit to review and represent. In addition it was agreed that the Chair and Finance Director would discuss the general issue of Internal Audit scopes and ratings following the meeting.

37.2.2 Prison Services

37.2.2.1 Mr Proudfoot advised that overall there was a good framework in place to provide satisfactory healthcare services for prisoners. He noted that there were 2 areas identified that required improvements to be made; access to General Practitioners and specialists; the control of non-controlled medicines. Members were assured that actions to resolve these matters were ongoing.

37.2.2.2 The Committee agreed to accept the report on the Prison Services audit.

37.2.3 Performance Targets and Reporting

37.2.3.1 Mr Proudfoot reported that the framework in place to support the reporting of performance was satisfactory. He highlighted that though the audit resulted in a satisfactory rating, Strategic Planning has identified and started to address issues to improve data quality and assurances. Members were assured that actions were ongoing.

37.2.3.2 Mr Houston advised colleagues of previous discussions at the Board surrounding the relevance of performance data received, how it was interpreted and used. Whilst the audit evaluated the control framework, the Committee debated whether the resulting performance reports meet the needs of the Board, expressing similar concerns to the Catering Audit regarding whether the report appeared “Satisfactory”.

37.3 NHS Waiting Times Arrangements Follow-up

37.3.1 Mr Woods advised that overall there had been good progress against the recommendations that arose from the audit on waiting times. He went on to give a detailed overview of progress made against each action.

37.3.2 Members noted that Mr Crombie, Director of Unscheduled Care had taken over the Chair of the Waiting Times Group from the Chief Executive and would continue to lead the focus on performance.

37.3.4 The Chief Executive reported that there was some concern that following the waiting times incident, NHS Lothian comparatively makes less use of the unavailability codes than other NHS Boards. He also advised that NHS
Lothian was currently offering patients 14 days to respond in comparison to the 7 days offered by neighbouring Health Boards. The view was informally expressed that it seemed reasonable to move to a consistent 7 day basis, but advised caution in the use of the unavailability codes.

37.3.5 The Committee agreed to accept the report.

37.4 Internal Audit Structure and Resource

37.4.1 Mr Woods introduced the report that advised the Committee on a proposed restructure of Internal Audit. He noted that the action taken to restructure the department would be determined by the outcome of the Job evaluations. In the meantime Internal Audit would remain to operate efficiently and focus on the areas of high risk.

37.4.2 Audit Scotland confirmed that they were able to place reliance on Internal Audit. They advised that although they did not have the remit to instruct internal audit colleagues, they have pointed out a possible need to increase the frequency of the financial systems audits. Members noted that increasing coverage of financial systems would impact on internal audit resource. Mr Woods advised that he would continue to manage the capacity and workload of the Internal Audit Team through the Internal Audit Plan.

37.4.3 The Committee agreed to accept the report, subject to Mr Woods providing brief report on the outcome of the job evaluations in parallel with the 2014/15 Internal Audit Plan at the next meeting, and confirming that he has sufficient resource to deliver the Internal Audit plan, or what extra resource he would need to deliver the desired Internal Audit plan.

37.5 CFS – Referrals & Operations – December 2013

37.5.1 Mr Woods introduced the summary of CFS referrals and operations as at December 2013. He advised that there had been no court appearances since the September meeting.

37.5.2 The Committee accepted the CFS – Referrals & Operations report.

38. External Audit Reports


38.1.1 Mr Perston gave a detailed overview of the report that provided details on how NHS Lothian had responded to the challenges of budget constraints and efforts to achieve sustainability. He went on to highlight that the key findings had focused on whether the Board have sustainable financial plans which reflect a strategic approach to cost reduction and whether senior colleagues demonstrated ownership of financial plans that were subject to scrutiny prior to approval.
38.1.2 Members noted that overall NHS Lothian had a good framework to address any challenges of public sector budget constraints that they may face. The Committee agreed to accept the report.

38.2 **NHS Lothian Review of Internal Audit 2013/14**

38.2.1 Mr Lodge introduced the letter that summarises the reliance that Audit Scotland can place on the Internal Audit Team.

38.2.2 The Committee agreed to accept the letter.

39. **Management Controls Capacity (Decision)**

39.1 **Quality and Outcomes Framework (QOF) 2012/13 Minutes of QOF Payment Verification Group 29 May 2013**

39.1.1 Mrs Goldsmith presented the minutes of the QOF Group.

39.1.2 The Committee agreed to accept the QOF Minutes.

39.2 **Procurement from Private sector for Waiting list Initiatives Update on Internal Audit Actions**

39.2.1 Members noted the report that updates the Committee on progress made against the Internal Audit Actions on the procurement from private sector for waiting list initiatives.

39.2.2 Mrs Goldsmith advised that the CLO was currently working with Medinet to produce a formal contract. She anticipated that all contracts for external providers would be complete by Christmas.

39.2.3 Members noted that following receipt of incomplete invoices from SPIRE, the Director of Unscheduled Care had reinforced that invoices without the necessary CHI numbers would not be processed.

39.2.4 The Chief Executive reported that a meeting had been scheduled with trade union colleagues to discuss concerns raised in relation to the use of private sector companies and procurement next week. Mrs Goldsmith agreed to circulate this report, the initial report and the clinical governance report as background information in advance of the meeting.

39.2.5 The Committee agreed to accept the report.

39.3 **Integration: Process and Update**

39.3.1 The Chief Executive introduced the report that updated the Committee on the integration process of establishment of the four Health and Social Care Partnerships. He explained that NHS Lothian would continue to pursue the “body corporate” integration model.
39.3.2 Following the recent Board Session on Integration it was noted that there would be a further session on 17 December 2013.

39.3.3 The Chief Executive anticipated that the integration plans would be produced for Board and Council approval in November / December 2014, and submitted to Scottish Government. It was unclear how long it would take for the Scottish Government to review and approve integration plans, colleagues to respond however they had instructed that the earliest opportunity that the system could go live was 1 April 2015.

39.3.4 The Committee accepted the Report. The Chair requested that Integration remains on the Audit and Risk Committee Agenda and that a short paper to update the Committee be brought forward to its next meeting. AMcM

39.4 Quality and Volume of Board Papers

39.4.1 The Committee noted the report on the work taken to improve the quality and reduce the volume of board papers.

39.5 Overview of Tax Compliance Risk in NHS Lothian

39.5.1 Mr Martin gave a detailed overview of the report on relevant issues in relation to overall compliance with tax laws within NHS Lothian. He highlighted that the main areas of compliance tax risk were VAT recovery on contracted services and business activities and employment taxes.

Contrary to paragraph 3.5 in the paper, Mr Woods advised the committee that Internal Audit does not test systems for VAT and employment taxes annually.

39.5.2 It was agreed that assurance on tax compliance would remain on the Audit and Risk Committee Agenda. Mrs Goldsmith would bring back a brief report to update the Committee in February 2014. SG

40. Items for information

40.1 Audit Scotland: Technical Briefs 2013

40.1.1 Mr McConnell introduced the report on Audit Scotland: Technical Briefs, he specifically highlighted item 3.5 of the report in relation to Internal Audits changing role and the consolidation of the accounts.

40.1.2 The Committee noted the report for information.

41. Any Other Competent Business

41.1 There were no other items of competent business.
42. Date of Next Meeting

42.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 10 February 2014 at 9:00 in Waverley Gate, Edinburgh. Committee members only are asked to attend by 8.45 for the scheduled 15-minute pre-meeting.
NHS LOTHIAN

Board Meeting
5 February 2014

The draft minutes of the meeting held on 18 December 2013 are attached.

This paper aims to summarise the key points in the attached minutes.

The relevant paragraph in the full paper is referenced against each point

Key issues discussed included:

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<tr>
<td></td>
<td>The Finance and Resources Committee spent time considering the draft Financial Plan 2014/15 and the requirement to deliver £37.4m of LRP (3%). Concern was expressed at the challenge in delivering this level of LRP. It was noted that further work was required on LRP including support to Business Units and the development of an outreaching approach and further discussion with Executive Directors. 45.1-46.1.11</td>
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<td>The Committee received an update on the main drivers for the overspend of £4.159m incurred to the end November 2013, and the action being taken to address the position. 47.1</td>
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<td>The Committee agreed to support the funding of the advanced works for the Royal Edinburgh Hospital and agreed an over-commitment against the overall capital programme to be managed in year. 47.1.4</td>
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<td>An update on the progress to date on disposing of properties was noted as was the receipt of the draft Community Empowerment (Scotland) Bill. 48.1</td>
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<td>The Committee considered the options for the redesign of the Northwest Edinburgh Partnership Centre and agreed to proceed with the project based on the inclusion of accommodation for a GP Practice of 5,000 patients. 49.1</td>
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<td>Consideration was given to proposed revisions to the Local Access Policy in relation to the minimum period of notice in advance of the paper being received at the February Board meeting. 51.1</td>
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George Walker, Chair
Susan Goldsmith, Executive Lead
Minutes of the Meeting of the Finance & Resources Committee held at 1:00 p.m. on Wednesday 18 December 2013 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (Chair); Mrs K Blair; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson and Mr B Houston.

In Attendance: Mr J Crombie; Mr P Gabbitas; Mr I Graham; Professor A K McCallum; Professor A McMahon; Mr C Marriott; Mr P Reith; Ms J Smith and Mr S Wilson.

Apologies for absence were received from Mrs M Hornet, Professor J Iredale, Mr P Johnston and Mr J Brettell.

Declaration of Financial and Non-Financial Interest

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

42. Minutes of the Previous Meeting

42.1 The previously circulated minutes of the Finance & Resources Committee meeting held on 9 October 2013 were approved.

43. Action Note

43.1 The previously circulated running action note of the Finance & Resources Committee was noted:

- Partnership Commissioning of Step-down Beds Capacity and Associated Issues – Mrs Goldsmith advised the committee that a presentation had been given to the recent Board development session and an update would be provided to the January meeting of the committee.

- Little France Campus – Property Acquisition – Mrs Goldsmith advised that the land at Little France had been purchased in order to allow site access, and to provide appropriate “frontage” to the RIE.
44. Matters Arising

44.1 Site Visit Schedule - The committee agreed a previously circulated schedule of site visits for 2014 noting that the meeting on 22 January would be held at the Western General Hospital, the meeting on 9 July would be held at a hospital in East Lothian and the meeting on 12 November would be held at the Royal Infirmary of Edinburgh.

44.2 Self Assessment – The Chairman reminded members that this had been touched on at the previous meeting and that Mrs Blair had shared a tool with him which he was now proposing they used as a pilot in NHS Lothian. It was agreed that once the tool had been adapted in discussion with Mrs Goldsmith and Mrs Blair it would be circulated to members for comment.

44.3 Master-planning – Mr Graham gave a brief report to the committee on the progress with the Master-plan and advised that a more detailed update would be presented to the January meeting including details of the Western General Hospital Master-plan.

45. Draft Financial Plan 2014/15

45.1 Mrs Goldsmith introduced a previously circulated report giving an overview of the Scottish Government draft budget for 2014/15; the financial implications for NHS Lothian and an overview of progress on the financial plan for 2014/15.

45.1.1 Mrs Goldsmith advised the committee that a meeting of the Efficiency and Productivity Group had been held that morning and had considered the impact of the reducing level of uplift implicit in the draft Scottish Budget for 2014/15 and 2015/16 for NHS Lothian. The Board would be starting the year with a significant recurring commitment carried forward whilst the originally anticipated NRAC uplift was not materialising at the predicted level. Whilst increased internal capacity was now being delivered there was still a need to make use of the independent sector.

45.1.2 Mrs Goldsmith advised that a recurring Local Reinvestment Plan (LRP) target of £37.4m was being set and plans were being put in place to build up some recurring reserves.

45.1.3 The Committee noted that there were deadlines on the delivery of capacity and Mr Crombie advised he would be working with Mrs Goldsmith through the framework to prioritise forthcoming business cases such as decontamination.

45.1.4 Mrs Goldsmith advised that whilst she was conscious the circulated papers were simply the 1 year financial plan, work was in hand on the production of a 3-5 year financial plan.
45.1.5 Mrs Blair commented that the situation presented a number of challenges and sought assurances on how the necessary levels of LRP could be delivered and how the Board could invest in order to save.

45.1.6 Mrs Goldsmith advised that discussions on LRP were being taken down to business unit level and that Mrs Smith, Head of Efficiency and Productivity, would be looking to align teams to focus on the achievement of LRP.

45.1.7 Mr Crombie commented that financial planning at business unit level was essential to the success of the exercise and Mr Davison concurred commenting that the following financial year 2015/16 would present a major challenge. He advised that with a reduced level of NRAC and the advent of Health & Social Care Partnerships which would retain any surpluses, NHS Lothian would have less flexibility as around 45% of the budget would be delegated to Partnerships.

45.1.8 Mr Houston commented that business units would have varying capacity for achieving radical savings and there would need to be an overarching approach as well.

45.1.9 Mrs Smith outlined the progress made to date and advised that £2m had already been used to pump prime savings generating projects.

45.1.10 Professor McCallum commented that the exercise would present an opportunity to deliver new ways in which to improve quality and safety whilst delivering services in a more cost effective way.

45.1.11 The committee agreed to note the draft financial plan; the intention to move to financial planning at business unit level and that the development of a 3 year financial plan was currently ongoing.

46. Efficiency and Productivity 2014/15: Forward Look

46.1 Mrs Goldsmith introduced a previously circulated report giving an update on the planned approach to the delivery of NHS Lothians recurring efficiency and productivity target in 2014/15 and the emerging plans.

46.1.2 Mrs Goldsmith advised that the detail of these proposals was being discussed with Mr Crombie and Mrs Hornett and a number of options were being considered. The impact of improvements in the way of delivering some services were already producing some savings.

46.1.3 Mrs Goldsmith commented that more thought needed to be given to ways of improving productivity and achieving cost savings and the Chair reiterated the need to focus on productivity as well as the achievement of savings. He commented that whilst the paper was a good start, more detailed figures were required and the committee agreed that efficiency and productivity should become a standing item on the agenda.

46.1.4 The committee agreed to note the overall proposed 3% recurring cash releasing efficiency target for 2014/15; to note the change in approach to delivery of
savings in 2014/15 with the allocation of the full targets across business units to be delivered through LRP and workstreams; to note the workstream targets already agreed and plans being implemented to which were expected to deliver savings across a number of business units in 2014/15 and to note the other opportunities which had been identified as potential workstreams for 2014/15 and the discussions now ongoing with Executive Directors around the development of more robust plans.

46. Financial Performance

46.1 Mrs Goldsmith gave a short update on the summary financial position to the end of November 2013 showing a total overspend to date of £4,159m. Contributing factors included an increase in theatre activity 284 patients per month over the past 2 months with clinical supply pressures of £400k together with diagnostic cost increases of £170k and a rise in energy consumption during the previous 2 months of £150k. There had been an increase in general practitioner prescribing costs of £200k come up a 4% increase in outpatient attendances in the year to date and a reduction in pay positive variance of £300k.

46.1.1 The achievement of the LRP was currently £3.5m under delivery with forecast slippages in efficiency and productivity for 2013/14 forecast to be £4,113m.

46.1.2 Mrs Goldsmith advised that whilst in most years 1-2% slippage could be expected in the current financial year most of these savings had gone to support work to reduce waiting times.

46.1.3 Mrs Goldsmith advised that discussions had been held with the Scottish Government and with service led recurring recovery plans, a refocus on the delivery of recurring LRP savings and a review of options for flexibility it was still anticipated that the Board would achieve a break-even position by the end of the current financial year and minimise the impact into 2014/15.

46.1.4 Mr Davison commented that discussions had been held with the Scottish Government on options for recurring changes and Professor McMahon advised that meetings were being held with Scottish Government colleagues at the mid year review.

46.1.5 Mrs Blair emphasised the need for a radical approach to dealing with the situation and suggested that there was a disconnect between delivering quality at the same time as improving efficiency.

46.1.6 The committee agreed to note the position.

47. Property and Asset Investment Programme 2013/14

47.1 Mr Graham introduced a previously circulated report giving the committee an update on the property and asset investment programme for the current year.
47.1.1 Professor McCallum commented that areas in which known problems still required to be resolved might be included and Mr Graham advised that most of such areas were contained in back-log maintenance.

47.1.2 Mrs Blair asked about progress on the redesign of services and Mr Graham advised that this was being worked on with 5 and 10 year programmes being prepared.

47.1.3 The committee noted the revised business case monitor presented in a new format and expressed a preference for the new way of presenting information although it was felt that a brief summary at the start of the business case monitor would be helpful.

47.1.4 The committee agreed to note the financial performance to date and the highlighted key risks and issues from this programme of work; to agree the funding of the advanced works for the Royal Edinburgh Hospital and to agree to proceed on the basis of an over commitment of £0.5m in respect of the overall programme to be managed in-year.

48. Property Strategy and Draft Community Empowerment (Scotland) Bill

48.1 The committee received a previously circulated report giving an update on the progress of the property asset management strategy in relation to disposal of properties and highlighting the draft Community Empowerment (Scotland) Bill which had been launched for consultation.

48.1.1 Mr Graham advised that where property disposals had been agreed these were being progressed and the committee agreed to note the progress of the property asset management strategy in relation to property disposals.

48.1.2 It was further agreed that Mrs Goldsmith and Mr Gabbitas would discuss further options for nursing home provision. SG/PG

48.1.3 The committee noted the draft Community Empowerment (Scotland) Bill that had been launched for consultation by the Scottish Government and Mrs Goldsmith confirmed that this would be looked at in more detail at the January meeting. SG

49. North West Edinburgh Partnership Centre

49.1 The committee noted a previously circulated report advising of the options and subsequent recommendation for the North West Edinburgh Partnership Centre, following the withdrawal of Muirhouse Medical Group.

49.1.2 Mr Gabbitas introduced the report and explained the background to the withdrawal of the Muirhouse Medical Group from the project.

49.1.3 The committee noted that following the decision of Muirhouse Medical Group not to move to the North West Edinburgh Partnership Centre, alternative options for the design of the centre had been under consideration and that following
discussion at the previous committee meeting the options were reduced to include only those with GP provision.

49.1.4 The committee noted that the preferred option of the Project Board was option 2, to redesign the Partnership Centre and include practice accommodation for 5000 patients, which was supported by the Shadow Health and Social Care Partnership Board and the Bundled Project Programme Board.

49.1.5 The committee agreed to approve the recommendation to proceed with option 2, the redesign of the Partnership Centre and the inclusion of practice accommodation for 5000 patients.

50. Replacement of an MRI Scanner for the Royal Infirmary of Edinburgh

50.1 The Chairman reminded members that this report had been previously circulated and thanked members for providing comments in advance of the meeting in order that an early decision could be taken to enable the procurement to proceed through National Procurement Framework Contracts linked to multiple procurements within the NHS and academic establishments throughout NHS Scotland to gain maximum cost efficiencies.

50.1.1 The committee noted that the proposal had been approved by the Lothian Medical Equipment Review Group and the Lothian Capital Investment Group and agreed to homologate approval of the expenditure of £1.3m for the MRI room from the existing approved Lothian Medical Equipment Review Group budget to replace this essential equipment.

51. Local Access Policy

51.1 Mr Crombie introduced a previously circulated report outlining revisions to the current Local Access Policy.

51.1.1 Mr Crombie explained that NHS Lothian was the only NHS Board in Scotland offering a 14 day minimum period of notice for reasonable offers for non urgent patients from the time a letter was produced to advise the patient of a date or the conversation occurred until the day of attendance. All other Boards had a 7 day minimum period of notice.

51.1.2 Such a change would increase the availability of late offer appointments and allow for more patients to be treated whilst making more efficient use of existing resources.

51.1.3 Mr Crombie advised that some general practitioners had a concern that this would transfer work to primary care but advised that with all other Scottish NHS Boards following the 7 day period of notice there was no evidence to suggest that this was causing a problem.

51.1.4 The Chair commented that there would need to be clarity about dates as it was possible for letters to be posted 5 days after they had been written.
51.1.5 Mr Crombie agreed that procedures would need to be put in place to ensure that letters were sent out on the day or the day after they had been typed and that the possibility of using other methods to communicate with patients including email and text should be explored.

51.1.6 The committee noted that patients who had been referred for elective surgery or outpatient appointments had a responsibility to ensure that they were able to accept referrals and primary care needed to explain the procedures to patients they were referring so that patients were aware of what would be involved.

51.1.7 Mrs Blair commented on the need to emphasis the improvement in services to patients and in particular that this would enable offers of treatment to patients to be carried out more quickly.

51.1.8 Mr Davison suggested that there should be discussions with the General Practitioners Sub Committee in January in order that the policy could be considered at the February Board meeting.

51.1.9 Mr Crombie undertook to pickup the points mentioned in discussion and include these in the paper to be submitted to the Board meeting on 5 February 2014.

52. Date of Next Meeting

52.1 It was noted that the next meeting of the Finance and Resources Committee would be held on Wednesday 22 January 2014 at 9:00 a.m. at the Western General Hospital, Edinburgh.
HEALTHCARE GOVERNANCE COMMITTEE

The draft minutes of the meeting held on 3 December 2013 are attached.

1 Key Issues Discussed

In addition to the enclosed minutes from the Healthcare Governance Committee meeting held on 3 December 2013 I would like to draw the attention of the Board to the following items:

1.1 Primary Care Leadership Walkaround

The Chair and Vice Chair of the Healthcare Governance Committee reported verbally on their involvement in a successful pilot of a Scottish Patient Safety Programme Leadership Walkaround in primary care in NHS Lothian.

1.2 Mandatory Training

At item 48.1 in the minutes a paper from the Staff Governance Committee updating the Healthcare Governance Committee on the improvement plan to ensure clear processes for monitoring staff compliance with mandatory training was discussed.

Members of the Healthcare Governance Committee remained concerned that no timeline was identified in the paper for this work to be completed and they requested an update form the Chair of the Staff Governance Committee when further details were available. Members did not feel assured that systems and processes were in place to ensure that staff complied with mandatory training.

1.3 Medicines Reconciliation

The paper on medicines reconciliation discussed at item 48.2 in the minutes indicates that this key area of patient safety requires improvement in NHS Lothian as patients were not always receiving the correct medicines during transitions between hospital and primary care. Medicines reconciliation was also identified in the 2013 CEL (19) as one of ten key priorities for patient safety: http://www.sehd.scot.nhs.uk/mels/CEL2013_19.pdf.

1.4 Independent Healthcare Providers

The paper discussed at item 49.2 in the minutes outlines governance arrangements in the independent sector. Members welcomed the work described in the report and were satisfied that the systems in place were robust and gave assurance that patient safety would be maintained when using external providers to provide NHS services.

1.5 Diabetes Managed Care Network and the Heart Disease Strategy Programme Board

The Committee heard a presentation from the Heart Disease Strategy Programme Board and received a paper from the Diabetes Managed Care Network from both these groups and welcomed the key progress indicated in these areas.
1.6 **Customer Services and Feedback Team**

A report from the Customer Services and Feedback Team was discussed at item 51.1 in the minutes. The report indicated the ongoing challenges and outlined improvements made to the way the team responds to patient feedback. Members would welcome further developments in the patient feedback processes which would enhance NHS Lothian’s ability to demonstrate how patient feedback is used in its quality improvement processes from 2014.

1.6 **Organ Donation**

Members were pleased to note the success of the organ donors list campaign in NHS Lothian with large numbers signed up and the resulting number of transplants that have taken place in the Royal Infirmary’s Transplant Unit.

Dr Morag Bryce  
Chair of the Healthcare Governance Committee  
16 December 2013
Chair’s Welcome and Introductions

**Dr Bryce welcomed members to the meeting and members introduced themselves.**

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

### 46. Patient Story

#### 46.1 Ms Ballard-Smith read out a letter from a relative of a patient who described very poor communication from staff when the patient died. With this was a letter from a member of staff who had felt unable to give relatives the news that the patient had died because of lack of training and support. This letter was compared to the letter
read out at the previous meeting in which the excellent communication skills of staff in a different unit were praised.

47. Committee Cumulative Action Note and Minutes from Previous Meeting (1 October 2013)

47.1 The minutes of the meeting held on 1 October 2013 were approved as a correct record.

47.2 The updated cumulative action note had been previously circulated.

48. Matters Arising

48.1 Mandatory Training Report

48.1.1 The previously circulated report had asked the Healthcare Governance Committee to agree that assurance on staff training was the responsibility of the Staff Governance Committee and that reports would be received when agreed by the Staff Governance Committee.

48.1.2 The Committee agreed that the Staff Governance Committee held responsibility for staff training but did not agree that there should not be regular reporting to the Healthcare Governance Committee. Dr Farquharson felt that the paper provided did not give sufficient assurance that this area was covered. Mr R. Wilson noted that the poor compliance levels shown in the paper increased anxiety about compliance with training.

48.1.3 Ms Ballard-Smith noted that the paper only covered eLearning and that she would like assurance that there was a process in place for ensuring compliance with face-to-face training and reporting achievement in terms of expectations. Training by day to day interaction and shadowing was also not captured.

48.1.4 Ms Gormley noted that eLearning was not an ideal way to train all staff once problems with access to computers, time, and computer literacy were taken into account. Ms Fairgrieve also noted that the way the material and assessment work on eLearning completion of assessment only may not always be effective training. Ms Eccles questioned how outcomes of training could be assessed, and how it could be shown that training had improved practice.

48.1.5 Mr R. Wilson noted that the patient story heard at the beginning of the meeting showed that NHS Lothian had let a member of staff down by lack of training.

48.1.6 The Chair agreed to ask Mr Joyce to speak to this item at a future meeting and provide a paper with data on compliance rates and assurance that work was being done to improve compliance.

48.1.7 Ms Scott-Macfarlane noted that there was no mandatory training module on dementia and felt that this was an important area of learning for all clinical staff. Ms
Meiklejohn noted that a module on dementia was available for staff but that it was not currently mandatory.

48.2 Medicines Reconciliation Compliance

48.2.1 The paper had been previously circulated. Dr Farquharson noted that the target for compliance with medicines reconciliation standards was December 2015. There was a focus on secondary care in improving compliance. Dr Farquharson noted that although electronic prescribing could solve many of the problems currently experienced, the importance to patient safety of improving compliance quickly meant that plans could not wait for the implementation of electronic prescribing.

48.2.2 Ms Bennett advised that medicines reconciliation in primary care was an enhanced service and was progressing well. Progress had also been made in improving standards at the Royal Hospital for Sick Children. The weakest area for compliance was front door areas; Scott Garden and Nikki Maran were focussing on these areas through the Scottish Patient Safety Programme.

48.2.3 Ms Scott-Macfarlane noted that prescriptions were taken from patients on arrival in hospital and further medication may be prescribed without a chance for patients to learn the reason for the change or how the new medication related to other medication being taken. As patients were being encouraged to self-manage their medication, Ms Scott-Macfarlane felt that it would be more efficient if patients who managed their own medication were allowed to keep it when admitted to hospital so that medication was not missed. Ms Scott-Macfarlane also suggested that a better relationship between referring GPs and hospitals would ensure that the relevant information about the patient was available at the right time. Professor Timoney noted that work was being done to help in this area, and that the Green Bag Policy encouraged medication brought in with patients to be kept at the patient’s bedside.

48.2.4 Dr Williams suggested that this item could be taken forward by the Area Drug and Therapeutics Committee and that the Healthcare Governance Committee would be updated through the minutes and as part of the patient safety updated. This was agreed.

48.2.5 The recommendations set out in the paper were agreed by the Committee.

49. Emerging Issues

49.1 Medical Revalidation

49.1.1 The paper had been previously circulated. Dr Farquharson noted that all doctors now had an annual appraisal and after five years had their membership revalidated by the General Medical Council. Doctors could be recommended to the GMC as ‘recommended for revalidation’, ‘defer revalidation’, or ‘non-engagement’. For this to be effective the appraisal system needed to be robust; this was currently better developed in primary care but more work was being done to improve compliance in secondary care.
49.1.2 In the first year, thirteen doctors from NHS Lothian were ‘deferred’; two for health reasons, one due to maternity leave and ten who were ‘not ready’. Deferrals could only be made for one year. One doctor was not revalidated in the first due to non-engagement, and this case was now with the GMC.

49.1.3 Ms Gormley suggested that gender inequalities should have been raised under item 6 of the report as it had been shown that doctors could have their revalidation deferred due to maternity leave. Dr Farquharson agreed, and advised that ill health and maternity leave were considered legitimate reasons for deferral and these doctors would not be penalised.

49.1.4 Ms Bennett suggested that an equality and diversity expert should sit on the Committee in place of Mr Glover so that papers could be have equality and diversity rapid impact assessments as before. The Chair agreed to speak to Mr Boyter to arrange this. MB

49.1.5 The Committee agreed that the paper gave assurance on medical revalidation. The recommendations in the paper were agreed.

49.2 Independent Healthcare Providers

49.2.1 The Chair welcomed Ms Walter and Ms Seville to the meeting and they presented the previously circulated paper. Ms Walter noted that it was laid out in HDL (2005) 41 and HDL (2006) 45 that the Board as a contracting party had responsibility for external treatment, including decontamination and procedures. Healthcare Improvement Scotland (HIS) had the role of regulation and inspection of independent hospitals across Scotland. NHS Lothian planned to use the assurance criteria used by HIS and outlined in the paper to ensure that standards were being met.

49.2.2 Ms Seville advised that the assurance framework would be tested in the Edinburgh Clinic which already had robust assurance reporting methods. Action lists would be updated every two weeks and reports would be considered at the Clinical Management Teams and the Contract Review Group. Any complaints received would be addressed immediately, outwith this framework.

49.2.3 Ms Ballard-Smith noted her support for the proposal of twice yearly visits to independent healthcare providers by NHS Lothian. Dr Farquharson welcomed the paper and agreed that it gave assurance that had previously not been given. Mr R. Wilson noted that he felt re-assured that NHS Lothian was not just relying on the HIS process but was actively seeking assurance that appropriate standards were being met for the treatment of its patients.

49.2.4 In response to a question from Ms Gormley, Ms Walter advised that the same mechanisms for patient involvement would be used with independent providers as with NHS providers. Each provider already gave a satisfaction survey questionnaire to each patient. Work was on-going to set up a process for getting the results of these back for NHS patients. Mr S. Wilson noted that it would be useful if this could be part of the existing complaints process in NHS Lothian and could be reported to the Healthcare Governance Committee in the Complaints Reports.
49.2.5 Ms Bennett suggested that an annual report including findings from visits and patient satisfaction would be useful to provide regular assurance. Ms Walter and Ms Seville agreed to do this.

49.2.6 Members agreed the recommendations outlined in the paper.

50. **Risk Register**

50.1 The paper had been previously circulated. Mr R. Wilson noted that prescribing had been put on the register under ‘patient safety’ and queried whether medicines reconciliation should be an individual risk due to the importance of compliance with these standards. Ms Bennett noted that the Board was well aware of this problem and there were regular reports on medicines reconciliation to the Board, Healthcare Governance Committee, the Area Drug and Therapeutics Committee and that it was also covered in the Quality Report. It was agreed that there was an appropriate amount of focus on this area. The Chair agreed to include this item in the summary of the Healthcare Governance minutes for the Board.

50.2 Ms Scott-Macfarlane noted that unscheduled care and healthcare associated infection were also included under ‘patient safety’ rather than separately. Ms Bennett advised that the Risk Management Committee were in the process of reviewing the corporate risks on the register according to what was set out in the technical notes, and that some risks might be removed or become separate items. This updated version would be included next time the risk register was discussed at the Healthcare Governance Committee.

51. **Person Centred Care**

51.1 **Complaints Report – Quarter 2**

51.1.1 The paper had been previously circulated. Mr S. Wilson noted reporting on complaints was improving but more work was still required in order to meet the challenge of responding to complaints appropriately.

51.1.2 The number of complaints was increasing but this was felt to reflect an increased willingness and more ways for patients to come forward with problems. Complaints also provided opportunities for improvement.

51.1.3 Mr S. Wilson explained that the system for receiving complaints had been changed and complaints were now triaged so that the problem could be solved if possible rather than going through the complaints process.

51.1.4 A new process for prisoner’s complaints whereby every time a prisoner made a complaint about prison healthcare this would be dealt with by the Complaints Team at Waverley Gate meant that there had been an increase in complaints from prisoners.

51.1.5 Mr S. Wilson noted that there were currently fifty complaints cases with the Scottish Public Services Ombudsman. The Ombudsman had asked for improvement in
dealing with complaints because NHS Lothian had only upheld 14% of complaints in favour of the complainer compared to the 56% upheld throughout Scotland. The Ombudsman had upheld 76% of complaints against NHS Lothian. A short life working group planned to set up an investigation team to carry out independent reviews in areas of complaint in order to ensure improvements were made where needed. There was no other similar system in place in the NHS, so this system would be reviewed again after a year.

51.1.6 Ms Bennett questioned whether if the complaints review process was centralised at Board level this would have the effect of removing responsibility of service areas to investigate their own problems damage the relationship with the external team reviewing their service. She emphasised that part of the culture of learning and improvement involved the need for departments to review their own services. Mr S. Wilson noted that the group felt that the only way to ensure that investigations were being done properly was to do them centrally, but that investigation teams would work with staff from the service. Mr S. Wilson noted that the paper had been written with advice from the Scottish Public Services Ombudsman and would also be discussed at the Board.

51.1.7 In response to a question from Ms Tait about the mechanisms for feedback and learning for staff and ensuring that areas understood that receiving complaints was important for the improvement of the service, Mr S. Wilson advised that feedback of outcomes to staff and learning from incidents would be improved, as previously no system was in place for this.

51.1.8 Ms Ballard-Smith noted that services were not learning from serious adverse events and the same skill was required for dealing with complaints. The review of the complaints process should be an opportunity to also review how to improve learning from adverse events.

51.1.8 Mr S. Wilson emphasised the need to focus on person-centred care rather than following of agreed processes. If processes in place were not producing the desired outcome then it should be possible to change them.

51.1.9 Ms Scott Macfarlane noted that problems in the system lead to complaints and the first step was to recognise and resolve these problems. Mr S. Wilson noted that the majority of complaints were about staff attitude and behaviour rather than adverse events or bad clinical management.

51.1.10 The Committee agreed the recommendations in the paper but expected points made about staff engagement to be addressed in the final paper after discussion at the Board. Mr S. Wilson agreed that this paper was a first step and that review would ensure any required changes could be made.

51.1.11 Ms Meiklejohn suggested that encouraging feedback might result in improvement while preventing formal complaints being made. Mr S. Wilson noted that the Patient Opinion Scotland website allowed patients to give feedback on their experience and figures for Lothian were included in reports. A separate Lothian feedback page could be considered. Mr S. Wilson noted that a representative from the Police had been invited to give information on their feedback and complaints systems but that
no-one had yet been able to attend. Ms Gormley noted that it would be useful to find out the effects of other feedback systems on organisational culture.

52. **Safe Care**

52.1 **Healthcare Associated Infection Update**

52.1.1 The report had been previously circulated.

52.2 **Improving Management and System Learning from Significant Adverse Events**

52.2.1 The report had been previously circulated. Ms Bennett noted that arrangements for reporting of serious adverse events were being revised for March 2014. A report showing key differences between national and Lothian policies would be submitted to the Healthcare Governance Committee in January 2014 and the new policy would be submitted in March 2014.

52.2.2 Ms Bennett noted that work was on-going on improving communication with patients following incidents. The Maternity and Neonatal Units in Lothian would be part of a pilot along with departments in other Boards which would consider communications training to encourage staff to be more open with patients and family and to build staff confidence and skills. This work should link with the complaints team as incidents and adverse events often lead to complaints. This work would help to diffuse problems locally and quickly by using better communication. Staff should feel empowered to apologise and be open when problems had been identified. Dr Farquharson noted that this national forum would also help learning to be shared across Scotland.

52.2.3 Ms Bennett noted that team based adverse events training were proving successful and also encouraged the discussion of culture within each team.

52.3 **Public Protection Update**

52.3.1 The report had been previously circulated. Ms Ballard-Smith noted that the new Child Protection Doctor had now been appointed. Recruitment for the new Adult Support and Protection Advisor was now at the interview stage.

52.4 **Emergency Planning**

52.4.1 The Chair welcomed Mr Elliott to the meeting and he gave a presentation on emergency preparedness and resilience. Mr Elliott noted the tendency to produce very long and comprehensive documents describing procedure, which could not be read at the time of an emergency, and the need to produce notes which would summarise from national policies what needed to be done, including action checklists and contact lists.

52.4.2 In response to a question from Ms Bennett, Mr Elliott noted that training courses were available in crisis management skills, coping with pressure, and working with people under pressure, and that it was the aim of the Resilience Committee that members of staff in each department had this training.
52.4.3 Mr Elliott noted that the priority of the Resilience Committee was to ensure plans were fit for purpose, guidance was accessible, and staff had relevant skills. This Committee would report directly to the Board.

52.4.4 In response to a question from Ms Gormley, Mr Elliott agreed that communication with patients also needed to be considered and was included in the Resilience Committee remit as part of NHS Lothian’s values.

52.4.5 In response to a question from Dr Williams, Mr Elliott advised that GP practices and independent contractors’ emergency plans would be dependent on their contracts. The Resilience Committee would work to ensure that emergency plans were built into any new contract, and contract partners would be included in training and business continuity exercises. Ms Christie noted that each practice currently had a business continuity plan which linked into the local authority business continuity plan.

53. **Effective Care**

53.1 **Quality Report – Diabetes**

53.1.1 The report had been previously circulated. Dr Farquharson that there was a focus on prevention by looking at causes of diabetes and the key role of Primary Care in prevention and management of diabetes. It was noted that a lot of resources went into this area and it was important to monitor outcomes.

53.2 **Diabetes Managed Care Network (MCN) Survey and Action Plan**

53.2.1 The report had been previously circulated. Ms Tait noted that an Efficiency and Productivity workstream had been set up in relation to prevention and management of diabetes with more focus on primary care and pharmacy support to ensure that prescribing strategy was implemented across primary and secondary care. Improvements in patient safety and efficiency were expected by the time of the next report.

53.2.2 Ms Scott-Macfarlane noted that there seemed to have been a reduction in podiatry care provision for the elderly which would not support efficiency in prevention of diabetes. Ms Tait agreed to take this back to the group.

53.2.3 In reference to the ‘My Diabetes, My Way’ website mentioned on page 3 of the report, Ms Scott-Macfarlane reminded Members that many elderly people were not able to access and use the internet and that there should be an alternative system for these patients.

53.3 **Heart Disease Strategy Programme Report**

53.3.1 The Chair welcomed Dr Bickler and Dr Northridge to the meeting and they presented the previously circulated paper. The Heart Disease Programme Board was established in February 2012 and reports on the Heart Disease Performance Indicators detailed in table 1 of the paper. Dr Northridge noted that differences in
figures between the Royal Infirmary, the Western General Hospital and St John’s Hospital were to be expected due to the way patients were transferred between these hospitals. For all indicators, NHS Lothian’s figures were similar to or better than other areas in Scotland.

53.3.2 Dr Bickler reported that the Heart Disease Programme Board improvement plan was based on the actions from a number of action plans and focussed on clinical guidelines and cardiac rehabilitation. Review of the guidance in response to SIGN 93 was also required but most areas were already covered. Work was on-going to improve compliance with the outcome measure risk stratification score.

53.3.3 In response to a question from the Chair, Dr Northridge advised that there had been a reduction in patients with STEMI over recent years and that these patients were now treated differently and made quicker recoveries. The new challenges were elderly patients with more complicated cases and co-morbidities, and patients with valve problems. Dr Bickler noted that primary intervention such as encouraging better lifestyles and providing earlier screening were likely to make more of a difference in reducing mortality from heart disease.

53.3.4 In response to a question from Ms Bennett, Dr Bickler advised that pilot work was being done on communication with patients and relatives about heart disease and end of life care, and how to discuss with patients whether to intervene or not.

53.3.5 Ms Meiklejohn suggested that the integration of Health and Social Care would provide an opportunity for Health colleagues to work with the third sector to improve lifestyles to help reduce the incidence of heart disease. Dr Bickler noted that joint training was already carried out but agreed that that this would provide further opportunity for joint working.

53.3.6 Dr Williams noted that the figures for St John’s Hospital in the indicators table appeared to be outliers for both re-admission and mortality and felt that as there were other hospitals in Scotland with small units these figures should still be within the expected limits. Dr Bickler explained that because the coding used to document the transfer of a patient was the same as that for a re-admission, this made re-admission rates look slightly higher at St John’s as more patients were transferred there. Other smaller hospitals had similar rates. Work was being done on changing the way transfers were recorded. Dr Bickler noted the mortality rate in all Lothian hospitals was fairly low. Ms Bennett noted that for assurance these figures would continue to be reported to the Healthcare Governance Committee through the Quality Report.

53.3.7 In response to a question from the Chair, Dr Northridge advised that figures from the Scottish Ambulance Service and NHS 24 show that over 90% of patients complaining of chest pain were reached within 10 minutes by a first attender.

54. Exception Reporting

The Committee noted the following items for information:

54.1 Older People in Acute Hospitals Unannounced Inspection, St John’s Hospital;
54.2 Organ Donation Annual Report

54.2.1 Dr Williams noted the exceptionally high number of Lothian residents who had signed the organ donation list. 46% of the population had signed, which was the highest percentage of any area in Scotland. The 1000th liver transplant and the 1000th kidney transplant in Lothian were both performed in the last twelve months.

54.3 HIS Inspection Report, Rachel House Children’s Hospital, Kinross;
54.4 Respiratory Managed Care Network Annual Report;
54.5 Scottish Intercollegiate Guidelines Network (SIGN) Annual Report.

55. Other Minutes Exception Reporting

The Committee noted the minutes from the following meetings:

55.1 NHS Lothian Health and Safety Committee, 24 September 2013;
55.2 Area Drug and Therapeutics Committee, 4 October 2013;
55.3 Clinical Management Group, 8 October 2013;
55.4 Divisional Dental Executive Committee, 26 September 2013;
55.5 Lothian Infection Control Advisory Committee, 3 September 2013;
55.6 Organ Donation Sub-Group, 3 October 2013.

56. Any Other Business

56.1 Involving People Framework

56.1.1 Mr S. Wilson noted that the Involving People Framework was being re-written following review. It was agreed that a presentation would be given at the meeting in March 2014 outlining the strategies for the future. SW

57. Date of Next Meeting

57.1 The next meeting of the Healthcare Governance Committee would be held from 9.00 am – 11.00 am on Tuesday 21 January 2014 in Room 7, Second Floor, Waverley Gate.

57.12 Further meetings would take place on the following dates in 2014:
- 25 March 2014;
- 27 May 2014;
- 22 July 2014;
- 23 September 2014;
Minutes of the Meeting of the Strategic Planning Committee of NHS Lothian NHS Board held at 10am on Friday 29 November 2013 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chair); Mrs J Anderson; Mrs K Blair; Mr J Crombie; Mr T Davison; Mrs P Eccles; Dr D Farquharson; Mrs S Goldsmith; Mrs M Hornett; Professor J Iredale; Mr A Joyce; Mrs A Meiklejohn; Mrs A Mitchell; Professor A McMahon; Dr R Williams and Mr R Wilson.

In Attendance: Mr M Hill; Ms D Milne; Ms L Tait; Ms D Welsh and Mr D Weir.

Apologies for absence were received from Mr J Forrest, Mr P Gabbitas, Mr D A Small and Mr G Walker.

14. Welcome and Introduction

14.1 The Chairman welcomed Mr J Crombie, Director of Scheduled Care to his first meeting of the Strategic Planning Committee.

15. Declaration of Financial and Non Financial Interest

15.1 The Chairman reminded members they should declare any financial or non-financial interest 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.

16. Minutes of the Previous Meeting held on 23 October 2013

16.1 The Minutes of the previous meeting held on 23 October 2013 were approved as correct record.

17. Matters Arising

17.1 Strategic Plan Diagram – The Committee noted the diagrammatic representation of the strategic planning process.
18. ** Unscheduled Care – Presentation **

18.1 The Director of Unscheduled Care provided the Committee with a detailed presentation on the future of Unscheduled Care in acute services which covered in detail what acute hospital Unscheduled Care would look like in the future. It was noted that there would still be a requirement for a substantial hospital base of beds with the bed complement currently still being under capacity. It was noted that ideally wards should run at 85% occupancy and if this was the case then the Royal Infirmary of Edinburgh and Western General Hospitals between them would require an extra 110 beds. The Director of Unscheduled Care advised that she was concerned about the lack of a dedicated decant ward. It was felt that there was a real issue about tackling diagnostics and that this needed to be looked at with there being a requirement to look at investment in endoscopy in order to release bed numbers.

18.2 The Committee received a detailed presentation from the Director of Unscheduled Care on issues by site covering St John’s Hospital, Western General Hospital and the Royal Infirmary of Edinburgh.

18.3 The Committee noted that moving forward there was a need to accept operational pressures would drive some changes outwith the clinical strategy and that there would be a need to agree short, medium and long term plans. This process would require robust clinical (especially Consultant) engagement as well as public / patient and partnership involvement. The Director of Unscheduled Care commented that there would be a need to understand that any service moves would inevitably cause upset and that there would be a need to agree criteria for moves which would have to consider clinical safety (patients and staff), achieving HEAT targets and achieving financial savings.

18.4 The Director of Unscheduled Care commented in order to achieve the above there would be a need to develop options around expansion of medicine of the elderly across sites as well as an expansion of the Western General Hospital front door. The forward position in respect of dermatology/ stroke/ rehabilitation services, orthopaedic rehabilitation services and Liberton Hospital would also require to be clarified. The Committee agreed that the Director of Unscheduled Care in conjunction with other colleagues should develop these issues to produce options containing numbers and consequences to feed into the strategic plan paper being submitted to the Board in April.

18.5 The Director of Unscheduled Care advised that discussions were ongoing with clinicians although these were tainted by operational pressures. She suggested that work over the next few months would clarify issues around numbers and consequences. She commented that in future the ideal would be for acute services to provide only acute needs and there would be a need to clarify at what point to set quantifiable parameters. The Committee noted that there would be a need to obtain data to predict exactly what was required moving forward in respect of primary care, community models and rehabilitation. It would be important to engender the co-operative way forward.

18.6 Mr Hill agreed there was a need to project forward as this would be the factor that would force the system to look at radical solutions. He felt there was also a need to
look at how other systems were fundamentally changing and referred to the position in Grampian where they were looking at a whole system approach to Unscheduled Care. The Committee noted the factors needed to deliver the future agenda required to be identified.

18.7 Mrs Blair commented while she had found the presentation excellent she was anxious about assumptions around bed numbers and she hoped that there was confidence around these. She felt in the short, medium and longer terms there was a need to look at barriers to achievement and in this respect there would be a need for robust engagement through Integration Boards and the Primary Care sector.

18.8 The Director of Unscheduled Care advised that currently there were around 3,000 beds in the system (1,000 in small community hospital settings) with there being a current lack of confidence around bed modelling. The Director of Strategic Planning, Performance Reporting and Information advised that work was being undertaken to allow more confidence in the use of this data. It was noted that a position was being reached where site based management teams were able to engage with General Practitioners and that this would lead to engagement at real clinical level.

18.9 Professor Iredale commented that he was pleased to see that headroom was being developed to allow thinking out of the box. He felt that consideration was being given to looking at the correct models and in this regard redesign would be important. He felt there was a need for proper robust data gathering to be undertaken with a need to major on patient outcome. He felt there was a need to think how best to tap into patient flows by looking at other models being used elsewhere. Professor Iredale made reference to the very positive comments made around a recent visit to the Cancer Centre which had demonstrated fantastic collaborative activity. He felt in respect of the decanting issues raised by the Director of Unscheduled Care that consideration should be given to the use of other sites.

18.10 Mrs Mitchell endorsed the comments made by Mrs Blair commenting that this was the most exciting thing that the Board would undertake for some time. She commented in respect of 48 hour assessment and discharge that there would be a need to map this into the Health and Social Care Partnerships and outpatients as well as the community. The Director of Unscheduled Care commented that this process was already good although she was keen to further enhance this. She felt however that the mapping to outpatient was an area where there was a significant amount of work yet to be undertaken.

18.11 Mrs Anderson commented in respect of stroke that there had been a lot of work undertaken through a previous 5x5x5x project which had looked at integrated models and in that respect there was not a need to go back to the drawing board for all workstreams. The Director of Unscheduled Care advised that consideration would be given to all previous or extant schemes although it was important to point out that there were divided clinical views around issues like the provision of the stroke service.

18.12 Dr Williams commented in respect of getting patients discharged quickly that there was a concern around the fact that this might lead to higher readmission rates. He
felt there was a need for a holistic assessment of patients to commence at the point of admission and the creation of a one stop shop in order to get patients assessed safely. He advised that the first of the Primary Care Patient Safety walkarounds had been very productive with colleagues having openly talked about the pressure they were working under and the potential risks this had for patients. He commented therefore that he was discomforted about the current assumption that Primary Care would cope with all the additional demands on it and felt that he needed to see further evidence of the sustainability of this assumption.

18.13 The Chief Executive commented there was a need to join up all workstreams although it would be important to improve the flow into Social Care as this was the only way of improving occupancy levels. He advised that discussions were currently underway with the City of Edinburgh Council in respect of the care deficit and the financial implications of these. He was of the view that there was a need for a major expansion of Social Care capacity within the City of Edinburgh.

18.14 The Chief Executive commented he would like to be ambitious around what was firmed up in the strategic planning document going to the Board in April particularly in respect of the clarity of choices that the Board needed to decide upon. He felt that the key issues were to obtain clarity around the Cancer service at the Western General Hospital, configuration of Laboratory services and what this would look like; the strategic position around the North West part of the Western General Hospital site which would partly require to be demolished to free up space to facilitate an expansion of the Acute Medical Assessment Receiving Unit, options around the configuration of Stroke services and the Stroke model. He felt that this would allow debate about services that might need to be displaced. He stressed that the acute bed numbers needed to shrink and that there was a need to consider services currently provided on sites like Liberton, Corstorphine, Astley Ainslie Hospital and the Royal Victoria Hospital in order to see whether these could be re-provided on a step-down Care Home facilities basis in conjunction with the City of Edinburgh Council and how this would feature and be delivered through the Health and Social Care Partnership and strategic commissioning plans. The Chief Executive commented that he would welcome the Committee’s views on how bold the aspirations should be set out in the strategic plan to be submitted to the Board in April.

18.15 The Chief Executive commented in respect of the Grampian model that they had consolidated their Medical Receiving Unit in to a single unit and this was not the case in Lothian. He commented that at the Western General Hospital staff were still working in silos and this led to services feeling dislocated and disconnected from each other with patients being disadvantaged through transactional hand-offs.

18.16 Mr Wilson commented that he agreed with the Chief Executive and his aspirations and questioned whether it would be possible at such an advanced stage for the paper to be available in March. The Director of Strategic Planning, Performance Reporting and Information felt that this could largely be achieved and that many workstreams were already underway.

18.17 The Chief Executive stressed that there was a need to have agreement around outpatients and laboratories for the 2nd April Board meeting and commented that
the Royal Victoria building was an example of a wrong assumption based on community infrastructure availability that did not transpire.

18.18 Mr Hill commented that it would be important to be careful not to over sell what might be delivered and for the Board meeting in April it would be important to have a discussion and focus into the main strategic priorities in order to provide a framework against which consultation could be undertaken in parallel with Strategic Planning and Health and Social Care Partnerships.

18.19 The Director of Finance confirmed the challenges of the financial position reminding colleagues that by March there would be no financial headroom and she therefore concurred with the views about the need to undertake bed modelling around step down beds. She commented that she was concerned that the health system could end up funding the Council Social Work deficit. Mr Wilson concurred, advising that the Integration process, although to be welcomed, carried the largest opportunity and risk. The Director of Finance advised that she had undertaken an indicative look at budgets for the Partnership model and this had shown that 43% of the budget would be allocated to Partnerships and in this respect there was a need to be clear about what they needed to do to support the redesign process.

18.20 The Director of Strategic Planning, Performance Reporting and Information advised that all aspects needed to be aligned and that the model of care would be driven by Partnerships and would include an expectation of how beds could be managed by them. Work would continue beyond April in respect of the development of strategic commissioning plans by the Health and Social Care Partnerships. The Chief Executive commented that currently, the system was compensating for Social Care deficits by using the most expensive resource available in the acute sector. The Chief Executive commented although there was a need to rebalance the model of care this would require a focus to work through tensions. The Director of Finance commented that there was a need to share the deficit and the problem.

18.21 The Committee noted the update and agreed the Chief Executive’s suggestion that a radical and bold approach should be adopted.

19.  Strategic Plan Progress Report

19.1 The Director of Strategic Planning, Performance Reporting and Information advised in terms of managing expectations it would important to be clear about what the strategic stakes in the ground were and what aspects of these required further engagement and consultation. He advised that considerable work was underway looking at data, pathways of work to include children. It would also be important to factor in the risk share around assumptions and finances to reflect shifts of responsibility. He advised that the strategic planning infrastructure was now in place and that regular Monday Informal Director sessions were in part being freed up to allow further broad thinking around the strategic planning process. This would allow the testing of assumptions. The meetings were facilitated by Mr Hill to bring additional challenge to the process. He advised that a gantt chart and outline plan were in place and that this would change on an iterative basis to reflect debate.
19.2 The Chief Executive commented there would be a point when discussions would require to be held with Civil Servants as well as consideration given on how to manage expectations and anxieties that might appear in a public document.

19.3 The Chairman commented he would reiterate his previous comments in respect of political sensitivities advising that it was the Board’s job to come up with the best possible solution for service provision and then to go through appropriate processes. If this was not acceptable to others then there would be a need to revisit. Mr Hill commented that an important point would be how the document was articulated and in that respect how it was constructed would be important. It was noted that the strategic planning framework document would continue to develop.

19.4 The Chief Executive commented it would be important to ensure that every proposition made in the document was either set clearly in the context of Government policy or was seen to address patient safety deficit. He commented however it would be important to recognise the political environment.

19.5 Mrs Anderson commented that communication would be important and although it was anticipated that the plan would set out principles it would also contain questions. It would be important to consider how best to answer these. She commented if there was an intention for the process to be bold then there would be a need to follow through on a number of issues and a robust method of communications would be vital.

19.6 The Committee noted the update on the strategic planning process.

20. **Board Finance Seminar Update**

20.1 The Director of Finance commented from the Board Workshop she had taken the key message that there was a need for more benchmarking and forward forecasting in order to identify the extent of the challenge. She commented that key aspects that required clarification were around laboratories and catering in order to be clear about desired outcomes.

20.2 The Committee noted that Finance were now adopting a workstream approach to LRP and that there was a need to maintain challenge into the organisation in order to meet financial targets as currently progress was not being made at a sufficient level in a number of areas.

20.3 The Director of Finance advised moving forward there would need to be more challenge around hospitals and sites with work requiring to be undertaken in order to determine what redesign was possible and what the likely savings were. The Director of Finance felt that the key areas of focus were around technology, pathways and workforce thinking which needed to be developed, probably on the basis of further consideration being given to specific areas.

20.4 Mrs Tait commented that pathways work was linked to technology and the workforce and stressed the need to design technology around the pathway as well as to ensure that necessary staff skills were available at the appropriate time. She
commented that a major challenge would be in driving change and the workforce in respect of existing employment practice.

20.5 Mrs Blair commented that there had often been chilling conclusions within the Finance presentation to the Board with interesting tensions between aspirations and what was achievable in financial terms. She felt that the quicker appropriate linkages were made the better. She commented in respect of the Edinburgh Health & Social Care Partnership Integration process that it would be helpful to obtain more health senior management input especially around finance as this was currently lacking. This viewpoint was endorsed by Dr Williams and Mr Wilson.

20.6 Mr Wilson commented it was important to recognise these tensions and commented that the discussion at the Board Finance event around technology had been naïve and unrealistic. He felt that currently the system was not as well sighted on workforce planning as it should be.

20.7 Mrs Anderson commented in respect of workforce that there was a lot of appetite for redesign and in this regard pathway work would be important in order to ensure that services were not replaced on a like for like basis. She felt that the adoption of a pathway process forced the system to look at multi-disciplinary workforce models rather than the current silo based structure. She stressed however that the position was not all about short term fixes and there was a need to look to the longer term to identify training needs.

20.8 The Director of Strategic Planning, Performance Reporting and Information advised that the other key issue emerging from the Finance workshop had been the need to look at disinvestment. He reminded the Board that they had recently taken a decision to disinvest in homeopathy albeit this was subject to possible judicial review. He advised that his colleagues had started to develop the criteria required for discussion at the 17 December Board workshop session and explained the process to be adopted for that event. He commented that the following weeks Joint Management Team would target debate around the topics of the strategic plan, Integration and Integration plans, the workforce plan and the finance and site master-planning plan.

20.9 The Chief Executive commented in respect of outpatients it would be useful to address 3 or 4 specialty silos as discussed with a view to disinvesting in procedures of low clinical value. It was noted this would require clinical champions to work to reduce return outpatients. He commented when looking at the 3 or 4 specialties for disinvestment it would be important to use technology to make the process real.

20.10 The Committee noted the update report.

21. Integration Process and Update

21.1 The Director of Strategic Planning, Performance Reporting and Information advised that this work was not progressing in isolation. It was noted that a Board workshop would be held on Tuesday 2 December and that part of the Integration process would be to make sure issues around site plans, workforce and finance were all aligned. The debate would also focus on the opportunities of how best to use
Partnership Boards. As part of the ongoing process Integration plans would be
developed that would require to be consulted upon with a April 2015 live date being
proposed.

21.2 The Chief Executive commented that this would be an important discussion as the
Board would need to agree what areas of service to delegate to Partnerships and
the same process would have to be undertaken within Councils in order that an
agreed position could be reached. He referred to the point made by the Director of
Finance about delegating almost half of the budget commenting that instinctively he
felt there might be a requirement to increase the level of delegation in order that
Health and Social Care Partnerships could take responsibility for aspects of the
acute service. The Chief Executive commented in real time it would be possible to
undertake work around St John’s with the view to reintegrating this into the West
Lothian Health and Social Care Partnership. If this were achieved this would
represent the only totally integrated Primary and Secondary care system in
Scotland.

21.3 The Committee noted that the Seminar scheduled for 17 December would debate
the aspects of service being put into Partnerships by March which would then
require a process of engagement with stakeholders.

21.4 Mrs Blair commented she did not disagree with the principle although she had
reservations about the position in Edinburgh and commented that prior to any
additional funding being made available further work was needed around
assurances in respect of accountabilities etc. Mr Wilson and Dr Williams concurred
with this view. The Chief Executive advised that he had held 3 specifically focussed
meetings with the Chief Executive of the City of Edinburgh Council along with other
colleagues in the respective management teams with a view to obtaining
agreement to treat the current position on a crisis basis. In that respect it had been
agreed to establish weekly meetings to look at the Social Work deficit. In addition
to this a high level meeting was being arranged with himself, the Chairman, the
Vice Chairman, Cllr A Burns, Leader of the City of Edinburgh Council, and
Councillor Henderson in order to hopefully seek political endorsement of this
position by politicians. Mrs Blair expressed concern that she was unaware that this
series of meetings was happening. It was agreed that the Chairman and the Chief
Executive would take off-line the issues of concern raised by Mrs Blair, Mr Wilson
and Dr Williams in respect of accountabilities around the Edinburgh position.

21.5 Ms Eccles advised that she sat on the Stakeholder Board in Midlothian and would
welcome guidance around the engagement of the third sector in terms of
governance. She felt that Partnership also needed to be engaged in Board
seminars moving forward. The Director of Strategic Planning, Performance
Reporting and Information advised that these were workshops established for
Board members and as such the Employee Director attended from a Partnership
perspective. It was noted in respect of the third sector that national guidance was
still awaited although actions could happen in advance of this issuing.

21.6 Ms Milne advised that the Joint Improvement Team from the Scottish Government
had undertaken a strategic needs analysis of Health and Social Care Partnership
capabilities and was asking Public Health to engage more widely in this process.
She advised within Lothian the Director of Public Health and Health Policy was
about to allocate a Consultant in Public Health Medicine to the Integration process. She advised that the Joint Improvement Team were proposing a raft of issues and she had asked for further detail around this commenting that the Team had written to all Partnerships identifying weaknesses and strengths.

21.7 The Director of Strategic Planning, Performance Reporting and Information advised that 2 recent publications had put Lothian at the head of the pack in terms of readiness for the Integration process. He commented however that there was a need to further review the Lothian performance in respect of the Change Fund. He advised he welcomed the Public Health engagement advising that it would be important to review the information that this engagement provided.

21.8 The Committee noted the Integration process update.


22.1 The Director of Strategic Planning, Performance Reporting and Information advised that the points made by the Chief Executive around outpatients were pertinent. He commented with the Director of Scheduled Care it would be important to look at a number of areas and identify what redesign might look like. He commented that Unscheduled Care work would pick up outpatients and focus on innovation and technology. The Committee noted there would be cultural aspects to be addressed around innovation in respect of the change that would need to be harnessed.

22.2 The Director of Unscheduled Care commented that the Scottish Government Health Directorates had required NHS Boards to have an innovation plan and committee and she felt that a focus on outpatients would be appropriate as this was an area ripe for innovation. There would also needed to be links with efficiency and productivity, workforce and finance generally. The Director of Strategic Planning, Performance Reporting and Information advised that he would work with the Director of Scheduled Care look at work undertaken so far and use evidence around technology to model something around initial and return outpatient numbers. The Chairman agreed with this approach advising that he would like to see innovation taking the Board forward in this way as this would result in it becoming an integrated part of the whole planning process.

22.3 Mr Hill commented in respect of innovation that the method of sharing ideas was important. He commented it would be important to ensure that the process adopted added value around the implementation of introducing new ways of working.

22.4 The Committee noted the update report.

23. Leadership Development

23.1 It was agreed to defer discussion on this item until the Director of Human Resources and Organisational Development was present.

24. Board Development Day Outline Agenda – 17 December 2013
24.1 The Director of Strategic Planning, Performance Reporting and Information commented that discussions had been held about using the 17 December Development Day to pick up on issues from the Finance Seminar. It would also be important from the debate at the current meeting to address the issues raised by the Chief Executive about outpatients with a view to identifying tangible actions through the use of technology. Disinvestment and the criteria for making these decision would also require to be considered.

24.2 The Director of Finance commented in respect of disinvestment she agreed that it would be important to discuss how to take this forward although she was thoughtful about what would be available for discussion in December. The Chairman suggested it would be appropriate to look at this as Phase 2 of the previous discussions held at the Seminar facilitated immediately following the Board meeting earlier in the week.

24.3 Mr Wilson concurred advising he was unsure how much more the Director of Finance could provide by 17 December. He commented that he had received from the Finance workshop a clear idea of the challenges and was not keen to hear more about the process. He felt that the stage had been reached where it would be important to expose some of the developing thinking. The Chief Executive commented that he felt he had done this through his discussions around the need to reduce 500 beds at the Finance Seminar held following the Board meeting and he would be keen to focus further work around issues like this.

24.4 The Chief Executive noted that there had been a number of Board Development sessions held in quick succession. He commented it would be important that the outputs of the 3 December Integration Seminar fed into the plans for the workshop on the 17 December in order to broaden the debate about Integration links. He advised there would be a need for a whole Board discussion about progress in respect of Health and Social Care Partnerships and their role in Integration. It was agreed that the focus of the 17 December session would be to review the outcomes of the session held on 3 December and the Partnership role in progressing these.

24.5 Mrs Blair commented in respect of ownership of strategic planning work it would be important to keep the wider Board involved. Mrs Mitchell concurred advising she would like to see an exercise undertaken to take Primary and Secondary care themes allocated to Integration and for further background work to be undertaken. The Chief Executive advised he would also be keen for this to be undertaken with a focus around beds.

24.6 The Committee agreed for the workshop session on 17 December that the key focus would be around general update on propositions for delegating to Health and Social Care Partnership; a fictional patient and patient work update and how Integration would work with a focus on Edinburgh as the largest area using shifting the balance of care as an example.

25. Date and Time of Next Meeting

25.1 The next meeting of the Strategic Planning Committee would be held at 10am on 13 December 2013 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place.
26. Declaration of Financial and Non Financial Interest

26.1 The Chairman reminded members they should declare any financial or non-financial interest 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.

27. Agenda Planning

27.1 It was agreed to defer the Site Master-planning Update until the next meeting when Mrs Goldsmith would be in attendance. It was also agreed to take agenda item 6 Activity Times and Projections as the first item in the meeting.

28. Minutes of the Previous Meeting Held on 29 November 2013

28.1 The minutes of the previous meeting held on 29 November 2013 were approved as a correct record subject to recording Mr Gabbitas’ apologies.

29. Matters Arising from the Previous Meeting

29.1 Integration Process and Update – Mrs Meiklejohn questioned when the report on the review of NHS Lothian’s performance in respect of the change fund would be available. Professor McMahon advised he would bring forward an update to the January meeting. The Chief Executive commented the debate around the ‘500’ beds referred to at the previous meeting would feature as a specific item on the Board seminar on 17 December and would be discussed thereafter at the Strategic Planning Committee.
30. **Activity Trends and Projections**

30.1 The Chairman welcomed Mr Purser to the meeting. Mr Purser provided a detailed presentation on trends over the previous five years covering A&E arrivals, A&E utilisation rate; acute bed utilisation by age group and CHP unscheduled care admission as well as trends and projections around adult unscheduled inpatient care and adult scheduled inpatient and day case admissions.

30.2 Mr Gabbitas commented that the assumptions around this data were fundamental because if the system does nothing there would be a requirement for an extra 811 beds. He commented with particular reference to the trends and projections around adult unscheduled inpatient care bed utilisation that he felt that some of the actions from the change fund investment were only now coming to fruition and would really only impact from 2012/13 onwards. Whilst it would be important not to make heroic assumptions around this he felt the benefits would not be insignificant and the current trend did not show this impact. It would be important therefore to be cautious about the extent of extrapolation based on the 4-5 years data presented to the committee without factoring in the impact of the change funds.

30.3 Mr Gabbitas commented it would also be important to understand the assumptions around demographic and population growth. Mr Purser commented there had been an increase in the expansion of patients aged over 65 years and the data in its current state assumed patients would present with the same conditions as before which would clearly not be the case as the population became more healthy. He stressed the health status of the population would affect how people were treated, probably more predominantly through primary care. He reminded the committee the data being used was high level crude projections and over time disease prevalence would change and it would be important to plan for this. Mr Purser commented in that respect further detailed work was needed and this would occur over the next months.

30.4 Mr Hill commented the value of the data was it showed what would happen if no further actions were put in place and it would be important through the Strategic Plan and its key actions to begin to modify the data in order to present a before and after position statement.

30.5 Professor Iredale commented he felt the data had been very useful and understanding the shifts and burdens of patterns of disease would be important.

30.6 The Chief Executive commented that the profile of hospital admissions would change with fewer people presenting with single conditions and more with multiple issues and it would be important therefore to reflect on what a future acute hospital would look like in respect of the changing profile of care. He commented the change fund had been in place in Scotland for three years and an interesting metric was that whilst the over 75 population had increased, bed days had decreased. In addition the number of people in care homes had reduced with there being more activity in primary care and home care which was likely to lead to an increase in primary and community support for people living with long term conditions. The Chief Executive commented therefore there was a need for a different model of
care and the introduction of more general beds in the acute sector as well as an expansion of primary care and community care facilities.

30.7 The Chairman commented it would be important data was developed to reflect different outcomes and it would be essential for data analysis to be joined up. The Chief Executive commented it was hoped evidence of this would be available for the Board development workshop the following week. Mr Purser commented in order to obtain full value from the data it needed to be produced on a continuous basis.

30.8 Mrs Anderson questioned whether the data had been compared with data available from 5 years previously and if so, whether the projection profile had changed. Mr Purser advised the data used was based on previous census information with the 2011 census data not yet available. He commented previously there had been erroneous national projections in respect of the growth of the 60 - 64 year old population as well as an over assessment of economic migrants both of whom made the least use of the acute sector.

30.9 Mr Purser advised demographic projections would be a key feature moving forward and he felt the position would not have been materially different using the five year period referred to by Mr Anderson with the health of the population having remained fairly stable. Mrs Anderson commented it would be important to consider how to use data in a planned rather than a reactionary manner. Mr Purser concurred advising there was a need for a level of granularity of data and the next iteration of data would provide this.

30.10 Dr Williams advised he agreed with all that had been said and commented whilst it was important not to become complacent in the last 12-18 months general practitioners had looked at admissions and referrals with there being evidence of significant improvement in this area. He commented there was a need to enhance the resource available in primary care to stop people being admitted into the acute sector in the first instance. He commented the position might not be as problematic as it might at first sight appear from the data presented although it was important to anticipate trends moving forward.

30.11 The Chief Executive commented the data presentation reinforced the point he had previously made that the planning strategy needed to be about health and social care and also reinforced the need to keep clear links and overlap and connectivity with the Health and Social Care Partnership Strategic Commissioning Plans. He commented moving forward there would be more demand for procedures like joint replacement and in that regard social care capacity would be more linear than unscheduled care activities.

30.12 The Chairman thanked Mr Purser for the presentation commenting it had been reassuring to have had the ability to have this discussion.

30.13 Mr Purser left the meeting.
31. Scheduled Care Future Proposition

31.1 Mr Crombie provided the committee with his initial impressions around strategic objectives, initial priorities and key deliverables. He advised he had noted a passive acceptance in the system around issues like the use of external private capacity. He commented work was underway in respect of governance to ensure recovery was delivered compliantly and he felt this was important given the systems current position. He advised there was a need to ensure consistency and robustness of information and in that regard it had been agreed within his team that the information coming forward from the Health Intelligence Team would assume primacy. Mr Crombie advised the Scottish Government Access Team was providing support and help with it being his personal objective to be able to allow the national team to step back although this could not occur until they had been provided with assurance that the system was on the road to recovery.

31.2 Mr Crombie advised he was required to provide an assurance document to the Cabinet Secretary early in the New Year and it would be his intention to do this on the basis of the availability of robust information which would be consistent across all specialties as well as providing clarity about where the system needed to go to help to provide future models for patient care delivery. It was noted this work required to be concluded by January 2014.

31.3 Mr Crombie explained the performance data currently being used around core capacity; external capacity; inpatient and day patient waits and trends including RTT data; imaging waits over 4 weeks; endoscopy waits over 6 weeks; theatre utilisation and clinic utilisation; local access policy; inpatient and day case unavailability and unscheduled care.

31.4 Mr Crombie commented the immediate challenges were around timelines with his focus currently being on compliance as well as firming up on population demographics and needs. He commented ongoing work would address multiple and varied complexities with the key focus for his team being to develop and deliver sustainable solutions moving forward. The committee noted the opportunities moving forward in respect of the commitment of staff and efficiencies to support recovery. Mr Crombie commented the achievement and delivery of these aspects would allow focus on other key priorities in the future.

31.5 Mr Crombie commented in respect of the Patient Rights Act and compliance with RTT he would be bringing forward a number of initiatives over the near future particularly in respect of ensuring more transparency around administrative functions largely around the Local Access Policy. He commented these proposals would include issues of patient responsibility.

31.6 Mr Crombie advised in the past within Lothian there had been a question mark around the use of unavailability criteria. He commented an initial review of the master patient index revealed a number of patients refusing reasonable offers and of people not attending appointments with no actions being taken in that respect. He commented it would be important to consider the potential of using unavailability and clock-stops in line with current legislation in order to report the true Lothian position.
31.7 The Committee were advised by Mr Crombie that the main icebergs moving forward were around bed models being compromised as well as non core waiting lists initiatives being compromised. He advised currently there was a significant administrative overhead in place which would require to be reviewed. Mr Crombie reported there remained an issue of clinical engagement and the need to resolve behaviours to ensure people understood the need to move back to in-house provision and away from the continued use of the external private sector. As an example he explained the positive changes in ophthalmology.

31.8 Mr Crombie commented the proposals he would bring forward before March would probably include a need to increase the provision of day surgery to prevent use of inpatient beds. There would also be a need to consider whether to move from day surgery to outpatient care to reduce demand for day case theatres. Mr Crombie commented he had been astounded by the commitment of the team and the enthusiasm to ensure recovery and he would be keen to support this culture moving forward.

31.9 The Chairman commented Mr Crombie had presented a very comprehensive and compelling picture in terms of steps being put in place to drive forward the solutions. He commented while a lot of the presentation had been around the detail and operational management it was reassuring to receive this feedback. He commented he felt the content of Mr Crombie’s presentation would be of significant interest to the rest of the Board. Professor McMahon advised the detail of the presentation had been scheduled for discussion at the Board Development Workshop the following week.

31.10 The Chairman commented he had welcomed the statement about consistent and unitary data and would like to learn more about how to use this in reporting of performance especially to the Board. Mr Crombie stressed the need to use one common set of data produced by the Health Intelligence Team and for this to have primacy. It was noted this approach had now been permeated through the whole team.

31.11 The Chief Executive commented the report to the Board currently over stated the position and he and Mr Crombie had agreed in future the report should focus on available TTG patients. He felt the consistency of data was important and assurance around the availability of this needed to be a key feature in the report submitted to the Cabinet Secretary in January 2014. The Chief Executive commented he had discussed with the Audit & Risk Committee the need to amend the Lothian Local Access Policy to reflect the position elsewhere in Scotland. This would mean the current 14 day patient period for accepting an appointment would reduce to 7 days. NHS Lothian was currently the sole outlier in applying a 14 day period.

31.12 The Chief Executive advised that when he had arrived in NHS Lothian, people had been scared of making mistakes in terms of applying unavailability and clock-stops resulting in over reporting of breaches and this had been explained to the Scottish Government. He commented this was a sensitive area and part of the report to the Cabinet Secretary would reflect on the fact NHS Lothian was over-stating its
position in comparison to other Boards and this would in part be rectified by tightening up on the Local Access Policy.

31.13 Dr Williams reminded colleagues the Board had previously spent a lot of time looking at and agreeing the Local Access Policy and if changes were being proposed, these, along with the potential implications would need the agreement of the full Board. Mr Crombie stressed the proposals would be in support of what the Board had previously agreed and would only bring Lothian into line with other health systems.

31.14 Mrs Mitchell commented it was good to have received the assurances contained in Mr Crombie’s presentation and in particular she welcomed the reference to NHS Lothian values. She questioned in respect of manipulation of data that she would be keen to receive assurance staff were not being pressurised to present data in a particular way. Mr Crombie commented his attention to governance had brought clarity down to the lowest level in the organisation about what compliance meant. He advised protocol guidance had been issued to the system and training development was provided and he felt this was a major step forward. He further advised oversight of the patient dashboard flagged up issues requiring review and reporting was now undertaken on a cross check basis. Mr Crombie commented his focus was strictly around compliant recovery and not recovery at any cost.

31.15 Mrs Meiklejohn commented once the data was fully understood there was a challenge in respect of available capacity not being in place to deliver the recovery programme. She stressed the need to ensure in all instances the proper clinical priority was applied to ensure breeches did not occur. Mr Crombie stressed clinicians would remain focussed on clinical priority and debate with them would be about how they delivered this and the recovery programme.

31.16 Mrs Meiklejohn further commented on the need to ensure primary care was actively engaged as part of the solution. In particular she felt there were opportunities around ophthalmology provision in the community. Mr Crombie advised this point was currently being looked at by his team. Mrs Meiklejohn reported at a recent patient safety walkaround at Roodlands it had been reported theatres were not being utilised and patients were being sent away. Mr Crombie advised utilisation of the theatre asset was being looked at.

31.17 Mr Joyce thanked Mr Crombie for his upbeat presentation. He commented however if theatre utilisation could be improved this would reduce the reliance on the private sector and questioned how quickly this position could be arrived at. Mr Crombie advised once theatre utilisation was considered at individual practitioner level appropriate scrutiny could then be applied to address specific issues as well as changing behaviour to encourage the earlier discharge of patients.

31.18 Professor Iredale advised he was impressed by the drive to get clarity and consistency around the data and to get this permeated through the system. He felt if data was accurate and defensible and could be owned then this would set the standard for the rest of NHS Scotland.

31.19 Mrs Anderson advised there were opportunities for looking at different models of care and how these were provided differently and not always using medical staff.
31.20 The Chairman thanked Mr Crombie for his presentation and commented that although it had focussed on operational delivery rather than planning it had been reassuring and welcome.

32. Primary Care Update

32.1 Mrs Tait provided an update on behalf of Mr Small who had been unable to attend the meeting. It was noted work was underway on the key elements of the primary care strategy with the underlying theme likely to be demand, capacity and access. It was noted this approach would allow capturing of the issues of population growth, demographic change, increase in complexity, shifting the balance of care and public expectations. It was noted steps were in place to ensure primary care would be a core component of the pathway work as it developed. Steps being taken to ensure that prevention and inequality were also core.

32.2 The Strategic Planning Committee noted an overview of demand capacity and access for 2014 would be produced which would include key actions for change in particular around premises, additional practices, new services to be developed (e.g. phlebotomy, diabetes, near patient testing, care homes/frail elderly) and communications (eHealth). It was noted this work would dovetail with each of the Health & Social Care Partnerships’ Strategic Plans and with local variations would form the core of the primary care element of these plans. It was noted the meeting of the Primary Care Forward Group on 5 December had been very constructive and had resulted in mapping of an engagement plan for January and February to engage with each Health & Social Care Partnership and each contractor group.

32.3 Professor McMahon commented the previous week’s strategic debate had been well supported with the key issue being to ensure primary care data was included in the mix with agreement being reached on forward steps. Dr Williams advised there was a lot of work underway and a key issue was around premises with there being a particular issue around this in Lothian with £24m investment required. Mrs Tait advised in each partnership work was underway factoring in issues around housing development and demographics and an overview position should be available in the New Year. The Chief Executive advised Lothian had recently invested significantly in primary care premises and provided details of new facilities which had recently opened. He advised that Mrs Goldsmith, if present, would have confirmed that capital investment continued in primary care and there was scope for further developments. He commented he was keen to adopt a radical strategy for office staff working patterns commenting in health centres large parts of the building were empty for a vast amount of the day and this could be better utilised by providing additional general practitioner input.

32.4 Mr Gabbitas commented increases in population and demographics also affected primary care as well as the acute sector. He advised a paper had been submitted to the Edinburgh Partnership Board to work through primary care pressures in consultation with GPs. He commented the solution was not always about providing new premises, with a key aspect being around expanding existing capacity.

32.5 The Committee noted the updated position in respect of the primary care strategy.
33. Leadership Development

33.1 Mr Boyter commented it would be possible to draw links between his presentation and the earlier presentations provided by Mr Purser and Mr Crombie.

33.2 Mr Boyter provided a presentation focussing on Leadership into Practice advising through a programme delivered by Harvard Business School and Edinburgh Napier University significant numbers of participants in the programme had either managed to secure Director level posts in other organisations or had achieved internal promotion. It was noted the Lothian framework would include the following components that leaders would be expected to possess: demonstrating personal qualities; working with others; managing services; improving services; setting direction; creating the vision and delivering the strategy.

33.3 Mr Boyter advised the leadership framework had already been used to assess senior teams and would in future help to tailor leadership programmes to individual needs.

33.4 Mr Boyter advised the organisational leadership priorities were around team development in the move into new structures and teams as well as coaching and mentoring. It would also be important to prepare for integration as well as building capacity and capability within the workforce. The programme priorities would also include multidisciplinary leadership and development as well as political astuteness.

33.5 Mr Boyter advised the refreshing of the learning plan would be submitted to the Staff Governance Committee at the end of January and would be based on NHS Lothian’s priorities. It was noted in March 2014 the current Human Resources and Organisational Development policy would expire with a set of update proposals being submitted to the Board in May following discussion with the Staff Governance Committee and the Lothian Partnership Forum.

33.6 The Chairman commented the policy would need to demonstrate a direct linkage with what the Strategic Planning Committee needed to deliver as well as identifying and securing the necessary leadership capacity. Professor McMahon advised that the Local Partnership Forum meeting in January would focus on this agenda area in order to ensure synergy. Professor Iredale questioned whether there was a need to revisit the timing around partnership arrangements being implemented in order to ensure a linear approach. Mr Boyter advised prior to the strategy being presented to the Board there would have been a consultation process including the Area Clinical Forum. Professor McMahon advised in January an event would be held for all clinical leaders in order to obtain their input into the development of the clinical strategy. Mr Boyter commented that the approach would involve both continuity and change.

33.7 Mr Hill commented the strategic plan needed to demonstrate actions that could be taken forward and should point to continuous improvement through the development of medical engagement; middle managers and joint development with local authority colleagues focus around strategic aims and objectives.
33.8 The Committee noted the update report on leadership development.

34. **Draft Strategic Plan**

34.1 Professor McMahon advised the development of the draft strategic plan remained work in progress and information and propositions were now being committed to paper. He commented in respect of the propositions that these would be set out under headings and further work was underway to refocus these down to an appropriate level of granularity and where this was not available options and questions would be posed through the strategy. He commented linkages were in place with social and primary care and the integration agenda would take forward some of these plans. He commented however further work was needed with Joint Directors to develop social care propositions.

34.2 Mr Hill commented the process was still in its early stages and it would be important to avoid the temptation of producing a shopping list of miscellaneous items. He commented there would be a need to describe single system care from a patients perspective and to create a public consultation document with headline information and background data behind it. Mrs Tait commented there was also a need to consider what level of detail needed to be taken to the public Board meeting in April and advised a meeting was scheduled with the Performance Manager of the Scottish Government Health Department in January.

34.3 The Chief Executive commented by and large the headline issues were known and the focus of the document needed to be around ‘our health our care our future’ and this would help to frame the outcome. It was noted further discussions would be held the following week and would include Mr Gabbitas, Mrs Hornett and Professor McMahon.

34.4 The Chief Executive commented he hoped significant progress would be made at the following week’s Board Development Workshop. Once Professor McMahon and Mrs Tait had held the first engagement session with civil servants there would be a need to follow up this in a more formal manner to include engagement with the Chief Executive and Chairman about the detail of what would be taken to the Board in April. The Chief Executive commented as stated at the previous meeting every proposition within the document would be couched in terms of delivering National Policy or supporting patient safety.

34.5 Ms Milne commented that in respect of clinical engagement with patient pathways, she would like to see this prominently featured in the strategy and work was underway in respect of producing graphics for public engagement. Mr Boyter reminded colleagues co-production and working with patient groups was part of ‘our vision’. He commented section 5 of the draft Strategic Plan would lend itself to being the reference point about how future discussions were taken forward and he felt this could have a more prominent position in the overall document.

34.6 Mr Wilson expressed a note of caution commenting if at the workshop session the following week the presentation was around work in progress then there was a danger of this creating difficulties. He commented his understanding was that detailed analysis was still being undertaken although discussions appeared to be
jumping to the point of producing propositions not necessarily supported by the analysis of data. Mr Hill noted this was a fair comment and advised as work developed emerging propositions would come out and this would inform what came forward to the Board for validation.

34.7 The Committee noted the update report on the strategic planning process.

35. **Programme for Board Workshop on 17 December 2013**

35.1 Professor McMahon advised the third of the Board Development Workshops would be held on 17 December 2013. He commented links would be made to ongoing strategic work and integration plans and patient pathways. It was noted the primary care, scheduled and unscheduled care presentations would be included in the workshop packs. The workshop would focus on the Edinburgh Partnership.

35.2 The Chief Executive commented having reviewed the programme further he wondered whether there was enough time to do the agenda justice. Mr Wilson commented there was a danger Board members would regard the event as superficial if it was not properly presented. He felt if a presentation was provided on the basis of a State of the Nations Update then this would need to be communicated to Board members in advance as he did not think this was what people were expecting from the event.

35.3 Following detailed discussion it was agreed the focus of the workshop would be to re-run the previous presentations on primary care, unscheduled care, scheduled care and patient pathways. The Chairman commented the context of the framework process development was important as this had been an area of criticism from Board members previously.

35.4 It was agreed the Chair, Chief Executive and Professor McMahon would meet and synthesise what to cover in the time available. It was agreed the time available for the workshop would be extended by 1 hour.

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

36.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on 9 January 2014 in Meeting Room 7, Waverley Gate, Edinburgh.
Minutes of the meeting of the Strategic Planning Committee of NHS Lothian Board held at 10am on Thursday 9 January 2014 in meeting room 7 Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston; Mr A Boyter; Mr J Brettell; Mr J Crombie; Mr T Davison; Dr D Farquharson; Mr P Gabbitas; Mrs S Goldsmith; Professor J Iredale; Mr A Joyce; Ms M Johnson; Mrs A Meiklejohn; Mrs A Mitchell; Professor A K McCallum; Professor A McMahon; Mr G Walker; Dr R Williams and Mr R Wilson.

In Attendance: Mr I Graham (for item 41); Mr M Hill; Ms D Milne; Mr J Megaw; Mrs L Tait and Mr D Weir.

Apologies for absence were received from Mrs K Blair, Ms P Eccles, Mr J Forrest and Mr D A Small.

37. Declaration of Financial and Non Financial Interest

37.1 The Chairman reminded members they should declare any financial or non-financial interest 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.

38. Minutes of the Previous Meeting Held on 13 December 2013

38.1 The minutes of the previous meeting held on 13 December 2013 were approved as a correct record.

39. Matters Arising from the Previous Meeting

39.1 There were no matters arising from the previous meeting not covered elsewhere on the agenda.

40. Agenda Management

40.1 It was noted that item 5 (Further Activity Analysis) would be deferred until Mr H Purser was available to present to the Committee.
41. Site Master-planning Update

41.1 Mrs Goldsmith tabled copies of a presentation to be provided jointly by herself and Mr I Graham, Director of Capital Planning and Projects. It was noted the content of the presentation deliberately focussed on the four strategic stakes in the ground namely the Western General Hospital, Royal Infirmary of Edinburgh, St John’s Hospital and the Royal Edinburgh Hospital. Details of other sites and strategies that would have a significant impact were also explained for example the catering strategy, laboratory strategy, outpatients and the need for smarter working offices. It was noted the presentation excluded the Royal Edinburgh Hospital as this was part of a separate workstream as well as primary care which was being developed elsewhere.

41.2 Mr Graham provided details of the current position and further thoughts around the following sites: -

41.3 Western General Hospital – It was noted no part of the Western General Hospital (WGH) site was currently listed although the clock tower would be retained to maintain some historical interest on the site.

41.4 The Committee noted the scope of WGH master-planning process. It was noted the focus was on the following strategic projects – cancer services, laboratories, imaging, renal, Regional Infections Diseases Unit (RIDU), catering, day surgery and endoscopy decontamination. Detailed debate was held around each of the above components and potential options around their future provision as well as service infrastructure constraints which came with an estimated £2m price tag.

41.5 Mr Graham commented the starting point to unlocking the site was around the assumption that the laundry building along with microbiology, RIDU, Department of Clinical Neurosciences (DCN), D Block, around the clock tower and possibly the current outpatient department services building would be demolished therefore freeing up large areas to the west side of the site for re-generation. It was noted the University of Edinburgh also had interests that needed to be taken into account. Mr Graham’s subsequent presentation highlighted the proposed buildings for demolition and the space requirements for each service as well as showing clearly what buildings needed to be retained.

41.6 The Chief Executive commented although the presentation was suggesting an end date of 2045 this needed to be significantly truncated. It was noted if the plan was to provide cancer services on the west corner of the site the earliest this could happen would be in 2018 after DCN moved in 2017. He felt the key to unblocking the site was to demolish DCN and relocate RIDU. If at the same time other inadequacies around renal, dialysis and decontamination services could be accommodated then this would allow progress in the shorter term to be made improving the site functionality.

41.7 Mr Walker suggested the balance would be around strategic unblocking which was vital versus the operational immediacy and this would need to be discussed. The Chief Executive commented he was clear in strategic terms RIDU was key to developing cancer services. He commented however to date no discussions had been held about developing surgical capacity on the site. Mr Crombie advised any
expansion around inpatient capacity would be dependant on the availability of diagnostic services.

41.8 Professor McCallum commented in terms of patient equality, efficiency and safety currently there were areas of service provision running at clinical risk and this position could not be managed indefinitely. She felt it would be important to look at creating solutions with more timely outcomes.

41.9 Mrs Mitchell commented following a recent Non Executive walkaround she had been concerned about the condition of the RIDU building. It had been pointed out by staff during the walkabout that close proximity to laboratories was important. The Chief Executive advised there was clarity laboratories would be split between the Royal Infirmary of Edinburgh (RIE) and the WGH sites with both having a significant laboratory presence with less so at the St John’s Hospital site. The specific configuration of laboratory services between these sites was subject to further ongoing work including dialogue with the University of Edinburgh who had an interest in this key area.

41.10 Mr Gabbitas reminded colleagues of models of provision adopted elsewhere in Lothian through facilities like community hospitals. Mrs Goldsmith suggested this was the reason why progress was needed around defining the outpatients strategy as it would be important not to reprovide services on a like for like basis unless this was justified.

41.11 The Chairman commented a debate at the meeting reflected the fact an iterative planning process was in place and it was therefore important Mrs Goldsmith with Mr Graham were happy linkages were made at the appropriate point. Mr Graham concurred and commented from his perspective he would welcome confirmation and clarity on what parts of the estate needed to be developed in building terms.

41.12 Mr Walker commented this was an important point and there was a need to be clear what the range of ‘givens’ were for the WGH and other sites to inform the testing of options. The Chief Executive advised this linked to a point raised previously by Mrs Blair and he suggested the main givens for the WGH site were around providing major surgical input DCN reprovision, a major laboratory presence and the development of cancer services.

41.13 The Chief Executive suggested fundamental discussions needed to be held around whether or not the WGH should operate as a hot acute receiving medical admissions site of whether the acute receiving sites should be the RIE and St John’s Hospital with the WGH being an elective site. It was agreed further analysis was needed to conclude this debate. It was noted consideration also needed to be given to increasing capacity at St John’s Hospital to reflect transport and access issues associated with the WGH.

41.14 Royal Victoria Hospital (RVH) – The Committee noted from the presentation the initial work strands around the RVH master-planning process. Mr Graham at the suggestion of Professor McCallum undertook to confirm the position around access between the WGH and the RVH which had historically been available using a footpath through the adjacent housing development.
41.15 *St John’s Hospital* – Mr Graham advised this was a substantial and well developed site with good facilities and connections.

41.16 Mrs Goldsmith commented one of the difficult issues around the site was the lack of clarity around the question to be answered in terms of master-planning and in that regard the focus had been around internal developments to ensure alignment with opportunities being looked at around additional beds and theatre capacity.

41.17 The Chief Executive commented issues around hospitals acting as medical receiving units was a fundamental question in terms of patient travel time. He advised for March 2014 a definitive position did not need to be reached but it would be important to be able to engage in options for future reprovision. The strategy going to the April Board would include a narrative detailing strategic givens.

41.18 The Committee noted the potential difficult discussions around travel time out to St John’s Hospital. It was felt whilst patients might accept attendance at St John’s Hospital for one-of elective procedures this might not be appropriate for people suffering acute illness or for frail elderly people.

41.19 *Royal Infirmary of Edinburgh* – It was noted until the Royal Hospital for Sick Children / Department of Clinical Neurosciences (RHSC/DCN) had been built there would be major construction work affecting both the inside and outside of the Royal Infirmary of Edinburgh site which would need to be managed on an ongoing basis. Details of the extent and timeline for works were provided between April 2014 and April 2016 which would also include Bioquarter engagement.

41.20 Mr Graham advised the potential for delivering change quickly on the RIE site was compromised by the fact NHS Lothian did not own the site and the bankers / lenders resisted change.

41.21 The Chief Executive advised a submission was about to be made to the Scottish Government about progress on the NHS Lothian Scheduled Care Recovery Programme. Mr Crombie updated the Committee on progress and advised recovery needed to happen in 2014/15 and provided details of proposals and options around the Princess Alexandra Eye Pavilion (PAEP), orthopaedics, ENT, plastics and critical care. He felt if the clinical strategy was properly linked to the recovery plan this would produce a sustainable position for the future but stressed the immediacy of action needed to address the current problem.

41.22 The Chief Executive commented from the Strategic Plan there would be a need to specify 3 points on a spectrum which would need to include areas where change was wanted along with detailed options. Firm proposals would be reflected in the paper to the Board in April.

41.23 Dr Williams reiterated his previous point that consideration should not just be given to travel time but patient mobility and this would need discussion with the Scottish Ambulance Service and others. Mr Gabbitas also stressed the importance of ensuring early proactive engagement with clinicians prior to any public debate in order to ensure they understood the drivers for change. Mr Crombie assured the Committee this process was already well underway and would be part of delivering the options.
41.24 **Lauriston Campus** – Mr Graham advised the campus worked well and benefited from appropriate linkages. He felt the outstanding issue was about defining service needs and agreeing what should be accommodated on the site.

41.25 **Liberton** – The Committee noted there were considerable backlog maintenance issues around Liberton and the building was not in good condition. The Blood Transfusion Service were relocating to another site and a meeting would be held with Scottish Futures Trust (SFT) the following week to discuss issues around this.

41.26 Mr Graham suggested the key issue to agree was whether Liberton was an overflow site, a community hospital facility or whether it should used for another purpose.

41.27 The Chief Executive commented in respect of Liberton and the RVH sites a specific workstream around a community model was being discussed between NHS Lothian and the City of Edinburgh Council at very high level based on a patient care village concept potentially to be provided on the existing Liberton Hospital site. This needed to translate into the strategy as a cutting edge example of the integration agenda.

41.28 The Chairman referred back to the 3 points on the spectrum as detailed by the Chief Executive and suggested the focus should be on constantly moving to a point of detailing a list of givens as a next step on the iterative process.

41.29 Professor McMahon advised in her absence Mrs Blair had asked for the following questions and response to be minuted. She had asked how had the Integration Boards needs had been identified and how had their strategic property and site requirements been fed into this process? She had also asked whether the strategic plan anticipated any significant changes to thinking which needed to be taken into account.

41.30 Professor McMahon commented he had responded stating it was fair to say this work was at its early stages. At this stage the master-planning work had focussed on establishing a baseline of what was currently on the 3 main acute sites and what space might be available or made available. He had advised Mrs Blair two new groups had been established, one for the WGH and one for St John’s Hospital. These were in addition to those already established for RIE and Royal Edinburgh and Associated Services (REAS). He commented there would also be a group for Lauriston and the Eye Pavilion. Professor McMahon had established various colleagues were now embarking on a process through the strategic plan of identifying what services might need to go where and also what other facilities systems might want to use differently and this would read across to the work on inpatient continuing care that the Integrated Boards would be very interested in. In that regard consideration was being given to looking at current NHS inpatient beds, as well as council facilities and those which were currently under a Private Finance Initiative (PFI) deal but for which contracts were soon to come to an end.

41.31 The Committee noted the updated report on the site master-planning process.
42. Reshaping Care for Older People: Change Fund Progress Report

42.1 Professor McMahon advised the circulated report was in response to a request at a previous meeting for further information about the use and benefits of the change fund following the publication of the November 2013 Joint Improvement Team Report.

42.2 The committee noted the progress achieved in Lothian from the change fund investment and acknowledged the areas where progress had not kept pace comparatively with other regions in Scotland. In addition the Committee were advised of lessons learned from this work and approaches taken which would feature as part of the development of both the strategic plan and strategic commissioning plans aligned to the Health and Social Care Integration agenda.

42.3 Professor McMahon reminded the Committee the total funding allocated to NHS Lothian and the four Council Partnerships through the change fund was £11.5m for 2013/14.

42.4 In summary the Committee noted Lothian compared favourably with other areas in Scotland against most of the areas the Joint Improvement Team had highlighted in their November 2013 Progress Report. The areas where NHS Lothian and two of its partnership areas performed less well were in relation to the reduction in delayed discharges from hospitals. It was noted however actions were being taken forward through the development of plans for unscheduled care and for Community Health and Social Care to address this issue.

42.5 Professor McMahon advised the Chief Executive and his counterpart at the City of Edinburgh Council were involved in high level strategic engagement to mitigate delayed discharge position and rebalance performance. A similar focus would be needed with the East Lothian Partnership.

42.6 Professor McCallum commented there was also a need to consider the health of those aged under 65 years where the number of people with multiple morbidity was greater than in older age groups. She felt there was a need to invest earlier to improve the health of this age group which was worse than in many other European countries. This would reduce the rapid increase in risk of downstream acute admissions among patients aged 45 upwards.

45.7 Mr Gabbitas questioned in respect of domiciliary care whether previous expansion was sufficient to keep pace with need.

45.8 Professor McMahon advised in her absence Mrs Blair had asked for the following questions and response to be minuted. She had asked what the system was doing to mitigate risk and what actions were in place and what was it expected these actions would achieve? Professor McMahon reported he had responded advising a series of meeting were being established. The first was with Edinburgh through the Council Leader and Board Chair, the Chief Executive and Directors to look at what needed to be done by way of actions and further investments to mitigate any deterioration and indeed improvements in performance to help the flow through acute care to reduce delays. A similar meeting was being proposed for East
Lothian as there were other pressures in that partnership which were causing the number of delays to increase with action currently underway.

46. Further Activity Analysis

46.1 This item was deferred.

47. Review of Inpatient and Continuing Care

47.1 Professor McMahon advised he was seeking the Committee’s support to review the model and provision of Inpatient Continuing Care (IPCC) beds in Lothian which would include a benchmark exercise with other providers.

47.2 Mr Megaw commented the data needed to be revised as it was based on last years statistics and services were now delivered differently. It was noted work was being taken forward between NHS Lothian and the City of Edinburgh Council to ensure a joined up approach for the strategic plan.

47.3 The Chief Executive advised a national workstream was underway looking at the future of residential care. He felt at practice level the availability of nursing care needed to be resourced more than was currently the case in order to meet future demand. He was of the view the Lothian Strategic Plan needed to be health and social care focussed with the four councils. It was recognised patient needs would change over time and a more integrated approach would be needed in future. The Chief Executive felt logically NHS Lothian would want to divest itself of IPCC beds where possible and this approach would be tested at Liberton and the Royal Victoria Hospitals and if successful rolled out elsewhere.

47.4 The Chief Executive in response to Mr Wilson reported a proposal would be brought to the Board to move patients from Corstorphine Hospital to the Royal Victoria Hospital to allow beds at Corstorphine to be closed. Advice from the Scottish Health Council suggested this would not require consultation as it did not constitute a major service change. The proposal could therefore be approved by the Board unless it was called in by the Cabinet Secretary. The same position pertained in respect of the transfer of beds from the Astley Ainslie Hospital (AAH). The Chief Executive advised these moves would be on an interim basis until the replacement plan for the Royal Victoria Hospital was developed. It was stressed however the condition of the facilities at the current Royal Victoria Hospital site was superior to those at Corstorphine and the AAH.

47.5 Professor McMahon advised he would be meeting with Scottish Government colleagues later in the day to discuss these proposals further with the aim being to take a paper to the February Board meeting.

47.6 Professor McMahon advised in her absence Mrs Blair had asked for the following questions and response to be minuted. She asked how criteria had been developed for evaluating the options, did they fit with the strategic plan, and how quickly would they move onto the next review stages? She had also asked what the barriers were to addressing this issue more quickly. Professor McMahon had
advised these issues would develop in the scoping stage and this had to be done by the end of February but was again aligned with the points and work referred to elsewhere.

48. **Any Other Competent Business**

48.1 **Draft Strategic Plan** – It was agreed an iteration of the draft strategic plan would come to the February and March meetings for comment and discussion prior to being finalised for the April Board meeting.

48.2 The Chief Executive stressed prior to any paper being submitted to the Board high level discussions would need to be held with the Scottish Government. This process would commence with Professor McMahon’s meeting later in the day and dependant upon the outcome might need further engagement at Chief Executive and Chairman level.

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

49.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on 13 February 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
The draft minutes of the meeting held on 31 October 2013 are attached.

Key Issues Discussed

The EL Sub Committee was pleased to receive

- A verbal update & DVD presentation on the Welfare Reform in East Lothian from Mike Kate Burton, Public Health Practitioner, NHS Lothian & John Cunningham, Benefits Officer, East Lothian Council

- A paper on The Health Improvement Fund (HIF) for East Lothian funded projects.

Items for Decision

- No items for decision.

Items for Discussion

- Health & Social Care Integration Update
  The Sub-Committee held a verbal discussion lead by DAS at the meeting.

- 5.2 EL Community Hospital Update
  The Sub-Committee considered a report which had been circulated in advance of the meeting given by Miriam Anderson, Business & Capital Manager, EL & ML CHPs.

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

Performance Reports

A range of routine performance reports were also received.

Mike Ash
Chairman of East Lothian, CHP
15 November 2013
1.0 Welcome and Apologies

Welcome and apologies were noted.

1.1 Welfare Reform Update

Kate Burton, Public Health Practitioner, NHS Lothian & John Cunningham, Benefits Officer, ELC attended to give a verbal update and show a copy of the ELC help DVD on the Welfare Reform and the Underoccupancy Charge.

John mentioned that those who are suffering financial hardship may gain an award from the Housing benefit scheme from the discretionary fund. Scottish Government will provide £20 million with ELC receiving circa £203k.

Please visit the site to view the DVD.
http://www.eastlothian.gov.uk/welfarereform

There will be a further update again in a few months time.

JT asked about the statistics for rent arrears in the county. JC advised
that this is going up circa £7,000 per month. Rent arrears were also increasing before this so that had to be taken into account.

JT asked about rent arrears and evictions. Is there any impact on this yet? JC advised that ELC is not adopting a ‘no evictions’ policy however it will be the very last resort. Other elements of welfare reform have not yet been implemented.

JT advised that the CAB (Citizen’s Advice Bureau) are based in Harbours Medical Practice and he feels there will be no difficulty in finding other Practices who would want this resource.

JC advised that the Council have incentives in place for tenants who wish to downsize.

MA asked that a further review of the situation is given at a future meeting.

**Decisions**

The report was noted.

**Actions**

An invite to be sent for March 2014 to Kate and John to provide a further update.

**2.0 Minutes of Previous Meeting 05.09.13**

Agreed as an accurate record.

**3.0 Action Note Previous Meeting**

Action log updated.

**4.0 Items for Decision**

4.1 No Reports for Decisions.

**5.0 Items for Discussion**

5.1 Health & Social Care Integration Update

The Sub-Committee received a verbal update given by DAS. DAS advised that the shadow board had discussed procedures for operating while in the Shadow period, an update on scope and structures and additional membership at the last meeting. The next formal meeting will be in January 2014.

The Board is now seeking 5 additional non voting members from independent contractors, independent sector, third sector, user/patient, carers.
Two key pieces of work are starting.

The integration plan. This needs to be ready by March 2014 for approval by NHS Board and ELC for public consultation, then approved by NHS Board and ELC and submitted to Scottish Government by November 2014.

Along side this plan there will be a strategic plan. This will set out how resources will be used to achieve the goals set out in the integration plan. This plan requires approval by NHS Board and ELC, but not Scottish Government.

A management meeting will be held in November to start the process on both plans.

It is proposed to engage the CHP sub committee in this process during 2014.

Health interim management structures are nearly complete.

Decisions

Circulate Shadow Board minutes once approved.

5.2 EL Community Hospital Update

The Sub-Committee considered a report which had been circulated in advance of the meeting by Miriam Anderson, Operational Business Manager, EL & ML CHPs.

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

There is engagement with Edinburgh Hospital colleagues on what services could be delivered in ELCH. The Initial Agreement report will now be ready for consideration in March 2014. Miriam Anderson is planning to staff and stakeholders locally in scoping the service options.

Decisions

Miriam will attend a future meeting next year after the above.

5.3 Public Protection Update

A verbal update was given to the Committee by DAS. A paper will be produced for the December 2013 meeting. Item was deferred to next meeting.

6.0 Performance Reports

6.1 Directors Report

Directors Report

The Sub-Committee considered a report which had been circulated in advance of the meeting.
The purpose of this report is to update and brief members on CHP Performance and developments. The Sub-Committee was asked to note the updates on:-

Delayed Discharges
Delayed discharges are now down to 16. Discussions are being held on step down beds and additional capacity for home care.

Capital Projects
Gullane Medical Practice and Day Centre is almost completed. Tranent Health Centre Extension will start on 4th November. Discussions are continuing on Cockenzie Health Centre development.

Decision
The report was noted. Agreed to circulate the structure diagram from Shadow Board meeting. (paper 5.0)

6.1.1 EL Change Fund 2013-14 Mid Year Review
The Sub-Committee considered a report which had been circulated in advance of the meeting.

The purpose of this report is to update and brief members on the review which was carried out on schemes funded by the change fund.

DS highlighted some changes resulting from the review based on The Change fund group agreement to prioritise the focus on delayed discharge, and supporting patients at home.

The next meeting of the group will be in December.

AT commented that it had been a difficult process and given the in depth review just completed, there will be a “light touch” check, on progress in December.

It was noted that there will be a £100 million integration fund from 2015/16. It is not yet clear what the criteria for funding will be. In 2014/15 the current change fund projects will be reviewed and assessed for longer term continuation. This will be fed into discussions on the Strategic Plan and the Integration Fund.

AMc identified a possible error in the return to JIT. The return indicated that the staff training project provided support for carers. DAS agreed this is an error.

Action
CL to clarify re last point.

6.2 Staff Governance Report
Verbal update given. Problems still exist with the reporting data.

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

The purpose of this report is to advise the East Lothian CHP Sub-Committee of the financial position to 30th September 2013.

The Sub-Committee is recommended to note the overall financial position as presented and note the Prescribing budget outturn.

The release of corporate support to address the Nursing incremental drift pressure across NHS Lothian has resulted in a favourable variance within Core services in month 6. Underlying pressures remain within Medical Staffing, Nursing, and Clinical Supplies and Equipment across Hospital Services.

Nursing incremental drift support has also impacted favourably on Hosted services, particularly Complex Care and LUCLS. However, the ongoing reliance on Ad hoc medical shifts within LUCLCs is driving the year to date overspend in this service. In addition, a number of small adverse variances within PCCO are also contributing to the overall year to date overspend in Hosted.

JT mentioned that there is a lot of work ongoing in Practices to assist with the Prescribing overspend. A Prescribing Support Pharmacist has been appointed and is working closely with practices.

**Decision**
The report was noted.

6.4 Chief Nurse Report

The Sub-Committee considered a report which had been circulated in advance of the meeting. Lorraine Cowan attended on behalf of Alison Macdonald.

The Sub Committee is invited to note the content of the report.

LC highlighted the following areas within the report: -

**District Nursing Service**

Vacancies across East Lothian are causing additional pressures. Recruitment is progressing as quickly as possible.

Workload continues to increase as more people are cared for in the community.

Sickness absence is not normally an issue for community nursing. However, the ageing workforce brings with it age related health problems leading to increased sickness absence.

Based on headcount, 25% of the community nursing workforce in East Lothian is aged over 55 years. 5% are aged over 60 years. NHS
Lothian has recognised the need to support the training of additional District Nurses (DN) across Lothian as a large percentage of our qualified DNs are aged over 55 years.

Public Health Nursing

Team Manager appointed for East Lothian, now in post and is progressing with induction/orientation.

New Nursery Nurse posts, Health Assistant & Staff Nurse posts now recruited to. Staggered start dates for staff between September/early October 2013. Orientation & induction planned as appropriate.

Health Visitor vacancies successfully recruited to. No HV vacancies in EL from October 2013 and plans to recruit to upcoming vacancies that we are aware of are progressing.

East Lothian Community Hospitals - Adult Services

Lorraine reported on various projects and activities ongoing within the Hospitals.

Highlights were the Mental Welfare Commission review starting on 9th October 2013.

Funding has now been released to address environmental issues in the ward areas within Roodlands, Ward 1a is now completed to include new wet rooms for patients and the creation of more appropriate toilet areas including disabled toilets.

Decision

The report was noted.

6.4.1 Prison Healthcare Update

The purpose of this report is to provide the East Lothian Sub Committee with information on the progress of the implementation of the recommendations from the prison nursing review and to inform of processes being put in place to ensure high quality health care in both prisons.

From 1 November 2011, the NHS has been responsible for providing healthcare within the Scottish Prison Service (SPS). NHS Lothian provides healthcare to around 1,800 male and female prisoners within HMP Edinburgh and HMP Addiewell.

The split of responsibilities between the NHS and SPS are set out in a national Memorandum of Understanding.

Within NHS Lothian, the service is hosted by East Lothian CHP, with the Chief Nurse for the CHP leading a multi-disciplinary management team which reports to the CHP Sub-Committee.
Each prison has a health centre, with healthcare provided by 9 salaried General Practitioners (3.1 wte) and 65 nurses (57.6 wte), with additional weekly sessions from Forensic Psychiatry and Substance Misuse. Other healthcare, such as podiatry and physiotherapy, is arranged as required, with a further 6 administration and support staff.

Policies and procedures for healthcare within prisons are continuing to be aligned with those of NHS Lothian.

The Sub-committee is recommended to recognise the completion of the prison nursing review recommendations and recognise the ongoing work which will ensure equitable healthcare in both prisons which focuses on continued service improvement.

**Decisions**
The report was noted by the group.

**6.5 Clinical Directors Report**
The Sub-Committee considered a report which had been circulated in advance of the meeting.

The purpose of this report is to update the East Lothian Community Health Partnership Sub Committee on medical issues within East Lothian.

The East Lothian Community Health Partnership Sub Committee is recommended to note the contents of the report.

Jon Highlighted the following: The Frailty Project, Quality & Outcomes Review Meeting, Psychiatry of Old Age in East Lothian

**Decision**
The report was noted.

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

The committee is asked to note the update contained in this report and make any comments directly to the AHP Manager.

RP Highlighted the following areas: - Physiotherapy, Occupational Therapy, Dietetics, Arts Therapies, and Paediatric Physiotherapy.

**Decision**
The report was noted.

**6.7 Primary Care Contractors Organisation**

**6.7.1 PCJMG Minutes 09.05.13**
The Sub-Committee considered a report which had been
circulated in advance of the meeting. The report was for noting by the Committee.

DAS highlighted item 5.2 on care inspectorate reports on care homes. This was useful information for practices to support their work in care homes. Care home activity is growing and a review of the current medical support arrangements is underway.

**Decision**
The report was noted.

### 6.8 East Lothian Health Improvement Alliance

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

The purpose of this report is to update the East Lothian Community Health Partnership Sub Committee on the recommendations to the Health Improvement Fund (HIF) Oversight Group regarding the funding of projects 2014 -17 following the evaluation of projects funded during 2011 -13.

The East Lothian Community Health Partnership Sub Committee is recommended to note the content of the Paper to the HIF Oversight Group, note the positive evaluation reports on the East Lothian projects that received funding 2011-13 and note recommendations on funding for 2014 -17, in particular the requirement for matched funding of £12,000 for 3 years for the ACE Project.

Mairi highlighted the following:

Five East Lothian projects have benefited from HIF (general fund) monies from April 2011 until March 2014. Project evaluation reports were completed and recommendations for continued funding made.

Further discussion to be held with JT and MS out with the meeting.

**Decision**
The report was noted.

### 7.0 Carers Forum

The Sub-Committee considered a verbal report given by Andrew Tweedy.

AT highlighted quick summary of analysis East Lothian total population census data. 17% increase in people identifying themselves as carers. Masks significant data of 31% increase over 22 hour a week. Trend repeated across Lothian. This has implications for carers, carer support and statutory services.

Decision
The report was noted.

8.0 Public Partnership Forum

8.1 PPF Business Meetings Minutes 17.09.13
The Sub-Committee considered a verbal report given by Ann McCarthy.

Ann highlighted the concern around the future of the PPF group due to integration and noted these are draft minutes which haven't been approved by the PPF.

PPF supported Patient Participation Groups run within Practices. PPF were positive about linking up. Groups should also be aware of each other’s existence.

Decision & Action
The report was noted. JT to raise at the next GP Forum.

9.0 Community Health Partnership Committee Appointments
None noted at this meeting.

10.0 AOCB

10.1 Nothing to report.

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<th>11</th>
<th>Date of next meeting</th>
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<td></td>
<td>It was agreed that the next meeting would take place on 19th December 2013 at 2.30 pm in the Saltire Rooms 1 &amp; 2, John Muir House, Haddington.</td>
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The draft minutes of the meeting held on 19 December 2013 are attached.

Key Issues Discussed

The EL Sub Committee was pleased to receive

- A verbal update & presentation on the Integration, Establishment of HSCP, Role of Sub-Committee from David Small
- An extension of the current Sub-Committee Officers roles for one year.

Items for Decision

ACE project funding was agreed

Items for Discussion

Frailty Programme update
The Sub-Committee held a verbal discussion lead by the Head of Health.

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

There are proposals to establish a public protection unit and this would be resource via councils, health, and police.

Performance Reports

A range of routine performance reports were also received.

Mike Ash
Chairman of East Lothian, CHP
15 January 2014
NHS LOTHIAN
EAST LOTHIAN COMMUNITY HEALTH PARTNERSHIP

Minute of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday, 19th December 2013, in the Council Chambers, Town House, Haddington

Present:  
Michael Ash in the chair) (MA)  
David Small, General Manager (DAS)  
Ann McCarthy, PPF Representative (AMc)  
Robert Packham, AHP Manager, EL&ML CHPs (RP)  
Fiona Mitchell, (Director of Operations NHS Lothian) (FM)  
J Turvill, Clinical Director, East Lothian CHP (JT)  
Mike Porteous Assistant Head of Finance, NHS Lothian (MP)  
Mairi Simpson, Joint Health Improvement Partnership (MS)  
Alan Tweedy, Carers of East Lothian (AT)  
Thomas Miller, Partnership Representative EL&ML CHPs (TM)  
Gill Colston, PPF Representative (GC)  
Alison MacDonald Chief Nurse (AXM)  
Councillor Donald Grant, , East Lothian Council (DG)  
Rod MacKenzie, Representing Murray Leys, Social Care Dept. (RM)

Apologies:  
Sharon Saunders, Head of Children’s Services, East Lothian Council (SS)  
Dr Amy Small, EL GP Representative (AS)  
Murray Leys, Head of Social Care, East Lothian Council (ML)

In Attendance:  
Jill Wilson, EL Health Network (JW)  
Miriam Anderson, Business Manager, (Minutes) (MiA)

1.0 Welcome and Apologies

Welcome and apologies were noted.

Keith Maloney, Margaret McKay, Maureen Allen, Eliot Stark

MA introduced the newly appointed additional members of the East Lothian Shadow Health & Social Care Partnership Board as above and welcomed them to this meeting as observers

MA also extended congratulations to Alison MacDonald who has been formally appointed as Head of Health for East Lothian.

1.1 Presentation – update on Integration, Establishment of HSCP
Role of CHP Sub-committee

DAS presented an update on the integration of health and social care a copy of the presentation had been previously circulated.

DAS reported that much information is still at a high level, there is still significant detail to be developed. Legislation will begin stage 2 in January 2014, guidance is still under development. The management team has started work on the development of an Integration Plan and a Strategic Plan for the Partnership. These must support the Single Outcome Agreement, The Council Plan and the NHS Lothian Strategic Plan.

The first formal meeting of the Health and Social Care Partnership Shadow Board is scheduled for 22nd January 2014.

DAS provided links to websites that have more detail on the legislative position.

DAS proposed to bring the draft integration plan to the sub committee. The strategic plan will also need to be discussed at the sub committee. The Initial Agreement for the new community hospital will require to be approved by the sub committee. These are the key discussion and decision items for the sub committee for the next few months in addition to routine business.

TM raised the issue about the number of staff that would be required in the community to facilitate reduction in beds. DAS said that this does need further consideration along with related issues such as housing support and adaptations. DAS said housing, health and social care are already having conversations about this for the future. GC highlighted the housing challenges in caring for complex people at home.

MA highlighted that there is much to consider and asked members to ensure that, where possible, all CHP members are part of any conversations and discussions.

MA proposed meeting schedules for 2014. MA proposed that the sub committee consider a meeting in mid-March in place of February. This was agreed. The meeting would discuss the integration plan. The meeting would be held on 27th March 2014.

MA proposed that a meeting be held in May 2014 to consider the Initial Agreement for the Community Hospital prior to it being submitted to NHS Lothian.

MA reminded members of the gap as a result of the vacancy of the Committee Administrator and asked members to contact Miriam Anderson for any business in the interim.
2.0 Minutes of Previous Meeting 05.09.13

Agreed as an accurate record.

3.0 Action Note Previous Meeting

Action log updated.

4.0 Items for Decision

4.1 JT has now identified funding the ACE project. MA welcomed this news and thanked MS for bringing this to the attention of this committee

5.0 Items for Discussion

5.1 Frailty Programme update

East Lothian Service for Integrated Care of the Elderly

AXM reported that there have been challenges in recruiting medical staff to this team; however 3 Advanced Nurse Practitioners are being appointed. JT added that it is disappointing that east Lothian has been unable to attract medical staff. JT noted that one of the existing geriatricians at Roodlands has left. MA asked JT for a view on why we have been unable to attract medical staff; JT intimated the intensity of the on call rota is not particularly attractive.

AMc asked what “NRAC funding” was and further requested a reduction on the abbreviations or acronyms. This was noted and MA requested that this is reflected in future minutes or notes of meetings. DS confirmed that NRAC stood for National Resource Allocation Committee. Action: Committee secretary

Decision
The report was noted

5.2 Public Protection Update

AXM explained that the proposal to establish a public protection unit is a sharing of resource from councils, police and health and is an exciting development in service.

MA highlighted that East and Midlothian will continue to work together on this. MS asked if Violence against Women was included. AXM will confirm this directly to MS. GC asked for feedback from the governance meeting due in February 2014, AXM will advise by circulation in advance of the next Sub-
6.0 **Performance Reports**

6.1 **Head of Health/Chief Nurse Report**

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

The purpose of this report is to update and brief members on CHP Performance and developments. The Sub-Committee was asked to note the updates on:-

Delayed discharges are a concern at the moment. Teams are working in innovative ways to try and resolve this. MA asked what the numbers are; DAS said the number was 24 in November but the December figure was not yet validated. MA highlighted that this is concerning and he would like to have an opportunity to discuss this.

DG said the problem was focused on specific geographic areas related to difficulties independent sector Home Care services attracting staff. There were also some issues with care homes. It was noted that some patients are also delayed waiting for healthcare. The management team is working on intermediate and step down care and re tendering of home care. In addition flexibility of use of staff is being considered.

Action: Report to next meeting DAS/AXM

Public health nursing – East Lothian is in a good position with no vacant posts currently. The Childrens Services Inspection report for East Lothian is awaited.

Roodlands is still experiencing bed pressures, however it is reported that GPs are using beds effectively to avoid admission to acute hospitals.

**Decision**

The report was noted

6.2 **Staff Governance Report**

Sickness absence is being managed and monitored. East Lothian percentage is at its lowest for many months. Unions and management are working together effectively on this.
6.3 **Finance Report**

MP reported on the first 8 months  
The overall position was a £653k overspend  
Core services were over by £122k  
Hosted services were over by £336k  
Prescribing was over by £206k

MA suggested that over 2014/15 budgets should be reviewed very carefully in respect of 2015/16 and moving into integrated budgets.

6.4 **Clinical Directors report**

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

The purpose of this report is to update and brief members on CHP Performance and developments. The Sub-Committee was asked to note the updates on:-

JT reported that the Phlebotomy Service is going to be delivered by GPs in future, some of the detail around this is still being worked through.

**Decision**
The report was noted

6.5 **AHP report**

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

The purpose of this report is to update and brief members on CHP Performance and developments. The Sub-Committee was asked to note the updates on:-

RP reported that currently 15 staff are in temporary posts and this requires to be stabilised early in the new year. Work is ongoing to achieve this.

Red risk in MSK in respect of staffing levels has now reduced to Orange, which is positive.

GC asked about the DNA rates for MPCC.
RP also highlighted to the committee that he was moving posts and as of February would no longer lead for East and Midlothian. MA thanked RP on behalf of the committee for all his detailed reports and attendance at previous meetings. He wished him well in his new post at Tayside.

**Decision**
The report was noted

6.6. **Primary Care Contracts Organisation**

DAS highlighted that the GP Support for Care homes contract is being reviewed and the step downs beds may be part of this.

7.0 **Carers Forum**

AT welcomed inclusion in this Group.

A recent survey highlighted that 99% of users said that they valued this service.

8.0 **Public Partnership Forum**

GC reported that they were concerned about the roles of PPF forums once the Shadow Board takes its role. MA said the operational side of liaison between partners would continue the connection and engagement would not be lost. GC asked if an extension to their constitution agreement could be agreed as there does not seem a point in redrafting it beyond the life of the sub committee. MA and members agreed this was beneficial for all parties.

JT also has some concerns on how the GPs link in to the new forum. This was noted.

AT added a point of the joint planning groups and the focus of carer engagement was featured in this.

GC also highlighted a concern about the joint planning groups and their effectiveness

DAS reported that Carol Lumsden is working on this agenda to ensure all of the above are considered.

MA encouraged these questions continue to be asked in order that all of these issues are addressed.
9.0 Community Health Partnership Committee Appointments

DAS updated.

10.0 AOCB

MA closed the meeting and thanked all for all their contributions over the last year and wished everybody a relaxing Christmas and a very happy New Year

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<th>11</th>
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<td>27th March 2014, 2-5 p.m. the Town House Haddington.</td>
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Shadow Health and Social Care Partnership 20 December 2013 – Summary

Matters Arising

• Two posts for service user and carer engagement have been widely advertised, the closing date for applications is 31\textsuperscript{st} Jan.

Integration Programme Status Report

• Good progress has been made in staff engagement, finance and delivering a briefing to all the political groups.
• It was noted that almost all processes were green, which was debated by members of the board. More detail will be provided in future reports for Human Resources and Organisational Development, as well as financial risks. More rigor will be adopted in documenting milestones.

Engagement Process for reconfiguration of beds in Corstorphine and Astley Ainslie Hospitals

• The main driver is to replace buildings that are no longer fit for purpose in these two sites. The facilities in the other three sites are good.
• A programme of engagement is planned with staff, carers and the public. 67 beds could potentially move to the Royal Victoria building.
• The approach to engagement was agreed, it was noted that the decision to re-provision services will require to be taken by the NHS Lothian Board.

Scope of Services

• The paper provided comprehensive information on the services that could potentially be within the scope of the new body.
• The decision on what should be included was for the parent bodies (NHS Lothian and CEC) to take.
• Health visitors may transfer to a children’s partnership in the future.
• A pro-active approach to the commissioning role of the partnership had the potential to impact positively on services and outcomes.

Population Growth and Primary Care Premises – Draft

• Between 1990 and 2010 Edinburgh’s population had grown by 50,000, projections suggested an increase of 100,000 by 2030.
• 19 of 71 practice lists have restrictions on new patients.
• A strategic approach to the issue and engagement with GPs will increase capacity more cheaply than building new surgeries. A further 10,000 people would receive a service by bringing additional capacity within practices into service.
Financial Planning 2014/15, including Budget Consultation (presentation)

- Susan Goldsmith and Hugh Dunn gave a joint presentation.
- The NHS needed to find 3-4% cash efficiencies each year to balance the budget as uplifts don’t cover factors like pay rises and drug inflation. Easy wins had been delivered and strategic initiatives were now needed. The NHS has to break even each year, money can’t be carried forward.
- CEC’s baseline finances are static, with inflation resulting in a reduction in real terms. The long term financial plan projects a £30m shortfall, with the final decisions on addressing this being made by Council in February. CEC have flexibility in carrying over money and retaining funds from the disposal of assets.
- While partnership organisations are struggling to achieve around £6m of savings this year, the requirement in 2014/15 is to save £15m jointly.

Financial Monitoring – Month 6

- The first aligned report was presented and showed a £690K pressure, mainly in domiciliary care (both home care and care and home).
- There are increasing numbers of people waiting for home care and pressure on complex care beds.
- Small items provided from the OT store could possibly be purchased more cheaply by people themselves.
- This joint approach to financial reporting would be developed further.

Performance Overview

- The narrative included delayed discharge, an area where improvements were evident and another where more work was needed.
- Work is ongoing to bring together outcome indicators, though these change slowly.

Integrated Risk Register

- Both organisations update risks quarterly and would like to join up their risk registers. The NHS use Datex software and the CEC Covalent.
- Systems are in place to identify risk, which is a standing item for some groups.
- It was agreed to prepare an integrated risk register for the Partnership.

Developing a Strategic Commissioning Plan

- The plan is required to: show how it will meet outcomes and work on the ground in two or more neighbourhoods; demonstrate how best use will be made of resources; describe consultation and engagement with people affected; link with the Single Outcome Agreement, organisational plans and strategies.
- Planned legislation and guidance will articulate minimum requirements; the Partnership will go beyond this in many ways, especially in engagement.

Any other business

- It was agreed to move to monthly meetings throughout 2014, beginning in February. It was noted that Peter Gabbitas would also organise a teleconference once a week which is open to all board members.
Minute of Meeting

Edinburgh Health and Social Care Partnership
City Chambers, Edinburgh 20 December 2013

Present: -
Councillor Ricky Henderson (Chair), Shulah Allan (Vice Chair), Councillor Elaine Aitken, Kay Blair, Councillor Cammy Day, Wanda Fairgrieve, Dr Gordon Scott and Dr Richard Williams

Also Present – Non Voting Members: - Kirsten Hay and Ella Simpson.

In Attendance, Lynda Cowie, Karen Dallas, Hugh Dunn, Peter Gabbitas, Susan Goldsmith, Dr Ian Mackay and Michelle Miller

Apologies: - Councillors Howat, Shields and Work, Monica Boyle and Dr Carl Bickler.

1 Welcome and Introduction

The Chair welcomed everyone to the meeting.

2 Minute

Decision

To approve the minute of the Health and Social Care Partnership of 18 October 2013 as a correct record.

3 Matters Arising

3.1 Service User and Carer Engagement

Decision

To note the update and request additional information for the next meeting.
4 Integration Programme Status Report

The integration status report for the period to September 2013 was presented. The report included the Reason for Status table RA(G) together with the risks associated, an action plan, key milestones and the programme critical path.

The current status of the programme overall was green.

Decision

1) To note the status report.

2) That a report on the Areas of Service Provision being considered for integration be submitted to a future meeting of the Partnership

(Reference – report by the Programme Team, submitted.)

5 Engagement Process for Reconfiguration of beds in Corstorphine and Astley Ainslie Hospitals

Outline plans to engage on, and transfer Inpatient Continuing Care (IPCC) beds from Corstorphine and Astley Ainslie Hospitals to the Royal Victoria Hospital site were presented.

The project plan would be developed further and implemented by a steering group consisting of representatives from Edinburgh Health and Social Care partnership, the Western General Hospital, City of Edinburgh Council, Partnership, Patient Focus and Public Engagement and medical staff.

The proposal would have a positive impact on the risk of HAI by providing healthcare services to a vulnerable patient group in more modern and clinically appropriate facilities.

Decision

1) To support the outline plans to engage on the transfer of the IPCC provision from Astley Ainslie Hospital and Corstorphine Hospital to the Royal Victoria Hospital site as a medium term solution.

2) To note that the final decision on bed transfers rested with NHS Lothian following engagement.

(Reference – report by the Chief Nurse, NHS Lothian, submitted)
6 Scope of Services

Details were provided of the current considerations regarding which health and social care functions would be delegated to Health and Social Care Partnerships, and which functions the Partnership would need to have influence over. The services to be included would formally agreed by NHS Lothian and City of Edinburgh Council and form a key part of the Integration Plan.

Decision

1) To note the discussions regarding scope which were underway in the parent bodies and develop a shared view on the future scope of the Partnership

2) To note that the final decision on scope rested with NHS Lothian and the City of Edinburgh Council.

(Reference – report by the Director of Health and Social Care, City of Edinburgh Council, submitted)

7 Population Growth and Primary Care Premises – Draft Report

Tim Montgomery gave a presentation on the steadily growing Edinburgh Population and the impact on Primary Care Services in the City. A draft paper detailing a series of actions at locality and city level to adjust the existing Primary Care Infrastructure to address this issue was presented.

Decision

1) To support the recommendations contained in the draft report, and

2) To consider how the Council could support the Partnership with understanding the impact of housing developments on the need for Health Services.

(Reference – presentation by Tim Montgomery, report by David White, Edinburgh Healthcare Partnership, submitted)

8 Financial Planning 2014/15, Including Budget Consultation

Susan Goldsmith Director of Finance, NHS Lothian and Hugh Dunn, Head of Finance, City of Edinburgh Council gave a joint presentation on the financial
planning being undertaken by both organisations in relation to the integration of Health and Social Care.

The presentation highlighted the following:-

- Continuation of financial/demographic challenge
- Growth and risks 2014/15
- Local Government Financial Settlement for 2014/15
- Health and Social Care Financial Plan
- Current Budget consultation
- Timetable for integration

Peter Gabbitas advised that the efficiency savings of £14M being sought from the Partnership for 2014/15 was substantially higher than in any other year at a time of substantial pressure and represented a significant corporate risk.

**Decision**

To note the presentation.

(Reference- presentations, submitted)

9 **Financial Monitoring – Month 6**

The six month aligned budgetary position of the Edinburgh Health and Social Care Partnership was presented.

**Decision**

1) To note the financial position of the partnership bodies;

2) To note that efficiency targets are on track and plans are in place for these to be met;

3) To note the significant pressures faced by the Partnership bodies in 2014-15.

4) To note that regular reports would be presented to future meetings of the Partnership.

(Reference – report by the Director of Corporate Governance, submitted)
10 **Performance Overview**

A summary was provided of performance across the Health and Social Care Partnership together with an update on progress towards the development of a performance framework to support the Health and Social Care Partnership.

The report was based on a selection of key performance indicators from Health and Social Care, Edinburgh CHP and REAS and provided a high level overview of key areas.

An overview of performance trends was provided in the appendices to the report.

**Decision**

1) To note the ongoing work to develop a performance framework to support the Health and Social Care Partnership.

2) To note the performance report for October 2013.

(Reference – report by the Chief Social Work Officer, submitted.)

11 **Integrated Risk Register**

An update was provided on the existing arrangements for corporate risk management across the Partnership. The report also outlined plans to identify, agree and monitor shared risks, including integration risks, and opportunities for addressing these shared risks.

**Decision**

1) To approve the update on existing risk management arrangements across Health and Social Care, CHP and REAS,

2) To approve the recommendations for the monitoring of shared risks and opportunities through the integrated performance and quality group and Integrated Senior management Team from January 2014.

3) To approve the proposal for quarterly reporting to the Partnership as described in paragraph 3.2 of the report

(Reference – report by the Chief Social Work Officer, and the Clinical Director submitted.)
12 Developing a Strategic Commissioning Plan

A proposed approach to the development of a strategic commissioning plan for Edinburgh Health and Social Care Partnership, in line with the requirements of the Public Bodies (Joint Working) (Scotland) Bill, was presented.

The Partnership had a duty to publish a strategic plan covering a three year period, which divided the area into at least two localities and set out separately for each locality:

- The arrangements for carrying out the integration functions
- How those arrangements were intended to achieve or contribute to achieving the national health and wellbeing outcomes
- Such other material as the integration authority saw fit.

Decision

1) To note the summary of the legislative requirements in respect of the strategic commissioning plan.

2) To approve the proposal to locate the strategic commissioning plan within an overall strategic framework.

3) To approve the proposed approach to produce the strategic commissioning plan, in collaboration with key stakeholders.

4) To approve the proposed timescale for the production of the strategic plan.

(Reference – report by the Strategic Commissioning Manager, submitted.)

13 Future Meeting Schedule

Decision

1) To agree that the Partnership meet on a monthly basis from February 2014, and

2) That visits to facilities would be arranged and communicated to members.
The draft minutes of the meeting held on 28 November 2013 are attached.

PRESENTATION

Tackling Hardship in Midlothian
EMcH provided information on a recently launched service in Midlothian “Midlothian Area Resource Coordination for Hardship” (MFIN)

Items for Discussion
Managing Demand on Acute Hospitals

The Sub-Committee considered a verbal report at the meeting given by EMc.

Planning is well advanced for the implementation of service changes to Rapid Response Service that will provide an assessment and treatment service for frail older people in their own homes. A community geriatrician has been appointed and the recruitment of advanced nurse practitioners and additional AHP capacity is about to commence. A key dimension to the service will be its operation during evenings and for periods at the weekends when many unscheduled care admissions take place.

Performance Reports
A range of routine performance reports were received.

Joint Directors Report
Finance Report
Clinical Directors Report
AHP Managers Report

Careers Forum Report

On 24 October 2013 VOCAL launched the new Carers Centre at Hardengreen Estate, Eskbank, which marked their 10 year anniversary in Midlothian.

The Centre will allow VOCAL and partner agencies to provide a wider range of support to more carers than ever before. The Centre will offer carers training, counselling, access to short breaks, expert advice, advocacy and one-to-one support.

Peter Johnston
Chairman, Midlothian CHP
24 December 2013
1.0 Apologies and Welcome
PJ noted the apologies as above.

2.0 Minutes of Previous Meeting
12 Pages in the minutes - minutes were accepted as an accurate reflection of the meeting on 26 September 2013

3.0 Action Note from Previous Meeting
Action 39 /40- Tackling Hardship in Midlothian
EMcH provided information on a recently launched service in Midlothian. “Midlothian Area Resource Coordination for Hardship (MFIN)”.

The Midlothian Area Resource Coordination for Hardship (MARCH) project aims to coordinate and improve the resources available for hardship in Midlothian. The service is funded by Big Lottery and was developed by Midlothian Council in partnership with Midlothian Financial Inclusion Network (MFIN), and Changeworks.

The proposed outcomes for MARCH are:-
1. People have improved access to welfare advice through increased local and targeted provision;
2. People seeking welfare advice have more effective support;
3. People experiencing hardship are better able to manage their finances, minimise their fuel costs, and avoid food waste;
4. People experiencing hardship receive support more quickly and effectively, due to improved coordination and awareness of sources of hardship support.

Action 35 - Breast Feeding Rate within Midlothian - This action is now complete.
Action 36 - Children’s Strategy
Children’s Strategy is currently under public consultation and will be considered by this
4.0 Items for Decision

4.1 Winter Plan

The Midlothian winter plan has been developed jointly for the first time across Health, Midlothian Council and the Voluntary sector.

A weekly meeting will update the senior team within the H&SC partnership and focus on issues requiring attention. Facilitate communications with partner organisations in acute care, care homes, across social and primary care.

Comments or feedback to the Head of Healthcare and/or Head of Adult and Social Care.

5.0 Items for Discussion

5.1 Managing Demand on Acute Hospital Services

For some time now Midlothian has performed well in managing delayed discharge, consistently meeting the new 4 week target.

Midlothian performs less well in relation to unscheduled care admissions and has not managed to reduce overall numbers of admissions or total bed days lost as a result of these admissions.

Planning is well advanced for the implementation of service changes to Rapid Response Service that will provide an assessment and treatment service for frail older people in their own homes. A community geriatrician has been appointed and the recruitment of advanced nurse practitioners and additional AHP capacity is about to commence. A key dimension to the service will be its operation during evenings and for periods at the weekends when many unscheduled care admissions take place.

JG commented that she is keen to have carer/patients etc involved, to ensure that their issues are taken into account. EMcH confirmed that engagement with carers will inform the service’s development.

HR advised the Committee about a practitioner’s workshop that is being held 23 January 2014. The development of the new service will be the main focus of the event, thus ensuring that developments are informed by practitioners’ experiences. HR to feedback at another meeting in the future.

6.0 Performance Reports

6.1 Joint Director’s Report

It is now expected that the earliest that the Shadow Health and Social Care Board will “go live” will be the 1 April 2015. This in effect means that the Midlothian Community Health Partnership will retain its governance responsibilities in relation to community health services in Midlothian until 31 March 2014.

Plans are being progressed across NHS Lothian for the establishment of four H&SCPs. One in each local authority area to take over from existing CHPs and CHCPs on the 1 April 2015.

It is anticipated that both Midlothian Council and NHS Lothian will have agreed a draft Integration Plan by the end of March 2014. This will include proposals...
for the scope of the Midlothian H&SCP and details of the proposed governance arrangements.

Following a consultation process the finalised integration plan will be submitted to the Scottish Government for approval November 2014. In parallel, the Shadow Board will have prepared a draft Strategic Commissioning Plan. The Bill requires each partnership to identify at least two locality areas and develop commissioning plans for these localities. The next Shadow Board meeting will consider proposals for the identification of localities in Midlothian. The Strategic Plan will also be subject to consultation.

The NHS Lothian Strategic plan is also being developed within the same timescales and will include consideration of how Midlothian Community Hospital can be developed to expand its capacity and contribute to the Reshaping Care agenda by providing patients with care nearer their homes.

6.2 Staff Governance Report
The staff governance report is not available. It will be circulated to members when available.

6.3 Finance Report
6.3.1 LRP Paper for Midlothian
The CHP is reporting an underspend of £45,000 for October 2013.

The release of corporate support to address the Nursing incremental drift and auto-enrolment pressures across NHS Lothian has resulted in a favourable variance within Core services year to date. The underspend reflects the level of vacancies within Hospital services, Community Nursing and Mental Health services which have offset these pressures in previous months. The CHP continues to work towards filling these posts and the level of underspend is forecast to reduce significantly by year end.

The month 7 position includes the Dietetics service which is now a Hosted service within the CHP.

Overall the CHP is delivering the majority of its LRP target recurrently. A small underachieved balance is being met on a non-recurring basis, pending identification of suitable schemes to meet the target recurrently.

Prescribing costs continue to exceed planned levels resulting in a pressure across the system. Under the risk sharing agreement, Midlothian is reporting an overspend of £164,000 for the year to date.

GW asked how much work is entailed of hosted services.

EMcH stated that Midlothian CHP hosted Learning Disability and Substance Misuse services in the past. These are now hosted in Edinburgh. Dietetics and Art Therapies continue to be hosted Midlothian. These services do not require a significant amount of management resource.

6.4 Chief Nurse's Report
No representation from the Chief Nurse’s office.
6.5 Clinical Director’s Report
6.5.1 NHS Prescribing Action Plan 2013 -14
There is a wide range of prescribing work going on across both Midlothian and Lothian. The core aim is to maintain our position as an organisation which is responsible for high quality and cost effective prescribing.

This requires a multi-disciplinary approach with input from, and joint working between GP’s, GP Practice Staff, Community Pharmacies, Primary Care Pharmacy Staff, Finance, Management and our Patients. The real cost savings generated by this work are of benefit to all in the system.

The Midlothian Prescribing Intervention Project (MEPIP) generated savings of £104,000, 2012/13, and to date has generated savings of £95,000 in 2013/14.

The CHP had previously agreed to the increase of an X-ray service at Midlothian Community Hospital to 5 mornings a week. To date the X-ray service has been unable to recruit the additional staff required.

The Chairman requested that HR convey the disappointment of the Committee to the X-ray service and request that the new service provision is commenced as soon as possible.

6.5.2 Quality and Outcomes Framework 2012/13
Midlothian Practices have performed comparatively well against the targets in achieving an average score of 98.8%.

6.6 AHP Manager’s Report
Work is ongoing to develop the most appropriate management and professional support arrangements for AHPs following the setting up of the two partnerships in East Lothian and Midlothian.

6.7 Primary Care Contractors Organisation
6.7.1 Primary Care Joint Management Group (PCJMG) minutes 12.09.13
For circulation only. No issues were raised.

6.7.2 Payment Verification in Primary Care Financial Years 2012/13 & 2013/14.
Nil

6.7.3 Primary Care Joint Management Group (PCJMG) Minutes 10.10.13
Nil

6.8 Joint Health Improvement Partnership
6.8.1 Neighbourhood Planning
MMcK presented a paper on Neighbourhood Planning in Midlothian.

Neighbourhood plans have been developed and approved in seven areas and are currently under development in a further six areas.
Members of Midlothian Public Partnership Forum for Health attend neighbourhood planning groups to create a link between the two structures for public involvement. Neighbourhood planning is a standing item on the PPF Steering Group agenda.

Neighbourhood Planning provides an opportunity to hear local voices on the way that services are planned and delivered.

EMcH confirmed that the Midlothian Shadow Board will consider at its next meeting. Proposals for the development of localities in Midlothian in accordance with the proposed requirement of the new legislation. These proposals will build on neighbourhood planning.

7.0  Carers Forum

Voice of Carers Across Lothian (VOCAL)
On 24 October 2013 VOCAL launched the new Carers Centre at Hardengreen Estate, Eskbank, which marked their 10 year anniversary in Midlothian.

The Centre will allow VOCAL and partner agencies to provide a wider range of support to more carers than ever before. The Centre will offer carers training, counselling, access to short breaks, expert advice, advocacy and one-to-one support.

In July 2013, VOCAL conducted a survey of carers in Edinburgh and the Lothians. The survey had two main purposes. It provided an opportunity for carers to comment on recent and imminent changes in the way carers receive support and services (including carers’ rights, Self-Directed Support (SDS), economic well-being and use of technology). It also sought feedback on carers’ experiences of VOCAL and the difference VOCAL support had made to their caring situations.

Read feedback via one of the following mediums:-

If you would like to read the summary of the survey please use link below:-

VOCAL have delivered leaflets and posters to all practices to distribute at their Flu Clinics. All practices have also been given VOCAL’s new programme for surgeries/training/workshops.

Carers Action Midlothian (CAM)
Older People’s Planning Consultation event took place on 1 November 2013, with different presentations and focus groups being held on the day.

Midlothian Council is now taking names of vulnerable people/carers who may require additional support during winter/extreme weather.

Parent carers reported that they are looking at their database. They have 53 carers on their mailing list and plan to have an open night in December, to try and engage new parents/carers to attend the groups etc. They have also planned for a speaker at the start of the New Year to cover topics such as puberty etc. Children & Families Consultation Event will take place on 21 November from 16:30 - 18:00. It is about listening to parent carers in relation to short breaks. The event is the start of discussions around the possibility of more flexible breaks, what is the best way forward and hopefully get the discussions started/debate open.

Breathtakers reported that the group is currently working to produce a programme for
next year. The Committee is currently trying to engage the group/members to get more involved.

At the recent Carers Parliament, the First Minister announced new legislation to give carers a right to services. A special CAM meeting is planned to consider the consultation.

8.0 Public Partnership Forum
The GP Better Together patient experience survey was carried out in 2011-2012. The survey is administered nationally by post and results are provided by GP practice at CHP level. The survey asks a range of questions about patient’s experience of using GP services, nursing services and out of hours services, including the process of accessing care, the quality of care they receive, and their health outcomes.

Issues raised were:
- Access to appointments;
- Being able to get through on the phone;
- Specific barriers to access, which may be experienced by people with disabilities;
- Time waiting at the surgery (i.e. patients being called late for their appointments);
- Referral to treatment time;
- Repeat referrals to a specialist come back to the GP to make, which increases their workload. Patients are then required to wait twice for treatment if they are referred from one specialist to another.

In 2013 Midlothian Public Partnership Forum for Health (PPF) representatives offered to visit each practice in turn, to discuss the results and actions the practice had subsequently taken to improve patient care.

A development day was recently held to look at what the Forum had achieved over the years and how it can function in the future. There was good feedback on the day and good discussions and ideas around how to change and adapt in the future. The main things were how to use more effective communication and also accessible language (promote use of plain English).

SE asked if papers for all future meetings can be sent out on A4 sheets and NOT A5, as they are too small to read.

9.0 Community Health Partnership Committee Appointments
No new appointments.

10.0 AOCB
A paper outlining the Midlothan CHP LRP target for 2013/14, was presented to an earlier Sub Committee. A request was made for further details of the schemes presented. The paper 6.3.1 provides that additional detail.

Clinical Governance
PE wanted to inform and update the Committee in relation to changes in NHSL’s Partnership Structure.

The development of the 4 Health & Social Care Partnerships and also changes in management structures across NHSL has resulted in the requirement to increase the number of local Partnership Forums.

This change results in the existing joint EL & ML Partnership Forum splitting into two separate Partnership Forums.
Co chairs for Midlothian are Eibhlin McHugh, Director and Patsy Eccles, Lead Partnership Rep. Midlothian PF is planning to extend the remit of the PF to include social care, trade union representation and management.

11.0 Date and Time of Next Meeting
Thursday 30 January 2014 at 14.00 - 17:00
Council Chambers | Midlothian House | Buccleuch Street | Dalkeith

Meeting finished at 15:25

V = Verbal report # = Paper to follow P = Presentation
<table>
<thead>
<tr>
<th>MEETING</th>
<th>KEY ISSUES</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Lothian CHCP Board 26 November 2013</td>
<td>Presentation on Primary Care Prescribing in Lothian</td>
<td>Noted Medicines Governance Strategy in Lothian and the work of the CHCP Prescribing Forum, delivering financial stewardship within primary care prescribing, through the implementation of a prescribing quality based Prescribing Action Plan.</td>
</tr>
<tr>
<td>West Lothian Health &amp; Wellbeing Profile</td>
<td></td>
<td>Agreed reports on themed areas should be brought to the Board at future meetings in relation to actions planned and taken as a result of the profile.</td>
</tr>
<tr>
<td>RCOP – Mid Year Report</td>
<td></td>
<td>Noted.</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td></td>
<td>Agreed to continue to support protected learning time programme “Time to Learn”.</td>
</tr>
<tr>
<td>Care Governance</td>
<td></td>
<td>Noted the launch of the re-designed Support at Home services.</td>
</tr>
<tr>
<td>Staff Governance</td>
<td></td>
<td>Noted SOA staff briefing sessions, Council governance review, Values into Action update, management of violence and aggression training, integrated approach to Health &amp; Safety across the CHCP and agreed to congratulate recent Celebrating Success winners.</td>
</tr>
</tbody>
</table>
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBOURN EH52 5LH, on 26 NOVEMBER 2013

Present – Frank Toner (Chair), Brian Houston, Jane Houston, John McGinty, Anne McMillan, Alison Mitchell, Ed Russell Smith

Apologies – Janet Campbell

In Attendance – Jim Forrest (CHCP Director), Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), Gill Cottrell (Chief Nurse, NHS Lothian), James McCallum (Clinical Director), Carol Bebbington (Primary Care Manager – NHS Lothian), Stephen McBurney (Primary Care and Community Pharmacy Co-ordinator - NHS Lothian), Sal Connolly (Primary Care Pharmacist - West Lothian CHCP, NHS Lothian); John Richardson (PPF)

Apologies – Carol Mitchell (Assistant Director of Finance, NHS Lothian)

1 DECLARATIONS OF INTEREST

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

2 MINUTE

The Board approved the minute of its meeting on 8 October 2013 as a correct record.

3 CHCP RUNNING ACTION NOTE

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

Decisions

1. To note and agree the Running Action Note.

2. Item 2 – to agree that a report be brought to Board in the New Year in relation to staff awareness of the health and social care integration agenda.

3. Item 3 – to agree that the list of practices and premises not participating in the Baby Friendly project should be re-circulated.

4. To amend the Running Action Note accordingly.

4 NOTE MINUTES OF MEETINGS OF THE PRIMARY CARE JOINT MANAGEMENT GROUP
The Board noted the minutes of the Primary Care Joint Management Group meetings on 9 May, 13 June, 12 September and 10 October, all 2013.

5 NOTE MINUTES OF MEETINGS OF THE CHCP SUB-COMMITTEE

The Board noted the minutes of the Primary Care Joint Management Group meetings on 23 May and 29 August, both 2013.

6 PRIMARY CARE PRESCRIBING IN LOTHIAN

The Board considered a report (copies of which had been circulated) by the Head of Health Services, and heard a presentation by the Primary Care and Community Pharmacy Co-ordinator - NHS Lothian informing Board members of the medicines governance structure in NHS Lothian which ensured that patients who require drug therapy received the most clinically and cost-effective medicines.

The report summarised the findings of Audit Scotland’s report into prescribing in general practice in Scotland, published in January 2013, and explained the ongoing local analysis by a short life working group to establish what proportion of the reported £26m of potential savings could be realistically attributed to NHS Lothian. It went on to summarise the aims of the NHS Lothian Medicines Governance Strategy NHS Lothian and the many underpinning policies, including the Lothian Joint Formulary (LJF). It pointed out the importance of decisions taken about the use of medicines and the ways in which medicines management activity has gradually increased in response to patient needs. The report explained the methods by which prescribing within primary care in NHS Lothian is continually monitored and the joint working amongst the West Lothian CHCP Primary Care Pharmacy team, individual general practices and the Community Nursing Team.

The report went on to describe the CHCP Prescribing Action Plan which had been developed by the NHS Lothian Primary Care Pharmacy Team and progressed through the CHCP Prescribing Forum, and it summarised the purpose and the key initiatives in the Plan.

Finally, the report explained the way in which the primary care prescribing budget was set, taking account of the Prescribing Pressures Report, financial analysis including expenditure, volume growth predictions, cost per item information and any anticipated in year benefit, with the budget being apportioned based on the risk sharing agreement in place across the Lothian CHCPs.

It concluded by confirming that individual CHCPs continue to be fiscally accountable for their General Practice and Community Nursing locality prescribing budgets.

Decisions
1. To acknowledge the Medicines Governance Strategy in Lothian.

2. To note the work of the CHCP Prescribing Forum, delivering financial stewardship within primary care prescribing, through the implementation of a prescribing quality based Prescribing Action Plan.

3. To agree the presentation slides should be circulated by email to Board members.

7 WEST LOTHIAN HEALTH & WELLBEING PROFILE

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director updating the Board on the Health & Well Being Profile of West Lothian’s population and highlighting the positive progress being made in tackling health inequalities and future challenges for the CHCP.

The report advised that the CHCP had updated the Health & Well Being Profile which enabled the tracking of progress and identification of key priorities for further action. The report was compiled from published statistics reflecting the most up to date figures available at September 2013. It demonstrated the positive impact that CHCP interventions were having on the West Lothian population. The main challenges continued to be the aging population, persistent health inequalities, the growth in number of people affected by long term conditions and those with multiple conditions and complex needs. The Profile was contained in Appendix 1 to the report.

The report explained the approach taken to improving health & well being, with the West Lothian Health Improvement and Health Inequalities Alliance (HIHIA) leading on actions to improve the health and well-being of those who live and work in West Lothian and to reduce the gap between those with the best health outcomes and those with the poorest health outcomes.

Finally, the report noted that the positive changes in life expectancy and population increase, particularly in the older population, pointed towards the need for local services to respond to demographic change by supporting people to lead more active and independent lives to ensure good health in later life, and concluded that the CHCP had an important role in supporting key activities and working with partners to ensure strategies were focussed on reducing health inequalities and improving health and well being.

Decisions

1. To note the positive progress being made.

2. To acknowledge the challenges and discuss the priorities for the future.

3. To support the approach being taken to improve health and well being.
4. To agree reports on themed areas should be brought to the Board at future meetings in relation to actions planned and taken as a result of the Profile.

8 RESHAPING CARE FOR OLDER PEOPLE - MID YEAR PROGRESS REPORT

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director advising the Board of the submission of the midyear progress report of West Lothian’s Change Fund Plan, Reshaping Care for Older People.

The report explained the establishment by the Scottish Government of the Change Fund in 2011/12, its principal policy goal and the requirement for local partnerships involving Council, NHS Lothian, Voluntary Sector and Independent Sector to develop and submit Change Plans for approval by the Scottish Government for the first 2 years of the programme. For 2013 – 14 the main requirement had been the development of Joint Commissioning Plans to include an annual action plan detailing the deployment of Change Fund resources. The Scottish Government, through the Joint Improvement Team (JIT), also required partnerships to submit annual midyear progress reports to share examples of how local partnerships have deployed their Change Fund, to understand what is working well, to share learning about the impact of successful innovations, and to identify areas of work that may require further improvement support in order to make progress on joint strategic commissioning and integration. Partnerships had been asked to report spend against 4 main the pillars of the RCOP pathway: Preventative and Anticipatory Care; Proactive Care and Support at Home; Effective Care at Times of Transition; Hospital and Care Homes.

The appendix to the reports provided the detail of the West Lothian Partnership’s midyear submission and the report concluded by confirming that an overview report will be shared with the Health and Community Care Delivery Group and the Ministerial Strategic Group.

Decision

To note the contents of the report advising of the submission of the midyear progress report of West Lothian’s Change Fund Plan, Reshaping Care for Older People.

9 HEALTHCARE GOVERNANCE

a) Clinical Governance

The Board considered a report (copies of which had been circulated) by the Clinical Director highlighting the Protected Learning Time programme, which was known as known as “Time to Learn” in West Lothian and was an established way of supporting practice teams to develop. Although
engagement was not compulsory, nonetheless the majority of practices chose to do so. Activities could involve only practice staff (split into administration and clinical or combined together); or engagement with attached staff or outside providers; or West Lothian or occasionally Lothian wide. It was a tangible and positive way in which the CHCP supported practice teams.

The report explained the costs involved and plans for 2014/2015 and the approach taken in relation to securing returns from practice units.

The Protected Learning Time report for 2013 was attached as an appendix.

**Decision**

To continue to support protected learning time programme “Time to Learn”.

### CARE GOVERNANCE

a) **Care Governance**

The Board considered a report (copies of which had been circulated) by the Head of Council Services advising the Board of the recently launched Support at Home Services.

The service incorporated the Home Safety Service, Crisis Care, Reablement, Domiciliary Care, Apetito/Scotmid shopping and frozen meals and the new Dementia Home Support Team. The new service aimed to improve user experience by providing a single point of contact for adults and older people who required short term support in their own home. The redesigned service had 160 staff and delivered services to around 4,500 users.

The report provided information in particular about the Crisis Care service, which, through a single point of contact, would streamline the experience for users, prevent duplication of contact, promote information sharing and speed up hospital discharge.

**Decision**

To note the launch of the redesigned Support at Home services.

### FINANCIAL GOVERNANCE

a) **2013/14 Revenue Budget - Monitoring Report as at 30 September 2013**

The Board considered a report (copies of which had been circulated) by the Head of Social Policy and Head of Health Services providing a joint
report on financial performance in respect of West Lothian Community Health and Care Partnership (WLCHCP) based on figures for the period 30 September 2013.

The CHCP advised the Board that the report had been included on the agenda in error, since the Board had recently agreed a different approach to financial reporting involving monitoring reports being brought after each quarter of the financial year. In the circumstances, the Board was asked to note the position and await the next quarterly monitoring report at a future meeting.

Decisions

1. To note that the report had been included on the agenda in error, the Board having previously agreed a programme of quarterly reporting in relation to financial and budget issues.

2. To note in any event that no issues of significance had arisen in relation to the CHCP budget and expenditure since the last quarterly report.

b) Resource Transfer Monitoring Report to 30 September 2013

The Board considered a report (copies of which had been circulated) by the Head of Social Policy providing details of phased expenditure incurred in the period to 30 September 2013. The resource transfer monitoring report for the first six months of the financial year was contained in the appendix.

The Board was advised the council had invested £3.30 million of the total £6.52 million resource transfer monies to the end of July and had maintained a zero delayed discharge position in the first six months of the financial year.

Decision

To note that the council continued to invest the resource transfer monies effectively in the prescribed areas and continued to maintain a zero delayed discharge position.

12 STAFF GOVERNANCE

The Board considered a report (copies of which had been circulated) by the Head of Social Policy and the Head of Health Services providing an update on staff issues within the CHCP. Information was provided in relation to Single Outcome Agreement staff briefing sessions, Council Governance Review 2013, Values into Action Update, Management of Violence and Aggression training, and the Integrated approach to Health & Safety across the CHCP.

Decisions
1. To note the information and work undertaken in relation to:-

(a) Single Outcome Agreement staff briefing sessions.

(b) Council Governance Review 2013.

(c) Values into Action Update.

(d) Management of Violence and Aggression training.

(e) Integrated approach to Health & Safety across the CHCP.

2. To agree that the Chair should write on behalf of the Board to the award winners mentioned in the report and others mentioned during the meeting to congratulate them on their effort and achievements.

13 DIRECTOR’S REPORT

The Board heard a report by the CHCP Director providing an update on key areas of work in which the partnership had been involved since the last meeting of the Board.

Decision

To note the information and work undertaken in relation to:-

(a) Partnership Agreement with Alzheimer Scotland.

(b) Funding for Children with Disabilities Health.

(c) Improvement Team initiatives.

(d) Issue 25 of West Life.
This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Paragraph</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performance against the 4 hour standard for the month of December 2013 was 92.3%.</td>
<td>3.1</td>
</tr>
<tr>
<td>• Our overall performance for week ending 19 January was 90.4% against the agreed LUCAP January trajectory of 93.2%. We are required to reach 95% by September 2014 and 98% thereafter.</td>
<td>3.2</td>
</tr>
<tr>
<td>• The HEAT T10 A&amp;E attendance rate at the end of December 2013 was 1,972 (per 100,000 population) but above the agreed HEAT T10 trajectory of 1,959 (per 100,000 population).</td>
<td>3.3</td>
</tr>
<tr>
<td>• As at end of December, an additional 152 beds had been opened to deal with the winter surge. Presently, 227 additional beds are open with the anticipation that this may rise to 259 by the end of March 2014</td>
<td>3.7</td>
</tr>
<tr>
<td>• Further ‘step-down’ beds will become available to support discharge from hospital. NHS Lothian has commissioned 42 beds of which 32 are now open</td>
<td>3.10</td>
</tr>
<tr>
<td>• A plan is being developed jointly between NHS Lothian and City of Edinburgh Council to expedite the discharge of patients at the RVH and to improve patient flow.</td>
<td>3.11</td>
</tr>
<tr>
<td>• Assistance has been sought from the Scottish Government to review the Western General Hospital in terms of patient flow and how this will aid our overall performance, commencing 17 January 2014.</td>
<td>3.12</td>
</tr>
<tr>
<td>• Day of Care Audit will be undertaken at the WGH on 13 March 2014 to support our ongoing commitment to improving systems of flow and performance.</td>
<td>3.14</td>
</tr>
<tr>
<td>• Meanwhile stroke Performance has improved against five of the six Health Improvement Scotland Stroke Standards throughout the first half of 2013/14 and throughout quarter 3.</td>
<td>3.16</td>
</tr>
<tr>
<td>• To date Norovirus season 2013 has comparatively less incidences of outbreaks and patients affected compared to the same time period in 2012. The resulting lower incidences have also reduced the impact of bed days lost</td>
<td>3.17</td>
</tr>
</tbody>
</table>
UNSCHEDULED CARE

1. Purpose of the Report

1.1 The purpose of this report is to provide the Board with data and analysis on Unscheduled Care performance and our measurement against agreed national targets.

2. Recommendations

2.1 To note the targets for measurement and NHS Lothian’s performance.

2.2 To note the actions being taken forward to support NHS Lothian’s performance outcomes for unscheduled care.

2.3 To note the key challenges being faced by the service in relation to patient flow and performance

3. Discussion of Key Issues

Performance

3.1 NHS Lothian’s unscheduled care performance against the 4 hour standard for the month of December 2013 was 92.3%. This compares with a performance figure of 86.7% for the same period in 2012. There were 17 twelve hour breaches during December 2013.

3.2 The achievement of the 4 hour unscheduled care target remains challenging. While compliance varies across each site, the latest compliance data for NHS Lothian shows that our overall performance for week ending 19 January was 90.4% against the agreed LUCAP January trajectory of 93.2%. [The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter.]

3.3 NHS Lothian is required to reduce the rate of attendance at Emergency Departments (A&E) in accordance with the trajectories agreed as part of the HEAT (T10) targets. Attendance rates show a steady but significant fall of almost 5% from September to December 2013. The attendance rate at the end of December 2013 was 1,972 (per 100,000 population) but remains 0.66% above the agreed HEAT T10 trajectory of 1,959 (per 100,000 population). The HEAT T10 trajectory rate is set to reduce to 1,956 (per 100,000 population) as at March 2014.
3.4 Further intelligence against HEAT T10 milestones are required to be submitted to the Scottish Government by the end of January outlining the actions taken so far in mitigating A&E attendance. This will be followed with a meeting to formally review performance on 5 March 2013.

3.5 NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP), approved by the Board on 26 June, has been updated and submitted to the Scottish Government on 19 December 2013.

**Winter / Surge Capacity**

3.6 NHS Lothian’s Winter Plan (2013/14) builds on the overall work alluded to within NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP). Each winter, additional bed capacity is provided across acute hospitals, to deal with surges in activity and to cope with increasing numbers of delayed discharge.

3.7 As at end of December, an additional 152 beds had been opened to deal with the winter surge. Presently, 227 additional beds are open with the anticipation that this may rise to 259 by the end of March 2014. (This compares with 164 beds opened last year.) Plans are in place to scale down these additional beds (subject to performance and social care capacity) from March 2014 in order to avoid downstream consequences around service, workforce and financial management.

3.8 Looking ahead, an additional 31 beds will become available at RIE from 10th February and we also plan to expand the Acute Assessment footprint, including additional bed capacity in 2015.

**Delayed Discharge**

3.9 The issue of delayed discharge remains a key pressure on the system, particularly during winter. Weekly meetings involving the Chief Executives of City of Edinburgh Council and NHS Lothian, along with key executive colleagues, offers a more direct focus on the challenges posed by delayed discharge. Given Delayed Discharge pressures, Additional beds have been identified for RVH to ensure downstream flow.

3.10 Further ‘step-down’ beds will become available to support discharge from hospital. NHS Lothian has commissioned 42 beds of which 32 are now open. This additional capacity is aimed at reducing delayed discharge and improving patient flow across a number of sites.

3.11 A plan is being developed jointly between NHS Lothian and City of Edinburgh Council to expedite the discharge of patients at the RVH and to improve patient flow. This potentially will support the transfer of patients and services from peripheral sites such as Corstorphine and Astley Ainslie to be centred at the RVH. In principle this will offer an improved patient experience as services are provided in a high quality and more up-to-date setting.

3.12 East Lothian Partnership is developing plans to implement step down capacity from April 2014. It is planned to establish 10 beds in April 2014 and move to 20 beds in September 2014.
Review of Systems/ Patient Flow

3.13 Assistance has been sought from the Scottish Government to review the Western General Hospital in terms of patient flow and how this will aid our overall performance. Data analysis and an initial site visit will inform further process mapping and the production of an improvement plan for the WGH.

3.14 The whole process will be conducted over a period of 4-6 weeks commencing on 17th January 2014. The review will be iterative in nature with ongoing dialogue to inform further potential developments and improvements.

3.15 In addition a Day of Care Audit will be undertaken at the WGH on 13th March 2014 to support our ongoing commitment to improving systems of patient flow and performance.

Stroke

3.16 Plans are underway to increase Stroke medical cover at SJH and ensure a robust Stroke service continues to develop at the WGH site. A consistent Stroke Outreach service across each of the three acute sites will be achieved so that Stroke Standards are delivered consistently across all of Lothian. Further work will be complete to improve the Thrombolysis pathway, with a pre-alert system to be trialled in partnership with the Scottish Ambulance Service. Better linking of Stroke Standard compliance to staff training is planned and several members of our acute teams are to be trained to deliver STAT training, improving NHS Lothian’s ability to up skill staff across the entire hospital Stroke pathway.

3.17 Meanwhile performance against each of the six Health Improvement Scotland Stroke Standards is outlined below

<table>
<thead>
<tr>
<th>NHS Lothian Performance</th>
<th>Target</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to Stroke Unit</td>
<td>90%</td>
<td>82%</td>
<td>78%</td>
<td>77%</td>
<td>84%</td>
<td>83%</td>
</tr>
<tr>
<td>Swallow Assessment</td>
<td>90%</td>
<td>81%</td>
<td>76%</td>
<td>71%</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td>Aspirin</td>
<td>100%</td>
<td>87%</td>
<td>86%</td>
<td>74%</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>Scanning</td>
<td>90%</td>
<td>100%</td>
<td>99%</td>
<td>96%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Stroke/TIA Clinic</td>
<td>80%</td>
<td>83%</td>
<td>90%</td>
<td>95%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Thrombolysis Door to Needle</td>
<td>80%</td>
<td>38%</td>
<td>33%</td>
<td>28%</td>
<td>44%</td>
<td></td>
</tr>
</tbody>
</table>

Norovirus

3.18 NHS Lothian Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to service. Health Protection Scotland notified boards that Norovirus season commenced on the 9th of December 2013 based on the number of boards affected. NHS Lothian noted gradual increase in the incidence of Norovirus from October 2013. To date Norovirus season 2013 has comparatively less incidences of outbreaks and patients affected compared to the same time period in 2012.
The resulting lower incidences have also reduced the impact of bed days lost.

<table>
<thead>
<tr>
<th></th>
<th>Apr 12-Mar 13</th>
<th>Apr-Dec 2012</th>
<th>Apr-Dec 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norovirus positive patients</td>
<td>747</td>
<td>415</td>
<td>273</td>
</tr>
<tr>
<td>Bed days lost</td>
<td>6,750</td>
<td>3,118</td>
<td>1,014</td>
</tr>
</tbody>
</table>

### 4 Key Risks

4.1 The failure to deliver against the 4 hour emergency care standard increases the risk to patient safety while diminishing the overall patient experience.

4.2 The performance against Delayed Discharge and the impact this will have on patient flow and overall performance.

4.3 The impact of winter demand and Norovirus on current capacity and performance across all sites.

4.4 The move from the Astley Ainslie to the RVH will reduce the fire risk.

4.5 The move from both the Corstorphine and Astley Ainslie Hospitals will reduce the risks related to Healthcare Acquired Infection (HAI) and improved patient and staff safety. Reducing the provision of services on peripheral sites will have a longer term positive impact on financial risk.

### 5 Risk Register

5.1 Risks are noted within the NHS Lothian corporate risk register for Unscheduled Care.

### 6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was carried out as part of the LUCAP. Any specific services moves to the RVH will be subject to a Rapid Impact Assessment according to Board policy.

### 7 Involving People

7.1 Progress against targets and those actions detailed within the LUCAP are reported into the Unscheduled Care Board whose membership is drawn from across Councils, Primary Care, CHCPs and the Acute Sector. Any plans to transfer services are subjected to full involvement of patients, families and other stakeholders including the Scottish Health Council and Scottish Government. All proposals will follow NHS Lothian’s comprehensive Organisational Change Policy and Procedure for staff and volunteers.

### 8 Resource Implications

8.1 The resource implications for unscheduled care, including winter, are £14.4 million for 2013/14. This figure is regularly reviewed with Finance colleagues and through the Unscheduled Care Board.
8.2 A total of £1,331,545 has already been allocated to NHS Lothian from the Scottish Government to support unscheduled care, including £125,000 set aside as HEAT T10 funding.

8.3 Further Scottish Government investment (£1,022,317) has been allocated to NHS Lothian by the Scottish Government in support of the LUCAP in 2014/15 and 2015/16.

8.4 The Step Down programme will initially be funded through the Change Fund. It is anticipated that the development of Step Down will reduce the need for boarding beds and that this will release funding for the ongoing provision of the service.

Neil Wilson
Unscheduled Care Manager
24 January 2014.
neil.wilson@nhslothian.scot.nhs.uk
### SUMMARY PAPER - WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

The key points of the paper are summarised here.

<table>
<thead>
<tr>
<th>Point</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 week performance from referral to treatment was 84.6% in November, below the 90% expected.</td>
<td>3</td>
</tr>
<tr>
<td>Both 31 day and 62 day performance against Cancer waiting time standards were better than the 95% across October and November. While performance against the 62 day standard in the month of November reached 93.3%, it is expected the standard will be met across the quarter as a whole.</td>
<td>4</td>
</tr>
<tr>
<td>During December 93.5% of patients were seen within the treatment time guarantee. A total of 448 patients were beyond the TTG at month end. Of these, 209 have since been treated or removed and 103 have a date for admission or are with external providers.</td>
<td>5</td>
</tr>
<tr>
<td>Outpatients over 12 weeks decreased in December to 4,039.</td>
<td>6</td>
</tr>
<tr>
<td>Loss of capacity impacted on performance against the diagnostic standard of six weeks with 85 endoscopy patients and 1 radiology patient exceeding this timescale at the end of December.</td>
<td>7</td>
</tr>
<tr>
<td>The surveillance endoscopy position is anticipated to continue to improve with 591 patient waiting beyond their review date, having reduced from 2118 in April.</td>
<td>8</td>
</tr>
<tr>
<td>The existing Audiology standard and forthcoming standard for IVF continue to be met.</td>
<td>9,10</td>
</tr>
<tr>
<td>Progress towards an accurate dataset continues for services under the psychological therapies target continues, with 75% of patients reported within 18 weeks</td>
<td>11</td>
</tr>
<tr>
<td>Performance against the 26 week treatment standard in Child and Adolescent Mental Health worsened to 74% in December.</td>
<td>12</td>
</tr>
</tbody>
</table>
NHS LOTHIAN

Board Meeting
5 February 2014

Director of Scheduled Care

WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on recent performance on waiting times.

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

2 Recommendations

2.1 It is recommended that the Board receives this update on performance and progress on inpatient, outpatient and other waiting times.

3 18 Weeks Referral to Treatment Standard

3.1 The table below shows the recent trend for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard. 90% compliance is expected.

3.2 As this standard measures performance throughout the patient pathway, challenges in meeting outpatient, inpatient and diagnostic stages will impact in the level of performance reported here.

3.3 Figures for December are being compiled at the time of writing.

<table>
<thead>
<tr>
<th>Table 1 – Trend in 18 Week Performance and Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient journeys within 18 weeks (%)</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>86.1</td>
</tr>
<tr>
<td>Number of patient journeys within 18 weeks</td>
</tr>
<tr>
<td>Number of patient journeys over 18 weeks</td>
</tr>
<tr>
<td>Patient journeys that could be fully measured (%)</td>
</tr>
</tbody>
</table>

4 Cancer

4.1 Recent performance against cancer standards is shown in the following tables.

4.2 95% compliance was maintained in both October and November against the 31 day standard from diagnosis to treatment (Table 2). Against the 62 day standard, performance was 93.3% in November, 4 patients below the expected level.

4.3 Average performance across the two months reported to date continues to meet the standard (Table 3) and provisional information suggests that NHS Lothian will still
deliver the 95% standard for 62-day standard for patients with cancer across the quarter as a whole.

4.4 The slight dip in performance is as a result of three issues;

- Difficulties in referral to diagnosis in the lung service. These problems have now been addressed. Unfortunately as the lung pathway is complex it is not possible to recoup this past delay in reaching diagnosis for the patients affected as they progress to receive treatment;
- Delays experienced by patients presenting with neck lumps. Additional capacity has now been put in place to address this;
- A temporary difficulty in accommodating inpatients at Western General due to unscheduled care pressures.

Table 2 – Trend in Cancer Performance (31 days from diagnosis to treatment)

<table>
<thead>
<tr>
<th>Percentage Compliance</th>
<th>Scotland Jul - Sep 13</th>
<th>Jul - Sep 13</th>
<th>Lothian Oct-13</th>
<th>Nov-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Cases</td>
<td>5709</td>
<td>1087</td>
<td>371</td>
<td>359</td>
</tr>
<tr>
<td>Excluded Cases</td>
<td>119</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>%age excluded Cases</td>
<td>2.0%</td>
<td>0.5%</td>
<td>1.1%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Table 3 – Trend in Cancer Performance (62 days from urgent referral to treatment)

<table>
<thead>
<tr>
<th>Percentage Compliance</th>
<th>Scotland Jul - Sep 13</th>
<th>Jul - Sep 13</th>
<th>Lothian Oct-13</th>
<th>Nov-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Cases</td>
<td>3086</td>
<td>540</td>
<td>188</td>
<td>180</td>
</tr>
<tr>
<td>Excluded Cases</td>
<td>120</td>
<td>13</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>%age excluded Cases</td>
<td>3.7%</td>
<td>2.4%</td>
<td>3.1%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

4.5 The tables also show the proportion of cases excluded from consideration. National guidance indicates that clinically complex patients, those declining treatment and those who die during treatment should not be incorporated into performance measures.

5 Inpatients and Daycases

5.1 During December 93.5% of patients were seen within the treatment time guarantee. A total of 448 patients were beyond the TTG at month end. Of these, 209 have since been treated or removed and 103 have a date for admission or are with external providers.

5.2 A further 107 patients not covered by guarantee were also waiting over 12 weeks at the end of month.

5.3 The trend over time is illustrated in Figure 1 with Table 4 showing the same information numerically since April 2013.

5.4 As anticipated at the last meeting, the number over 12 weeks fell at the end of November. However, during December a combination of capacity reduction linked to Christmas holidays and an increase in elective cancellations due to reduced bed availability impacted directly on our flow and resulted in an increase in the number of patients waiting > 12 weeks.
5.5 The increased pressure from ‘elective’ cancellations will be evident in January also.

5.6 Within the ‘Delivering for Patients’ paper there is an update on changes to our Information System that will see an increase number of both TTG and OP > 12 weeks. This change will occur from March 2014 when the system is upgraded.

**Figure 1 - Inpatients waiting over 12 weeks**

![Bar chart showing inpatient waiting over 12 weeks by specialty]

**Table 4 - Trend in Key Specialties over 12 weeks**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>18</td>
<td>13</td>
<td>36</td>
<td>45</td>
<td>264</td>
<td>185</td>
<td>149</td>
<td>120</td>
<td>68</td>
<td>72</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>573</td>
<td>89</td>
<td>63</td>
<td>66</td>
<td>76</td>
<td>85</td>
<td>100</td>
<td>89</td>
<td>87</td>
<td>105</td>
</tr>
<tr>
<td>Urology</td>
<td>672</td>
<td>52</td>
<td>99</td>
<td>112</td>
<td>126</td>
<td>131</td>
<td>52</td>
<td>74</td>
<td>76</td>
<td>72</td>
</tr>
<tr>
<td>ENT</td>
<td>192</td>
<td>8</td>
<td>27</td>
<td>28</td>
<td>31</td>
<td>53</td>
<td>73</td>
<td>66</td>
<td>38</td>
<td>66</td>
</tr>
<tr>
<td>Colorectal &amp; General Surgery</td>
<td>218</td>
<td>63</td>
<td>40</td>
<td>37</td>
<td>37</td>
<td>41</td>
<td>44</td>
<td>45</td>
<td>48</td>
<td>57</td>
</tr>
<tr>
<td>Maxillofacial/Oral</td>
<td>110</td>
<td>9</td>
<td>4</td>
<td>6</td>
<td>11</td>
<td>15</td>
<td>21</td>
<td>46</td>
<td>64</td>
<td>73</td>
</tr>
<tr>
<td>Others</td>
<td>216</td>
<td>161</td>
<td>172</td>
<td>136</td>
<td>138</td>
<td>133</td>
<td>126</td>
<td>126</td>
<td>113</td>
<td>111</td>
</tr>
<tr>
<td>Total &gt; 12 weeks</td>
<td>2000</td>
<td>381</td>
<td>441</td>
<td>430</td>
<td>683</td>
<td>654</td>
<td>614</td>
<td>554</td>
<td>484</td>
<td>555</td>
</tr>
</tbody>
</table>

5.7 Table 5 outlines the trend in list size and unavailability. Board members will recall the introduction of discontinuities from July 2013. These were discussed in September’s board paper.

**Table 5 – Inpatient List Size and Unavailability**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>6703</td>
<td>8673</td>
<td>8489</td>
<td>7763</td>
<td>7812</td>
<td>8176</td>
<td>8081</td>
<td>7951</td>
<td>8325</td>
</tr>
<tr>
<td>Unavailability</td>
<td>1128</td>
<td>1287</td>
<td>1302</td>
<td>1264</td>
<td>1117</td>
<td>1001</td>
<td>975</td>
<td>1129</td>
<td>1098</td>
</tr>
<tr>
<td>Total Waiting List Size</td>
<td>7831</td>
<td>7980</td>
<td>7791</td>
<td>8972</td>
<td>8929</td>
<td>9177</td>
<td>9057</td>
<td>9080</td>
<td>9423</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>14.4%</td>
<td>16.2%</td>
<td>16.7%</td>
<td>13.4%</td>
<td>12.5%</td>
<td>10.9%</td>
<td>10.8%</td>
<td>12.4%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>
5.8 Table 6 outlines the patient choice codes active at the end of December. This has risen on previous month as discussions and training on the application of these codes has progressed.

5.9 Board members will recall that it has been reported previously that these codes were being underused. As they remain at a low level, further increases in the application of this code are anticipated.

Table 6 - "Patient Choice" Unavailability - Inpatients

<table>
<thead>
<tr>
<th>Patient Advised - requests specific consultant</th>
<th>Patient Advised - requests specific location</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>RHSC</td>
<td>13</td>
</tr>
<tr>
<td>Ear Nose and Throat</td>
<td>RIE</td>
<td>13</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>SJH</td>
<td>4</td>
</tr>
<tr>
<td>Gynaecology</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Urology</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

6. Outpatients

Figure 2 – Trend in Outpatients over 12 weeks

6.1 The number of outpatients waiting over 12 weeks at the end of December was 4,039, improvements in urology and colorectal surgery in particular contributing to a reduction in those waiting more that 12 weeks since the last board report.
6.2 As described in “Delivering for Patients”, this position is expected to improve month on month until March 2015.

| Table 7 – Trend in Outpatients over 12 weeks – Key Specialties |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Ophthalmology   | 299     | 161    | 199    | 363    | 693    | 1106   | 905    | 704    | 552    | 650    |
| Rheumatology    | 193     | 215    | 303    | 365    | 417    | 687    | 664    | 701    | 631    | 650    |
| Colorectal & General Surgery | 844 | 493    | 592    | 511    | 754    | 651    | 492    | 531    | 443    | 355    |
| Gastroenterology | 856     | 111    | 137    | 135    | 187    | 394    | 512    | 445    | 465    | 438    |
| Urology         | 1454    | 528    | 490    | 359    | 324    | 381    | 405    | 365    | 260    | 223    |
| Others          | 852     | 743    | 1026   | 795    | 1100   | 1642   | 1682   | 1598   | 1623   | 1656   |
| Total > 12 weeks | 4118    | 2241   | 2747   | 2614   | 3675   | 4683   | 4661   | 4335   | 4094   | 4039   |

6.3 The majority of the “Others” category is accounted for by those waiting over 12 weeks in Clinical Neurosciences (397), the Dental Institute (390), Vascular Surgery (197), ENT (156) and Pain Management (116).

6.4 Table 8 outlines list size and unavailability for outpatients over recent months while Table 9 shows the level of patient choice unavailability being applied to outpatient waits currently.

<table>
<thead>
<tr>
<th>Table 8 - Outpatient List Size and Unavailability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
</tr>
<tr>
<td>Unavailable</td>
</tr>
<tr>
<td>Total Waiting List Size</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 9 – “Patient Choice” Unavailability in Outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
</tr>
<tr>
<td>Patient Advised - requests specific location</td>
</tr>
</tbody>
</table>

7 Diagnostics

7.1 Loss of capacity, primarily due to leave around the festive period, impacted on performance against the diagnostic standard of six weeks with 85 endoscopy patients and 1 radiology patient exceeding this timescale at the end of the month.

7.2 The tables below show the breakdown on waits in both areas by diagnostic test. The increase in waits beyond 4 weeks can also be seen. Improvements in both measures are evident in provisional information available for January.
8 Surveillance Endoscopy

8.1 The number of patients waiting beyond their planned review date is outlined in the Table 12, showing the improving pattern since April.

8.2 The position is anticipated to continue to improve with specific focus being placed on improving patient attendance in cystoscopy, which is reducing the number of patients that are being seen within a session.

Table 12 – Surveillance and Review Patients overdue appointment

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Endoscopy</td>
<td>235</td>
<td>204</td>
<td>167</td>
<td>150</td>
<td>131</td>
<td>107</td>
<td>104</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>Lower Endoscopy (other than colonoscopy)</td>
<td>117</td>
<td>83</td>
<td>73</td>
<td>64</td>
<td>49</td>
<td>42</td>
<td>36</td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>1417</td>
<td>1115</td>
<td>860</td>
<td>696</td>
<td>572</td>
<td>487</td>
<td>460</td>
<td>249</td>
<td>169</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>288</td>
<td>354</td>
<td>280</td>
<td>270</td>
<td>222</td>
<td>213</td>
<td>261</td>
<td>247</td>
<td>265</td>
</tr>
<tr>
<td>Other</td>
<td>51</td>
<td>64</td>
<td>62</td>
<td>54</td>
<td>57</td>
<td>55</td>
<td>51</td>
<td>50</td>
<td>59</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2118</td>
<td>1820</td>
<td>1442</td>
<td>1213</td>
<td>1031</td>
<td>904</td>
<td>908</td>
<td>644</td>
<td>591</td>
</tr>
</tbody>
</table>

9 Audiology

9.1 An overall 18 week standard applies to audiology patients, which is also included with the 18 week figures covered earlier in the paper.

9.2 In addition to this pathway standard, audiology services are expected to also meet stage of treatment targets for assessment and for treating and hearing aid fitting.
9.3 These standards are set locally within an overall 18 week timeframe. Adult services elected to adopt 9 weeks for both elements, while paediatric services selected timeframes of 12 and 6 weeks.

9.4 Performance against these two standards for these services is shown in the tables below. The number on the list is also detailed.

9.5 Both services met the standards in November as has tended to be the case in most months during 2013/4.

<table>
<thead>
<tr>
<th>Table 13 – Adult Audiology – Performance against Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Waiting</td>
</tr>
<tr>
<td>Over Standard (9 Weeks)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fitting/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Waiting</td>
</tr>
<tr>
<td>Over Standard (9 Weeks)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 14 – Paediatric Audiology – Performance against Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Waiting</td>
</tr>
<tr>
<td>Over Standard (12 Weeks)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Waiting</td>
</tr>
<tr>
<td>Over Standard (6 Weeks)</td>
</tr>
</tbody>
</table>

10 IVF

10.1 IVF treatment is expected to be within 12 months by March 2015.

10.2 NHS Lothian is currently meeting this standard and using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland.

10.3 Planning of capacity for 2014/5 is currently underway nationally. Consideration is also being given to the increase in referrals which coincided with the change in national referral criteria.

10.4 Arrangements are also progressing for reporting arrangements on performance, compliant with requirements set out by the Human Fertilisation and Embryo Authority.

11 Psychological Therapies

11.1 The required work to provide the relevant Psychological Therapies HEAT target data for reporting to ISD has been ongoing. Unlike the CAMHS Access target which extends the treatment time guarantee to every intervention offered by CAMHS, the psychological therapies target is limited to the delivery of formal psychological therapies which are defined in “The Matrix” (Scottish Government, 2011). NHS Lothian delivers 19 of these formal evidenced based psychological therapies
11.2 Within mental health services, substance misuse, and learning disabilities services, formal psychological therapies represent one type of intervention that may be offered to patients. It has been a key task of the QUEST funded A12 Team to extract the data which relates to the formal psychological therapies from within a service's workload.

11.3 To address data quality, completeness and timeliness an incremental approach to the data development has been adopted and since November, activity information from all seventeen teams is now available for the first time.

11.4 However it is likely that some of the patients being reported by adult mental health services in Edinburgh do not fall under auspices of the target and thus is expected that the numbers featured in future reports will fall as this is addressed.

11.5 Patients waiting for assessment and treatment from East, Mid and West Lothian Adult psychology account for 44% of all patients waiting and 52% of all patients waiting over 18 weeks. These areas will be the prime focus of the non-recurring funding detailed below.

11.6 From the data, two immediate issues require to be addressed:
   - The number of people who have been waiting longer than 18 weeks;
   - The disproportionately large numbers of people waiting for higher intensity therapy on waiting lists.

11.7 A number of planned actions to address this are underway including:
   - Development of a waiting times dashboard be completed by the end of January;
   - Improved systems to ensure patients are booked in turn, including online waiting lists developed in PiMS;
   - Increased use of group therapy and more efficient delivery of group therapy (e.g. Edinburgh city wide groups instead of in each sector);
   - Implementation of reminder systems to improve non attendance for new and follow-up appointments;
   - Demand and capacity work with teams to identify additional opportunities to increase capacity within current resource.

11.8 Non-recurring funding has been made available and by the end of January it is anticipated that there will be an additional 8.00 WTE Psychological Therapists recruited. These posts are being used to augment capacity in these teams where there people have waited the longest. The additional staff will be given short term contracts for six months.

11.9 It is recommended that the impact of this additional staffing is reviewed in May 2014, by which time seven months' full data will allow a clearer view of priorities to be taken.

### Table 15 – Psychological Therapies

<table>
<thead>
<tr>
<th></th>
<th>Apr 13</th>
<th>May 13</th>
<th>Jun 13</th>
<th>Jul 13</th>
<th>Aug 13</th>
<th>Sep 13</th>
<th>Oct 13</th>
<th>Nov 13</th>
<th>Dec 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage seen within 18 weeks</td>
<td>63%</td>
<td>49%</td>
<td>65%</td>
<td>71%</td>
<td>58%</td>
<td>57%</td>
<td>65%</td>
<td>73%</td>
<td>76%</td>
</tr>
<tr>
<td>Trajectory for seen within 18 weeks</td>
<td>60%</td>
<td>60%</td>
<td>65%</td>
<td>70%</td>
<td>60%</td>
<td>70%</td>
<td>60%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Total waiting at end of month</td>
<td>820</td>
<td>858</td>
<td>974</td>
<td>979</td>
<td>1084</td>
<td>1282</td>
<td>2822</td>
<td>3640</td>
<td>2787</td>
</tr>
<tr>
<td>Those waiting more than 18 weeks</td>
<td>177</td>
<td>189</td>
<td>308</td>
<td>256</td>
<td>201</td>
<td>351</td>
<td>865</td>
<td>1137</td>
<td>985</td>
</tr>
</tbody>
</table>

* The July data for patients seen was adjusted for non-attendance in line with national guidance.
11.10 Table 15 shows performance reported against this target since April. Trajectory figures, which ended in September 2013, are to be considered by the A12 Board shortly and their completion was deferred until a full dataset is available.

12 Child and Adolescent Mental Health

12.1 The performance against the current 26 week RTT target reduced to 75% in November and 74% in December. Table 16 shows the trend in recent performance.

Table 16 – Child and Adolescent Mental Health Performance

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage seen within 26 weeks*</td>
<td>91%</td>
<td>85%</td>
<td>84%</td>
<td>89%</td>
<td>86%</td>
<td>86%</td>
<td>82%</td>
<td>75%</td>
<td>74%</td>
</tr>
<tr>
<td>Percentage seen within 18 weeks</td>
<td>84%</td>
<td>73%</td>
<td>76%</td>
<td>87%</td>
<td>72%</td>
<td>76%</td>
<td>76%</td>
<td>65%</td>
<td>66%</td>
</tr>
<tr>
<td>Trajectory seen within 18 weeks</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Total waiting at end of month</td>
<td>1136</td>
<td>1159</td>
<td>1134</td>
<td>1170</td>
<td>1095</td>
<td>1168</td>
<td>1211</td>
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<tr>
<td>Those waiting more than 26 weeks</td>
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<td>88</td>
<td>53</td>
<td>102</td>
<td>109</td>
<td>151</td>
<td>152</td>
<td>139</td>
<td>198</td>
</tr>
<tr>
<td>Those waiting more than 18 weeks</td>
<td>223</td>
<td>264</td>
<td>202</td>
<td>259</td>
<td>240</td>
<td>283</td>
<td>306</td>
<td>253</td>
<td>313</td>
</tr>
</tbody>
</table>

Data for patients seen was adjusted for non-attendance in line with national guidance.

12.2 The service has recruited additional staff on fixed term contracts and has increased the number of patients starting treatment each month. However, there continues to be pressures through a continued increase in referrals to the service.

12.3 The QUEST funded A12 team have been working with the clinical services on a number of service improvement strands including:

- Cleansing of data to ensure accurate wait times information
- Introduction of standard operating procedures for ensuring data quality and improved data completeness
- Agreement of standard operating procedures to ensure consistent and efficient management of services’ waiting lists.
- Development of a monthly CAMHS waiting times dashboard
- Planned implementation of the Remind+ telephone and text reminder system to reduce non-attendance

12.4 In addition, the Choice and Partnership Approach model (CAPA) which is designed to improve services’ capacity and patient flow will be fully implemented across these services in Lothian.

12.5 Further capacity will be released through the transfer of care arrangements for a number of children with ADHD being seen by CAMHS. Approximately 20% of the total number of children with ADHD being cared for CAMHS can be transferred back to GP care as their clinical condition is stable.

12.6 However, it is recognized that there is an ongoing gap between the current service capacity and the rising demand. This is currently being considered as part of the 2014-15 financial planning prioritisation process.

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22 January 2014
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DELIVERING FOR PATIENTS

The key points of the paper are summarised here.

Delivering for Patients is attached as Appendix 1.

<table>
<thead>
<tr>
<th>“Delivering for Patients” sets out NHS Lothian’s approach to how it will once more deliver on its access commitment to patients</th>
<th>3.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>It outlines that no eligible patient will be waiting beyond the treatment time guarantee at the end of December 2014</td>
<td>3.2</td>
</tr>
<tr>
<td>It states that on 31 March 2015, no patient covered by the outpatient standard will be waiting over 12 weeks.</td>
<td>3.2</td>
</tr>
<tr>
<td>The resources required to support delivering this commitment are set out with £17.4M in 2014/5 to £20.0M in 2016/7, with the reliance on external providers reducing over this time.</td>
<td>3.3</td>
</tr>
<tr>
<td>That Delivering for Patients was developed in the context of NHS Lothian’s Strategic Plan to ensure safe, effective patient centred care</td>
<td>3.5</td>
</tr>
</tbody>
</table>

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27 January 2014
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DELIVERING FOR PATIENTS

1 Purpose of the Report

1.1 The purpose of this report is to ask the Board to consider “Delivering for Patients” which sets out the NHS Lothian’s approach to fulfil its access commitments to patients.

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

2 Recommendations

2.1 Consider “Delivering for Patients”, supporting the approach described and the underlying principles;

2.2 Recognise that approach is based on significant and complex analysis which has evolved in a relatively short period of time;

2.3 Note the timescales outlined for the recovery of the Treatment Time Guarantee and outpatient standards;

2.4 Note the investment schedule laid out from 2014/5 to 2016/7.

3 Delivering for Patients

3.1 Delivering for Patients sets out how NHS Lothian will deliver once more on its access commitment to patients. It is attached as Appendix 1.

3.2 It outlines the timescale for achieving this with;

- No eligible patient will be waiting beyond the treatment time guarantee at the end of December 2014;

- On 31 March 2015, no patient covered by the outpatient standard will be waiting over 12 weeks.

3.3 The resources required to support delivering this commitment are set out with £17.4M in 2014/5 to £20.0M in 2016/7, with the reliance on external providers reducing over this time.

3.4 The principles that underpin the way in which this will be progressed and how performance is to be managed are also articulated.
3.5 The approach described was developed in the context of NHS Lothian’s Strategic Plan to ensure safe, effective patient centred care

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List of Appendices:

Appendix 1: Delivering for Patients
Delivering for Patients

NHS Lothian's Commitment to meet and sustain the Treatment Time Guarantee and Outpatient Standards

January 2014
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Key Summary
This paper outlines the principles to be followed in recovering NHS Lothian’s Waiting Time position and was developed in the context of NHS Lothian’s Strategic Plan.

It outlines that:

- Patients are central;
- Effective decision making is underpinned by analysis;
- Performance is robustly managed, effective and efficient.
- Responsibilities are clear to all;
- Compliance with National Requirements and Standards is absolute;
- A culture of delivery, honesty and quality prevails;
- Transparency of process and measurement is total,
- Whole system approach ensuring calibration of Acute, Scheduled & unscheduled flow, role of consultants and of Primary Care, responsibilities of local authorities

It indicates that putting them into practice means that:

- The dependency on the independent sector should end;
- “Headroom” needs to be introduced into waiting times to provide flexibility;
- Elective work should occur over 7 days to make better use of facilities;
- Where hospital care is required, daycase treatment and outpatients are the norm, with preadmission minimised in other situations.

Recovery Profiles are provided with an illustration of the approach being adopted across key specialties. These state that:

- No eligible patient will be waiting beyond the treatment time guarantee at the end of December 2014;
- On 31st March 2015, no patient covered by the outpatient standard will be waiting over 12 weeks

The supporting financial work is also described.

Separate consideration is currently being given to other areas where patients are waiting unduly, such as in psychological therapies and child and adolescent mental health.
1 Delivering Waiting Times for Patients

1.1 Principles for Delivery
NHS Lothian is not delivering on its access commitments to patients.

Patients are waiting beyond the waiting time standards agreed with the Government and set out by Parliament. Moreover this is not limited to areas of high complexity but is occurring in some instances where capacity for these patients to be seen could be available.

This position must be recovered.

This paper outlines that approach to ensure that NHS Lothian makes good on its commitment and for the confidence patients place in the service to be justified.

It is based on the following principles:

- Patients are central;
- Effective decision making is underpinned by analysis;
- Performance is robustly managed, effective and efficient.
- Responsibilities are clear to all;
- Compliance with National Requirements and Standards is absolute;
- A culture of delivery, honesty and quality prevails;
- Transparency of process and measurement is total,
- Whole system planning;

1.2 NHS Lothian’s Strategic Plan
The approach described has been taken forward in the context of the strategic plan under development.

The strategic plan sets out the short, medium and longer term actions to reliably and efficiently deliver care.

The configuration of services will be considered as part of the plan. Some of the sites and buildings used now are not fit for purpose. The plan will address this by considering how best to meet future demand effectively.

When determining these actions, the plan will also take account of anticipated population and technological changes as well as the best contemporary models of patient care.
2 Principles for Sustainable Delivery

2.1 Patients are at the Centre
Delivery of safe, effective patient centred care is paramount. Its importance is recognised by both staff and patients and a foundation to both the Government’s 2020 vision and NHS Lothian’s strategic clinical framework.

The Government has also recognised the commitment in law through the creation of the Patients Rights Act. This places a duty on Health Boards to treat patients within 12 weeks by establishing a “treatment time guarantee”, which should be met taking account of any additional needs of the patient.

2.2 Effective decision making is underpinned by analysis
Good decision making is dependent on good information.

Clinical Management Teams therefore require ready access to such information with support from Analytical Services.

Good, shared and consistent information also supports performance management processes.

2.3 Performance is robustly managed, effective and efficient
With comprehensive information available, clear plans can be outlined and supported by explicit assumptions.

This level of detail allows progress against plan to be closely assessed with any deviation quickly identified.

Comprehensive information also helps to pinpoint what may be the underlying cause of the variance and for potential remedies to be scoped.

Such a performance management framework also focuses on ensuring efficient and effective delivery.

2.4 Responsibilities are clear to all
Treatment and care involves many people.

All involved – patients, staff and the Board – need to be clear on their own responsibilities and what to expect from others.

NHS Lothian must:

- Outline its approach to waiting times through its Access Policy;
- Produce standard operating procedures reflecting national guidance and the policy;
- Train staff to use them effectively and monitor use;
- Provide comprehensive reports to fulfil governance duties;
• Ensure that core capacity is in place to deliver waiting times effectively and sustainably.

Staff must:

• Provide safe and effective care for patients, acknowledging any additional needs;
• Support clinical pathways across primary and secondary care;
• Undertake duties in line with procedures and training provided.

Patients and Public must:

• Ensure that their GP and NHS Lothian are aware of changes in circumstances;
• Rapidly respond as requested to NHS communications;
• Attend agreed appointments.

2.5 Compliance with National Requirements and Standards is absolute
Local practice must reflect national requirements if NHS Lothian is to fulfil its role as a public service.

No effort can be spared in meeting standards set out by the Government.

2.6 A Culture of Delivery, Honesty and Quality Prevails
Meeting the standards set by the Scottish Government is what is expected.

Where they have not been, this should be conceded. Where actions are required, this should be highlighted.

In meeting standards NHS Lothian and its staff will the embrace the values of NHS Scotland. These are quality, teamwork, care and comparison, dignity and respect, openness, honesty and responsibility.

2.7 Transparency of Process and Measurement is Total
NHS Lothian’s Access Policy has to be clear, as should the way in which it is communicated to patients. A revised version will shortly be considered by the Board.

Key elements will be:

• A 7 day turnaround time on patient communication;
• Ensuring unavailability is appropriately applied;
• Effective enforcement of patients’ responsibilities.

When patients opt not to be seen at a particular site or by an alternative clinician, unavailability can be applied. This unavailability is not being applied often in Lothian despite a proportion of patients declining treatment offered elsewhere. This means that patients are being reported as exceeding standards where this is not so.
Figure 1 shows the Lothian’s low relative level of unavailability compared to other boards.

Figure 1 - Inpatient and Daycase Unavailability by Board

Equally clear should be the standard of performance, how it has been achieved and the extent of reliance on non-core capacity.

2.8 Whole System Planning

It is essential that this ‘Scheduled Care’ strategy is seen in the context of NHS Lothian’s strategic plan and the contribution and responsibilities of their key partners. This approach must evolve to contextualise key issues including:

- Provision of effective Local Authority ‘care’ capacity to support patient flow. Referencing the significant planning work with Edinburgh City Council but flagging ‘lag time’;
- Bed modelling and options to ensure availability of core capacity. This may include proposals on clinical configuration/hot and cold sites;
- Impact on 4 hour target for unscheduled care
3 Applying the Principles

3.1 Putting Principles into Practice
To meet the principles outlined, NHS Lothian has to deliver its waiting time standards routinely in core capacity.

This means that:

- The dependency on the independent sector should end;
- “Headroom” needs to be introduced into waiting times to provide flexibility;
- Elective work should occur over 7 days to make better use of facilities;
- Where hospital care is required, daycase treatment and outpatients are the norm, with preadmission minimised in other situations;
- Delivery of clinical activity performance in line with benchmarks and agreed baselines

To achieve this, services must be able to match demand and capacity and do so efficiently. Where this is not so, the improvements and investments required must be identified along with the timescales for recovery.

Clinical Management Teams have been using such an approach to identify the necessary steps in key specialties.

3.2 Developing Capacity Requirements and Recovery Profiles.
Recently Analytical Services have taken significant strides in its role supporting services.

Services are now receiving unprecedented levels of information on trends impacting on their waiting lists.

These reports focus on subspecialty area and provide an understanding of:

- Trends in waiting list size;
- Additions to and Removals from the list;
- Patient unavailability;
- Reliance on external support;
- The shape of the waiting list; and
- The order in which patients are booked.

Used alongside job planning and benchmarking information, these new reports enable capacity requirements and recovery profiles to be produced.
4 Applying the Approach

How the approach has been applied is shown in three specialties in this section.

Planning has been undertaken either at specialty or subspecialty level - as there tends to be a variety of different patients within one service requiring different support. To facilitate more detailed planning, Clinical Management Teams have been provided with this level of information as standard.

The following diagrams illustrate the benefit of this. At an aggregate level, the size of the urology outpatient list can be seen as reducing week by week over the last 15 months (Figure 2). Normally one would expect a reduction in list size to be accompanied by a reduction in those exceeding standard. Yet this has not occurred.

Figure 3, where the different scale should be noted on the vertical axis, allows the reasons behind this to be understood. The subspecialty shown here, Joint Incontinence, has limited capacity options and accordingly the waiting time position has shown little improvement over recent months.

While some inroads have been made by assessing options for individual patients, causing some reduction to be observed, the granularity of the data shown allows it to be understood that until a specific answer is identified, waits will continue to be reported in this subspecialty.
4.1 Hand Surgery in Plastics
The DCAQ exercise in plastic surgery identified hand surgery as the area in most of need of support.

4.1.1 Determining Demand

Figure 4 - Outpatient Referrals for Hands in Plastic Surgery
Demand for hand operations was assessed across that 7 outpatient queues over the last 3 years. Growth in referrals was evident until 2012, from which point it has stabilised. This is shown in Figure 4. It was decided to base demand requirements on this stable period but to recognise the importance of continuing to monitor demand given previous growth.

4.1.2 Determining Capacity
Assessment of job plans for the plastic surgeons involved in hand surgery identified sufficient capacity for 1167 operations annually. Yet the capacity requirements, calculated based on the level of referrals in the year to September 2013, outstripped this by almost 50%. The 1739 total procedures required on average, over a 42 week year, an additional 3.8 theatre sessions weekly.

Hand surgery patients currently rarely wait more than 12 weeks for their treatment guarantee. The shortfall in capacity is currently supported through the independent sector. The extent of this can be seen in Figure 5, where the orange blocks represent operations not provided by NHS Lothian. Just under 50% of these were hand operations.

Resolving this capacity shortfall is necessary if dependency on this external support is to be addressed.

4.1.3 Accounting for Improvements
One element of hand surgery, those involving injections, has been able to be moved out of theatre into the newly opened Hooper Hand Unit. This will allow them to be treated in clinic setting.

This change has freed up one theatre session available to offset the required increases
4.1.4 Identifying Investments
The DCAQ exercise identified an overall shortfall of 9.95 theatre sessions per week across all of plastic surgery. As Figure 6 shows hand surgery accounting for the largest proportion, then skin and laser procedures.

Figure 6 – Demand v Capacity - Theatre Sessions - Plastic Surgery

This overall shortfall in theatre sessions taking together with the 6 sessions identified for outpatient support, where again hand surgery was the biggest factor, equates to the workload of 3 consultant surgeons.

The clinical activity associated with these posts also increases theatre requirements. The additional theatre sessions required result in the need for 16.14 wte staff, 2.04 of whom are consultant anaesthetists.

Recognising this capacity shortfall has been costed at £1.86M and is incorporated in the financial figures in Table 6 on page 21.

4.2 Paediatric ENT
4.2.1 Determining Demand
Although outpatient referrals have remained fairly stable (see Figure 7), the additions to the inpatient list has risen (Figure 8).
Investigating the change, the service concluded this was a step-change in additions to the inpatient waiting list related to advances in practice, particularly in cooperation with other disciplines\(^1\).

This suggested that it was appropriate to base demand on the most recent year available and not to assume ongoing growth. This assumption is to be kept under review through the monitoring of actual additions against forecast.

### 4.2.2 Determining Capacity

While in the past year, paediatric ENT had seen 995 elective inpatient and daycase admissions, there was significant activity undertaken outside of “core capacity”. Comparing theatre records, job

\(^1\) Some of the variation in additions during 2013 is due to addressing a backlog in outpatients, considered by itself the inpatient trend could be misleading.
planning information and waiting list initiatives schedules it was possible to identify the additional capacity that had been put in place.

This amounted to 65 non-ENT lists undertaken by the service in-hours above job plan plus the equivalent of a 50 waiting list sessions. When this was taken into account, core capacity at RHSC fell 396 cases short of that required to keep waiting lists stable (ie, matching activity against additions to the list with removals not seen deducted).

<table>
<thead>
<tr>
<th>Site</th>
<th>Total Additions to IPWL</th>
<th>Removals</th>
<th>Net Additions to IPWL*</th>
<th>Core IP Capacity</th>
<th>Capacity Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHSC</td>
<td>964</td>
<td>112</td>
<td>852</td>
<td>456</td>
<td>-396</td>
</tr>
<tr>
<td>SJH</td>
<td>207</td>
<td>13</td>
<td>194</td>
<td>113</td>
<td>-81</td>
</tr>
<tr>
<td>Total</td>
<td>1171</td>
<td>125</td>
<td>1046</td>
<td>569</td>
<td>-477</td>
</tr>
</tbody>
</table>

With a throughput of 3.1 cases per session at RHSC, this equated to 128 additional lists annually, three per week on a 42 week job plan.

4.2.3 Accounting for Improvements
Assessment was made of daycase levels, length of stay, cancellations and theatre efficiency. Of the major centres, RHSC had the highest daycase rate and its length of stay was one of the lowest of peer group assessed by Civil Eyes (1.3 days).

Despite concluding that it may be possible to improve further in these aspects, focusing on theatre utilisation and cancellation rates were viewed as offering greater potential.

Lothian has agreed a combined standard of 88% utilisation but to date in paediatric ENT it is 86%, linked to on the day cancellations.

This is an area where Lothian fared poorly compared to peers (6.1% cancellation against a median of 4.5%). Raising utilisation to the required standard in theatre reduced the shortfall in capacity by 0.2 sessions per week.

Improving theatre utilisation was therefore identified as an action within the service’s improvement plan and one element of this, a telephone reminder inpatient service, has now commenced at RHSC to pre-empt potential last minute cancellations and to refill this vacant theatre capacity.

4.2.4 Identifying Investment
Coupled with similar analyses of outpatient areas and daycase activity at St Johns, the requirement of 1.1 Consultants was calculated. This is included in the costs set out for the specialty in Table 6.

4.3 Ophthalmology Cataract Clinics
Ophthalmology is a specialty facing significant challenges. The impact of an aging population is exacerbated by the need for many conditions to be managed on a long term basis.

Putting the necessary capacity in place to manage those requiring ongoing contact with the service is a key aim. To do this, an understanding of the demand for these long term arrangements is necessary. This is being worked on currently.
Requirements to accommodate new referrals for cataract surgery in clinic have however been undertaken.

4.3.1 Determining Demand
Figure 9 shows the pattern of cataract outpatient demand over the last 3 years (displayed as the solid line). Despite a stable position initially, the number of referrals has grown in the most recent year with 2013 volumes 22% higher than 2012 levels.

![Figure 9- Cataract Outpatient Subspecialty Queue (Eye Pavilion)](image)

Considering the variation in referral patterns and the recent rise, required capacity has been set marginal above the 2013 level of demand at 5700 patients annually. As with other areas, it will be necessary to keep this under review.

4.3.2 Determined Capacity
Assessment of clinic schedules, alongside consultant working patterns, identified 3609 appointment slots to see the patients. This leaves a shortfall of 2091.

In terms of new outpatient capacity, cataract provision is the one identified with most need of support. The key deficits highlighted in the DCAQ exercise are highlighted in Figure 10.

---

*The increased use of external capacity to accommodate cataract patients is also evident in this figure. As is the reduced capacity directed towards cataracts as clinically prioritised review patients are accommodated.*
4.3.3 Accounting for Improvements
Assessment of the activity in clinics at the eye pavilion identified that redesigning the flow in the department should increase the number of new patients seen in a clinic.

A lean event is shortly to occur to progress this but the aim is increase the capacity from the current level of 12 patients to 15.

Over the year this will generate potential for a further 756 patients to be seen annually and reduces the number of additional clinics which need to be established.

4.3.4 Identifying Investments
The establishment of 2 additional weekly clinics is sufficient to bridge the remaining capacity gap for new cataract outpatient and forms one element of the costs, alongside operating capacity for their subsequent treatment, detailed for ophthalmology in Table 6 on page 21.
5 Recovery Profiles

5.1 Anticipated Position against Waiting Time Standards

Table 3 and Table 4 below outline the end of month performance against standards for treatment time guarantee and outpatient areas.

Routinely meeting waiting times also requires contingency headroom. There is some evidence to support the view that a 12 week standard cannot be delivered routinely if there is little or no room for contingency. Services need to be in a position when unpredictable, but not infrequent, events do not prevent compliance.

This strategy paper should be seen in the context of phase 2 of NHS Lothian’s approach.

In this second phase the capacity to meet the 12 week TTG target and a maximum wait for OP of 12 weeks will be delivered. This position will remain fragile and therefore the need for further work to support contingency capacity and delivery remains extant.

A further number of phases will evolve throughout 2014/15, these can be summarised at this point as;

• Phase III; consideration to reduce stage of treatment targets internally to below 12 weeks to offer some contingency time to sustain National Max standard

• Phase IIIa; evidenced Unscheduled Care proposals that reduce inroads to Scheduled Care capacity & infrastructure

The tables also include an estimate of the impact of the change in the calculation of waiting time which take effect when the local patient administration system is upgraded in the coming weeks.

5.2 Adjustment to Trajectories to account for System Upgrade

Board members were advised in early 2013 of a need to modify and upgrade NHS Lothian’s patient management system to take full account of national guidance.

The upgrade is scheduled to occur in Lothian in March, in tandem with changes being undertaken concurrently in other Health Boards as highlighted in Audit Scotland’s report in December.

Analytical advances have recently enabled this impact to be quantified and are factored into the Table 3 and Table 4 below.
<table>
<thead>
<tr>
<th>Table 2 – TTG Recovery Trajectories – Numbers outstanding at Month End</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTG</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Plastics</td>
</tr>
<tr>
<td>OMFs</td>
</tr>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>Colorectal/General</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Paed ENT</td>
</tr>
<tr>
<td>Paed Plastic</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td>Total**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3 – Outpatient Recovery Trajectories – Numbers outstanding at Month End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Rheumatology</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Colorectal</td>
</tr>
<tr>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Dermatology</td>
</tr>
<tr>
<td>Orthopaedics</td>
</tr>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>Sleep</td>
</tr>
<tr>
<td>Vascular</td>
</tr>
<tr>
<td>Plastics</td>
</tr>
<tr>
<td>Pain</td>
</tr>
<tr>
<td>Dental Institute</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td>Total*</td>
</tr>
</tbody>
</table>

* Total rows in tables include impact of change in waiting time calculation which will occur with system upgrade.
6 Implementation

6.1 Programme and Priority Leadership Group
The Director of Scheduled Care is establishing the Programme and Priority Leadership Group to ensure the delivery of the national waiting standards in Lothian.

The group will oversee the progress of the Clinical Management Teams, review and manage performance and manage the risks inherent in the work.

6.2 Managing Risk in Process
A new approach can introduce new risks.

The key risks identified in this work is summarised in the table alongside mitigating actions.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of core capacity may be poor</td>
<td>Detailed job planning information to be available electronically by the Summer. Utilisation of key capacity such as Theatres and outpatients is developing and will be a key component of ongoing performance framework</td>
</tr>
<tr>
<td>Variation in demand and capacity poorly understood leading to erroneous projections</td>
<td>Develop prospective element in Analytical Services reports which recognises seasonality</td>
</tr>
<tr>
<td>Modelling will not account for complexity in the waiting list</td>
<td>Analysis undertaken at the lowest practical level, based on procedural and queue information</td>
</tr>
<tr>
<td>Assumptions over demand and activity may be understated</td>
<td>Advanced DCAQ process deployed and managed as part of performance management framework</td>
</tr>
<tr>
<td>Necessary improvements identified are not progressed</td>
<td>Monitored through performance management framework and through implementation group</td>
</tr>
<tr>
<td>Investment decisions may not yield expected activity in planned timescales</td>
<td>Investment timescales to be kept under review against plan. Resulting activity to be monitored against plan.</td>
</tr>
<tr>
<td>Recording of information and choice codes not acted upon</td>
<td>Reinforce through governance framework</td>
</tr>
<tr>
<td>System changes impacting on clock calculations</td>
<td>12 week reset impact levied on projection figures following analytical review</td>
</tr>
<tr>
<td>Timescales have initially determined a top down approach that may persist.</td>
<td>Intensive involvement with clinical teams coupled performance management process to address</td>
</tr>
<tr>
<td>Absence of headroom in waits means unpredictable events can cause patients to wait longer than waiting time standards.</td>
<td>Discussion over Headroom to occur in 2014/5</td>
</tr>
<tr>
<td>Capital Build Programme at RIE Service disruption and capacity reductions may occur during this significant redevelopment programme</td>
<td>Implement effective project and programme control to identify risks and establish capacity contingencies</td>
</tr>
</tbody>
</table>
7 Finance

7.1 Background
Recurring investment of £15M to increase NHS capacity has been agreed to date (including £9M investment in 2013/14 Financial Plan and release of recurring Waiting Times reserves).

The expenditure includes a number of areas where there has been an ongoing requirement across a number of years (e.g. use of Golden Jubilee).

Recurring investment to date has been based on analysis undertaken in 2012/13 against specialties highlighted as high risk in March 2012. It is expected that the majority of this investment will have been fully implemented by April 2014 and the proposals presented below have been prepared based on the updated baseline capacity after investment in 2013/14.

7.2 Resource Requirements - Revenue
Total Revenue requirements of £17.4M are outlined in 2014/15, including provision for continued use of external provider capacity (at a reduced level) to manage the phased implementation of proposed investments.

Table 5 - Investment Requirements

<table>
<thead>
<tr>
<th>REVENUE</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
<td>1,153,584</td>
<td>2,077,810</td>
<td>2,187,168</td>
</tr>
<tr>
<td>PLASTIC SURGERY</td>
<td>927,627</td>
<td>1,762,491</td>
<td>1,855,254</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>1,371,512</td>
<td>2,154,053</td>
<td>2,267,424</td>
</tr>
<tr>
<td>ORAL AND MAXILLOFACIAL SURGERY</td>
<td>203,945</td>
<td>387,496</td>
<td>407,890</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>462,938</td>
<td>617,251</td>
<td>617,251</td>
</tr>
<tr>
<td>ENDOCRYSTOSCOPY</td>
<td>733,730</td>
<td>733,730</td>
<td>733,730</td>
</tr>
<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
<td>1,360,471</td>
<td>2,584,895</td>
<td>2,720,942</td>
</tr>
<tr>
<td>PAEDIATRICS - ORTHOPAEDICS</td>
<td>25,500</td>
<td>48,450</td>
<td>51,000</td>
</tr>
<tr>
<td>PAEDIATRICS - ENT</td>
<td>96,500</td>
<td>183,350</td>
<td>193,000</td>
</tr>
<tr>
<td>RHEUMATOLOGY</td>
<td>94,255</td>
<td>179,084</td>
<td>188,509</td>
</tr>
<tr>
<td>CRITICAL CARE</td>
<td>366,500</td>
<td>696,350</td>
<td>733,000</td>
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<tr>
<td>THEATRES INFRASTRUCTURE</td>
<td>376,298</td>
<td>714,965</td>
<td>752,595</td>
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<tr>
<td>DIAGNOSTICS &amp; SUPPORT SERVICES</td>
<td>1,233,581</td>
<td>1,563,384</td>
<td>2,319,750</td>
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<tr>
<td></td>
<td>8,406,440</td>
<td>13,703,308</td>
<td>15,027,513</td>
</tr>
<tr>
<td>EXTERNAL PROVIDER CAPACITY</td>
<td>9,000,000</td>
<td>7,000,000</td>
<td>5,000,000</td>
</tr>
<tr>
<td></td>
<td>17,406,440</td>
<td>20,703,308</td>
<td>20,027,513</td>
</tr>
</tbody>
</table>

The planned level of investment in 2014/15 presents a significant challenge to NHS Lothian’s Financial Plan, which includes further commitments to support major investment programmes in relation to Unscheduled Care. The overall financing of the plan requires NHS Lothian to deliver an estimated £37m of recurring cash releasing savings and investment plans are therefore directly linked to a requirement for increased efficiency and to demonstrate best value use of available resources.
7.3 Resource Requirements - Capital

The development of infrastructure to support planned increases to capacity within existing NHS facilities in Lothian will require capital investment in both facilities and equipment. Availability of (capital) resources will therefore be a key requirement to ensure the sustained delivery of the overall plan.

The capital investment requirements noted above are focussed on immediate requirements to provide expanded capacity on existing sites; a provisional assessment of existing facilities has highlighted areas to be reviewed as part of the developing NHS Lothian site master planning and 10 year Property & Asset Management Investment Programme. These include the following significant capital requirements:

- Repatriation of Independent Sector Orthopaedic activity within RIE
- Reprovision of existing Eye Pavilion
- Redevelopment of Lauriston Campus
- Development of purpose built facilities for Diagnostic Outpatient and Day Surgery treatment

Short/medium term priorities highlighted in specialty plans include proposals for the development of additional theatre and critical care capacity across Acute sites within Lothian. Effective scheduling of these works will require coordination with other infrastructure development in relation to unscheduled care and the RHSC/DCN project.

Expenditure requirements are based on initial estimates and will be reviewed as part of the NHS Lothian capital investment programme.

Capacity expenditure anticipated during 2014/15 is outlined below.

Table 6- 2014/5 Capital Requirements

<table>
<thead>
<tr>
<th>CAPITAL</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPHTHALMOLOGY</td>
<td>508,500</td>
</tr>
<tr>
<td>THEATRE 7, WGH</td>
<td>497,000</td>
</tr>
<tr>
<td>PAEP - THEATRE UPGRADE/CLEAN ROOM DEVT.</td>
<td>560,000</td>
</tr>
<tr>
<td>THEATRE TRAYS/INSTRUMENTATION</td>
<td>378,000</td>
</tr>
<tr>
<td>HDU, WGH (WARD 58)</td>
<td>885,104</td>
</tr>
<tr>
<td></td>
<td><strong>2,828,604</strong></td>
</tr>
</tbody>
</table>

7.4 Phasing of Investments

Investment phasing is key to the delivery of recovery trajectories and maintenance of sustainable balance thereafter; this will be influenced by availability of workforce, recruitment timescales, agreement of infrastructure developments and scheduling of works, available capacity with external providers.
The revenue investments noted above have been phased based on a high level of assessment of recruitment timescales. Further work is required to develop implementation plans that align recruitment with the development of infrastructure (both capital and revenue).

7.5 **Use of External Support**

7.5.1 **External Contractors**
Investment plans are predicated on the goal of achieving a sustainable internal NHS Lothian service to meet ongoing demand, however there are areas where this will not be possible in 2014/15 and a degree of reliance on the independent sector will continue.

The agreement of phasing plans for implementation of the additional capacity requirements outlined above will determine the requirement for use of external capacity. A general provision of £9M has been made for additional capacity to support delivery of targets including TTG during the implementation phase. This general provision represents a 50% reduction with non-NHS providers against the level of spend forecast in 2013/14. Any further requirement will be managed against slippage on the investment plan.

7.5.2 **Other Parts of the NHS**
NHS Lothian has made use of capacity elsewhere in NHS Scotland to shorten waiting times for patients. Using capacity available elsewhere in NHS is set to continue with the implementation of the proposed regional endoscopy unit.

Particular use has been made of the Golden Jubilee National Hospital over the past few years essentially for Orthopaedics with Ophthalmology and Plastics being added to planned capacity.

Robust use of this facility consistently has not been evidenced. Over the past two months more effective streaming of patients to this NHS hospital in Clydebank has been introduced. In 2014/15 further increased use of this NHS resource is proposed.

Negotiations on access levels will be completed by the end of February.

7.6 **Efficient Use of Resources**
The NHS Lothian Financial Plan for 2014/15 requires cash releasing savings of 3% to support the overall board expenditure plans.

In order to ensure that the revised baseline capacity is utilised effectively, each specialty will be expected to manage performance against a portfolio of key performance indicators which will support delivery of best value against core resources.

Management of theatre utilisation, patient booking and scheduling, implementation of enhanced recovery and improved day case rates will form part of the suite of performance measures to ensure the full service capacity is utilised. Each specialty capacity plan includes an improvement plan outlining actions to maximise utilisation in these and other relevant areas.

Efficiency & Productivity gain forms an important element of the improvement actions required to deliver sustainable capacity plans. However this will not contribute to the 3% requirement except where it can be delivered to generate real cash releasing savings or a reduction in overall investment.
8 Delivering for Patients

What does this strategic approach offer that will ensure success?

It is essential that this ‘recovery’ strategy allows NHS Lothian to deliver and sustain the access standards that are required.

The strategic approach outlined will ensure a number of components that will support effective progress toward compliance. These include:

- Informed decisions on capacity requirements based on robust analytical profiling;
- Newly established Performance Framework to maximise utilisation of current assets and ensure developments are implemented and focus on areas of need;
- Effective management structure;
- Leadership focus to deliver;
- Clarity of roles & responsibilities;
  - Strong collaboration with Unscheduled Care;
- Clinical engagement and collaboration.
9 Conclusion

This paper is the result of significant and complex analysis and planning.

Whilst its detail has evolved in a relatively short period of time, the conclusions and resultant deficits are from a foundation of science and validated data review.

The strategy describes how NHS Lothian will deliver once more on its access commitment to patients.

It sets out the timescale for achieving this with;

- No eligible patient will be waiting beyond the treatment time guarantee at the end of December 2014;
- On 31\textsuperscript{st} March 2015, no patient covered by the outpatient standard will be waiting over 12 weeks.

The resources required to support delivering this commitment are set out, as are the principles that underpin the way in which this will be progressed and how performance is to be managed.

The approach described was developed in the context of NHS Lothian’s Strategic Plan to ensure safe, effective patient centred care.
SUMMARY PAPER - QUALITY REPORT

This paper summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

| Para |
|------|----------------|
| 3.1.1 | • Responding to complaints within 20 days remains a challenge with 63% of the 186 complaints in October 2013 achieving a 20 day response. This is in part due to increasing numbers of complaints from Prison Services (Graph 1). |
| 3.1.2 | • Patients who are ready for discharge continue to wait longer than 2 weeks (target to be achieved by April 2015) with a number of patients waiting over 4 weeks (Graph 4). Compliance with A&E 4 Hour Waiting Times target also remains a challenge (Graph 15). Actions to address this current situation are set out in the Unscheduled Care Report under item 2.1 of the February Board agenda. |
| 3.1.3 | • Achieving the HEAT target for C.Difficile and *Staph. aureus bacteraemias* infection remains a challenge (see Graphs 10 & 11). Actions to address this are set out in the HAI paper on the Board agenda under item 1.4. |
| 3.1.4 | • Stroke targets compliance – although there has been an improvement as a result of actions taken to address compliance, there remains a challenge for admissions into the stroke unit (Graph 17) and swallow screens (Graph 18). |
| 3.2 | • Patient Experience data is being reported for the first time in the Quality Report and it is recommended that a formal report goes to the Board in April on the implementation of the Person-Centred Programme as this has been identified by the Board as requiring further consideration. |
| 3.3.2 | • A prioritised self-assessment plan against Healthcare Improvement Scotland Lanarkshire Rapid Review is set out for agreement by the Board and includes priorities plus methodological approach. |

Simon Mackenzie
Medical Director Quality Improvement
20 January 2014
Simon.Mackenzie@nhslothian.scot.nhs.uk
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for January 2014, to provide assurance on the quality of care NHS Lothian provides.

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

2 Recommendations

2.1 Review the quality dashboard and exception reporting to inform assurance requirements, (context and technical appendix are set out in Appendix 1).

2.2 Review the results on the two questions, agreed by the Board in November 2013, that will be used in the Quality Report to provide assurance on patient experience.

2.3 Agree the proposal that a dedicated paper/presentation on NHS Lothian’s implementation of the National Person-Centred Programme goes to the April 2014 Board.


3 Discussion of Key Issues

3.1 Exception Reporting

3.1.1 Responding to complaints within 20 days remains a challenge with 63% of the 186 complaints in October 2013 achieving a 20 day response. This is in part due to increasing numbers of complaints from Prison Services (Graph 1).

3.1.2 Patients who are ready for discharge continue to wait longer than 2 weeks (target to be achieved by April 2015) with a number of patients waiting over 4 weeks (Graph 4). Compliance with A&E 4 Hour Waiting Times target also remains a challenge (Graph 15). Actions to address this current situation are set out in the Unscheduled Care Report under item 2.1 of the February Board agenda.

3.1.3 Achieving the HEAT target for C.Difficile and Staph. aureus bacteraemia remains a challenge (see Graphs 10 & 11). Actions to address this are set out in the HAI paper on the Board agenda under item 1.4.
3.1.4 Stroke targets compliance – although there has been an improvement as a result of actions taken to address compliance, there remains a challenge for admissions into the stroke unit (Graph 17) and swallow screens (Graph 18). Actions to address this current situation were set out in the Stroke Performance Report under item 2.6 of the November 2013 Board. Stroke care was also on the January 2014 agenda of the Healthcare Governance Committee and included a presentation from the lead clinician and manager on current compliance with standards and actions being taken to improve this.

3.1.5 New goals in the Dashboard - There is a new measurement framework for the Acute Adult Patient Safety Programme. One of the 9 Point of Care Priorities is to improve the management of the deteriorating patient. The previous goal for this workstream was a 30% reduction Cardiac/Respiratory Arrest calls compared to the baseline. This has been increased to 50% reduction. Graph 12 sets out current NHS Lothian progress on this new goal. When considering our progress against this goal on a site basis, it should be noted that St. John’s Hospital has shown a sustained reduction of 59% compared to baseline in Cardiac/Respiratory Arrests by implementing a change package based on work conducted by Salford NHS Foundation Trust which focuses on reliable identification, response and escalation of deteriorating patients at a ward level. This approach is being rolled out across the two other acute sites and recent non-recurrent 1 year funding has enabled additional resources at the end of January to continue implementation of this package and undertake local learning sessions. The deteriorating patient plan is currently being updated and forms part of the HSMR plan approved by the Board in January 2013.

3.1.6 The Quality Dashboard will be updated on a monthly basis to ensure that any Governance Committee or management group is considering the most timely data. There are also plans to have monthly site-based reports which, where appropriate, break these measures down on a site basis to inform improvement and planning. The first draft reports were issued in December for comment. It is planned to send these out monthly at the end of each month starting in February 2014.

3.2 Capturing Patient Experience

3.2.1 In November 2013 the Board agreed two system questions (on a five point scale), the results of which are to be included in the February Board 2014.

3.2.2 Eleven test teams self nominated to participate across a range of clinical areas including both primary care and acute inpatient and out-patient clinical areas. The frontline clinical staff have not been asked to undertake any additional data collection and the patients who completed the test questionnaires were supported by the Person-Centred Health & Care Team (PCH&C), this has also minimised the risk of staff/patient bias. A total of 155/6 patients were asked about their experience which included the two agreed Board questions and the results are set out below:-

- 92% of patients would rate their care as very good or excellent
- 76% of patients would feel comfortable if a family member or friend was admitted to this ward or unit if they needed similar care and treatment (strongly agree & agree).
3.2.3 The PCH&C Team are feeding back to the clinical teams about their data which covers the above along with a range of other questions derived for the National Collaborative Patient Experience Tool to inform local improvement.

3.2.4 The Board has regularly highlighted the importance of hearing and responding to the patient voice and it is suggested that a formal paper and presentation on the Person-Centred Programme be made to the April 2014 Board. This will include reporting of Patient Experience.

3.3 Board Development Day – HIS Rapid Review NHS Lanarkshire

3.3.1 A Board development day was conducted to examine the HIS Rapid Review of NHS Lanarkshire on 15th January 2014. It was agreed that a proposal would be brought to the February 2014 Board in terms of next steps. The context and review of the proposed approach is set out in Appendix 2.

3.3.2 It is proposed that NHS Lothian conducts a rapid, high-level self-assessment against all the recommendations in the Lanarkshire report, within the context of the key lines of enquiry. This will be under the overall direction of the Medical Director for Quality & Safety and will agree measures to correct any deficiencies building on existing workstreams where they exist. The initial proposal is to prioritise more detailed assessments against the following recommendations from the report which were discussed at the January 2014 Development Day:-

- Nurse staffing numbers and skill mix (recommendations 10,11,12,13,14)
- Medical staffing, particularly out of hours (recommendation 7)
- Governance and reporting of the Scottish Patient Safety Programme (recommendation 6)
- The deteriorating patient workstream of that programme (recommendation 5)
- The data available, how it is collected, validated, presented and used for improvement and for judgment (recommendation 20). This links to making and presenting to the Board a comprehensive assessment of mortality and quality concerns that exist at present within NHS Lothian.
- Improving patient experience, including mechanisms for learning from complaints and compliments to inform improvement (recommendations 3 and 4).

3.3.3 The following methodology is proposed:-

a) This is to be led by the relevant executive director and will incorporate assessment at different levels in the organization (i.e. learning from Lanarkshire and not relying on the executive view but seeking the views of those delivering the service). This may involve use of existing data, for example the views of staff given in the values work. The Medical Director for Quality Improvement, the Associate Medical Director for Patient Safety and the Clinical Governance and Risk Manager will be available to support and advise.

b) Some parts of the self-assessment relate to the functioning of the board and the governance and leadership structure. Internal assessment of this is not possible and it is proposed that an external interviewer is commissioned to conduct semi-structured telephone interviews and a report produced for the Chair.
c) The output of each assessment should include an outline of actions proposed. Where the view of the Exec Director or subsequently the Board is that immediate action is not possible then this will need to be included in the Risk Register with appropriate controls and solutions built into the Board’s Strategic Plan.
d) The assessment should be reported by 31 March 2014.

3.3.4 Actions that can take place immediately

- Timely production of discharge letters (recommendation 2). This work has been initiated by NHS Lothian Medical Director.
- A range of governance workshops to be organised for board members by the Medical Director for Quality Improvement & Safety to include learning from complaints, adverse events and patient experience as agreed at the Board Development Day.
This table shows a monthly summary of process and outcome quality measures. Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focussing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.

If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

QUALITY AMBITION

PERSON-CENTRED - Process Measures
20-day Complaints Response Rate *
3-day Complaints Response Rate *
Delayed Discharges and Average Length of Stay *

PERSON-CENTRED - Outcome Measures
Number of Complaints *
Staff Absence Levels *
Patient Experience
- Overall rate of care received at ward/unit – 92% (very good or excellent)
- I would feel comfortable if family/friend admitted to this ward/unit – 76% (strongly agree & agree)

Staff Experience

SAFE – Outcome Measures
Hospital Standardised Mortality Ratios for RIE, WGH & St. John’s *
Incidents with harm *
C. Difficile Numbers *
Staph. Aureus Bacteraemia Numbers *
Number of Cardiac/Respiratory Patients 2222 Calls *
Inpatient Falls with Harm *
Inpatient Pressure Ulcers Grade 2 or above *

EFFECTIVE – Process Measures
A&E 4 Hour Wait *
Cancer Waits 62 Days from Diagnosis to Treatment *
Admission to stroke unit on day or day after admission *
Stroke Treatment Measure: CT Scan *
Stroke Treatment Measure: Swallow Screen *

Additional Quality Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate (Per 1000 admissions)</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>23.3</td>
<td>21.1</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>45.3</td>
<td>40.6</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>49.7</td>
<td>47.4</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>115.6</td>
<td>109.4</td>
</tr>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>1.07</td>
<td>1.00</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>0.90</td>
<td>1.00</td>
</tr>
</tbody>
</table>
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.”

Title: 20-day Complaints Response Rate (Graph 1)
Numerator: Number of complaints responded to within 20 days
Denominator: Number of complaints
Goal: 85% of complaints responded to within 20 days

Process Measure

Data Source: Datix

Title: 3-day Complaints Response Rate (Graph 2)
Numerator: Number of complaints responded to within 20 days
Denominator: Number of complaints
Goal: 100% formal acknowledgement within 3 working days

Process Measure
3-Day Response Target across NHS Lothian, Monthly (Sept 2012-Oct 2013)

Data Source: Datix

Title: Number of Complaints (Graph 3)
Numerator: Total number of complaints
Goal: Reduction in number of formal complaints

Outcome Measure

Data Source: Datix

Title: Delayed Discharges & Average Length of Stay (Graph 4)
Goal: No patient waiting longer than 2 weeks for discharge, by April 2015

Process Measure
Delayed Discharge and Average LOS/days

Data Source: Local data captured on EDISON shared data with Health & Social Care

Title: Staff Absence Levels (Graph 5)
Numerator: Total staff hours lost
Denominator: Total staff hours available
Goal: 4% or less

Outcome Measure
SWISS Sickness Absence %

Data Source: Scottish Workforce Information Strategic Systems (SWISS)
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, HAIs indicators, arrest calls, falls with harm and pressure ulcers.

<table>
<thead>
<tr>
<th>Title:</th>
<th>Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Graphs 6 – 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Total number of in-hospital deaths and deaths within 30 days of discharge from hospital</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Predicted total number of deaths</td>
</tr>
<tr>
<td>Goal:</td>
<td>National goal 20% reduction against 2006/07 baseline by 2015</td>
</tr>
</tbody>
</table>

**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – June 2013

**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – June 2013

**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2013

**Title:** Incidents with harm (Graph 9)

**Numerator:** Number of incidents associated with serious harm reported per month in NHS Lothian (Dec 2011- Nov 2013)

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

**Outcome Measure**
NHS Lothian Incidents Reported with Serious Harm

**Title:** C. difficile associated disease against HEAT Target 2012-13 (Graph 10)

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

**Goal:** NHS Lothian is to achieve 254 or fewer CDI by March 2015.

**Outcome Measure**
Progress against HEAT Target for C.difficile Infection (CDI)
### Safe (cont'd)

**Title:** Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 11)

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

**Goal:** NHS Lothian is to achieve 184 or fewer SABs by March 2015

**Outcome Measure**

Progress against HEAT Target for S. aureus Bacteraemia

*Data Source: Infection Control Team*

**Outcome Measure**

Number of Cardiac & Respiratory Arrest Calls (Acute Wards) (Graph 12)

**Numerator:** Arrest – Number of 2222 calls which were for a cardiac or respiratory arrest. Calls relating to staff, visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ITU/day care procedures are excluded.

**Goal:** 50% reduction in Cardiac/Respiratory Arrest calls from February 2015, baseline within 2 years from baseline

**Outcome Measure**

Number of Pressure Ulcers per month across NHS Lothian (Graph 14)

**Numerator:** Number of Grade 2 or above pressure ulcers

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

**Outcome Measure**

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

*Data Source: Datix*
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 and stroke care.

**Title:** A&E 4 Hour Wait (Graph 15)
**Numerator:** Number of patients waiting less than 4 hours from arrival to admission
**Denominator:** Number of patients attending
**Goal:** 98% of patients waiting less than 4 hours from arrival to admission by March 2014

**Title:** Cancer Waits 62 Days from Diagnosis to Treatment (Graph 16)
**Numerator:** Number of patients waiting 62 days to treatment
**Denominator:** Number of cancer patients
**Goal:** 95% of patients from diagnosis to treatment wait no longer than 62 days

**Process Measure**

**Title:** Admission to Stroke Unit within 1 day of admission (Graph 17)
**Numerator:** Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
**Denominator:** Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
**Goal:** By March 2013 90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

**Title:** Stroke Treatment Measures (Graph 18)
**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**

Note: 2013 data is not validated and should be treated as provisional

**Data Source:** ISD

Note: 2013 data is not validated and should be treated as provisional

**Data Source:** ISD

**Data Source:** Patient Administration System (TRAK)

**Data Source:** SGHD Management Information
Effective (cont’d)

Title: Stroke Treatment Measures (Graph 19)

Numerator: Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival

Denominator: Number of patients admitted with initial diagnosis of stroke

Goal: 90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission

Process Measure

Note: 2013 data is not validated and should be treated as provisional

Data Source: ISD
4 **Key Risks**

4.1 Achieving the HAI HEAT targets and stroke targets.

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.

4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

5 **Risk Register**

5.1 Achieving HAI targets is also on the Corporate Risk Register (Risk 1076) and its risk grading has been increased to reflect that NHS Lothian is outwith HAI trajectory. Access to Acute Stroke Unit is on the University Hospital Services Risk Register – Medicine and Associated Services (Risk 2444). Compliance with stroke standards is captured in Unscheduled Care on the Corporate Risk Register. Patient Experience is also captured on the Corporate Risk Register.

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).

6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

7 **Involving People**

7.1 Not applicable.

8 **Resource Implications**

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

Appendix 1: Supporting Context and Technical Appendix
Appendix 2: Next steps following HIS Rapid Review NHS Lanarkshire
Context and Technical Appendix

Quality Report Development
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.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian’s Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

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.

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.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

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.

S.aureus Bacteraemia (SAB) rate
New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.
**C. difficile Infection (CDI) rate**

New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

**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)
Next steps following HIS Rapid Review NHS Lanarkshire

As agreed by CMT on 13th January 2014 and modified following discussion at Board Development Day 15th January 2014.

Summary: conduct a self assessment and implement measures to correct any deficiencies found whilst not creating a separate workstream and ensuring that account is taken of the new SPSP objectives and driver diagram and known concerns whether or not they were identified by the review in Lanarkshire (e.g. theatres).

It is also worth noting that:

1. The need to sustainably improve unscheduled flow was a major theme and recommendation and agreement is needed on how to achieve this in Lothian. It is arguably the most important safety issue.
2. The report recommended simplifying and clarifying management and governance structures and this may also have implications for Lothian.

Introduction: understanding the Rapid Review

1. The terms of reference for the review were:
   - provide an independent expert diagnosis of the factors which may underlie the Hospital Standardised Mortality Ratio figures, including a Rapid Review assessment of any systemic factors which may be impacting on the safety and quality of care and treatment being provided to patients in NHS Lanarkshire’s acute hospitals
   - consider whether the existing action by NHS Lanarkshire to address any key issues, identified in the diagnostic phase is adequate and whether any additional steps should be taken
   - advise if any additional support should be made available to NHS Lanarkshire to help strengthen and accelerate their improvement programme, and
   - advise on any areas that may require further action.

2. The report that has been published is the diagnostic phase and the planned Quality Summit with representatives from NHS Lanarkshire, the Review Team and other interested parties has not yet taken place. This would develop the recommendations into a detailed and agreed action plan and so the recommendations in the report should be taken as indicating areas of work rather than being precise about implementation plans.

3. In considering the factors underlying the high HSMR values, the Review Team identified data issues (not coding per se) which were increasing the reported value and concluded that the HSMR was only actually high in one hospital, not three as believed when the Review was instructed. It is notable that concerns were identified in all three hospitals, irrespective of the HSMR.
4. The Review was commissioned because of concern that the high HSMR might indicate issues with quality of care. The Review made no judgment of quality based on HSMR and explicitly rejected the use of HSMR to calculate ‘excess deaths’. The Review focused on areas where there is evidence that difficulties can adversely affect quality including safety.

5. The Review attached considerable importance to improving patient flow as a key safety measure

**Implications for self-assessment**

When planning self-assessment in NHS Lothian it is important to note:

- the scope of the review which involved a huge amount of person hours and was independent.
- The review explicitly did not accept assurance based on data supplied by senior management. A great deal of information was gained by talking to patients and front line staff. Almost invariably this transpired to be more accurate than the view of senior management.
- The review looked beyond processes and plans to see what was actually being achieved

Self-assessment whilst worthwhile is likely to be less rigorous and most unlikely to overstate issues.

When considering where NHS Lothian is against each of the recommendations, it is important to note that they are the output of the diagnostic stage of the review. It will be necessary to move from assessing any shortcomings to creating and putting into effect plans to address them. It is likely that some of this will be challenging.

**Self-assessment Plan**

The initial proposal is to prioritize assessment against the following recommendations from the report:

- Nurse staffing numbers and skill mix (recommendations 10,11,12,13,14)
- Medical staffing, particularly out of hours (recommendation 7)
- Governance and reporting of the Scottish Patient Safety Programme (recommendation 6)
- The deteriorating patient workstream of that programme (recommendation 5)
- The data available, how it is collected, validated, presented and used for improvement and for judgment. (recommendation 20). This links to making and presenting to the Board a comprehensive assessment of mortality and quality concerns that exist at present within NHS Lothian.
- Improving patient experience (recommendations 3 and 4)

**Methodology** under overall direction of Medical Director for Quality Improvement & Safety

a) For each priority area, this to be led by the relevant executive director and to incorporate assessment at different levels in the organization i.e. learning from
Lanarkshire and not relying on the executive view but seeking the views of those delivering the service. This may involve use of existing data, for example the views of staff given in the values work. The Medical Director for Quality Improvement, the Associate Medical Director for Patient Safety and the Clinical Governance and Risk Manager will be available to support and advise.

b) Some parts of the self-assessment relate to the functioning of the board and the governance and leadership structure. Internal assessment of this is not possible and it is proposed that an external interviewer is commissioned to conduct semi-structured telephone interviews and a report produced for the Chair.

c) The output of each assessment should include an outline of actions proposed. Where the view of the Exec Director or subsequently the Board is that immediate action is not possible then this will need to be included in the Risk Register with appropriate controls and solutions built into the Board’s Strategic Plan.

d) The assessment of these priority areas should be reported by 31 March 2014.

**Actions that can take place immediately**

- Timely production of discharge letters (recommendation 2). This work has been initiated by NHS Lothian Medical Director.
- A range of governance workshops to be organised for board members to include our learning from complaints, adverse events and patient experience (agreed by the Board). ACTION Medical Director for Quality Improvement & Safety.

Simon Mackenzie
Medical Director for Quality Improvement & Safety
January 2014
This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

| • The under spend of £0.2m in December, bringing the year to date position to £3.9m overspent. This reflects corporate support of £1.3m released in the month. | 3.1 |
| • The 2 key drivers are unachieved efficiency savings and, a reversal of the previous benefit in pay costs as recruitment steps up. This continues the trend on previous months. | 3.2 |
| • Expenditure on unscheduled care continues to rise in line with increases in delayed discharges and the opening of Winter Beds in advance of the planned date. | 3.7 |
| • The cost of providing elective capacity to meet waiting times targets is slightly above forecast, due to the unplanned use of short term capacity. It is still expected that we will deliver within forecast by Year End. | 5.1-5.3 |
| • The key challenges to delivering the forecast breakeven position are the investments in capacity required to address waiting times and unscheduled care pressures, as well as achievement of LRP targets. | 7.1 |
1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the financial position to the end of December 2013 and provide the Board with an update on the year end forecast.

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

2 Recommendations

2.1 The Board is asked to note:

- An in month under spend of £0.2m reducing the year to date overspend to £3.9m. This is after the release of £1.3m of non recurring flexibility;
- LRP is reporting an in month slippage of £0.5m bringing the year to date position to a £4.1m shortfall;
- The updated outturn forecast which includes use of non recurrent resources to support delivery of the statutory financial target (breakeven); and
- The introduction of a revised framework of financial performance management to support delivery of ongoing monthly balance.

3 Discussion of Key Issues

3.1 NHS Lothian is reporting an under spend in the month of £0.2m, giving a cumulative overspend of £3.9m. This reflects corporate support of £1.3m released in month to support operational pressures and slippage on efficiency savings.

3.2 The key driver of the position is unachieved efficiency savings, and the trends evident in previous months are continuing, i.e. the filling of vacancies offsetting increasing non pay costs. Financial performance meetings, led by the Deputy Director of Finance, are currently taking place to establish action plans to support monthly financial performance going forward.
3.3 The position is summarised in table 1 below and a detailed analysis by expenditure type is attached at Appendix 1 and by operational unit in Appendix 2.

### Table 1: Financial Position to 31 December 2013

<table>
<thead>
<tr>
<th></th>
<th>In month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Baseline position</td>
<td>(530)</td>
<td>(1,104)</td>
</tr>
<tr>
<td>Outstanding efficiency savings</td>
<td>(572)</td>
<td>(4,156)</td>
</tr>
<tr>
<td><strong>Net operational position</strong></td>
<td><strong>(1,102)</strong></td>
<td><strong>(5,260)</strong></td>
</tr>
<tr>
<td>Offset by: corporate support</td>
<td>1,300</td>
<td>1,300</td>
</tr>
<tr>
<td><strong>Total under/(over) spend</strong></td>
<td>198</td>
<td>(3,960)</td>
</tr>
</tbody>
</table>

3.4 As recruitment continues to step up (in particular to medical posts in the emergency department and nursing posts in medicine of the elderly) the benefit from vacancies experienced in the earlier half of the year is being eroded. As previously reported, other pay pressures include: increasing costs of close observations within the inpatient continuing care units; learning disabilities inpatient units; adult and older people’s mental health services; the cost of providing cover for GP out of hours services; and incremental drift in facilities and imaging. Elements of these pressures, including incremental drift and establishment and skill mix changes prioritised by the Director of Nursing, have been addressed in the 14/15 financial plan.

3.5 Whilst non pay costs continue to overspend, the in month movement is in line with previous months. With the exception of drug and prescribing costs, there has been no material change in the trend with the impact increases in activity and case mix throughout the system remaining the key concern. Although December saw a planned reduction in activity, it is anticipated that the associated non pay costs will reduce over the next quarter as stocks reduce. Results of the detailed exercise to link case mix, activity and cost in theatres will be available towards the end of the financial year and will improve understanding of the impact of waiting time activity on costs.

3.6 GP prescribing continues to show an in year pressure, contributing £1.8m to the year to date overspend and £2.4m to the year end forecast. The reduction in prices anticipated at the start of the year has not fully materialised. This is compounded by the loss of nationally negotiated discount income, however the volume of scripts has not increased in line with the forecast and this has provided some financial mitigation.

3.7 The cost of supporting additional bed capacity continues to increase as the number of delayed discharges rises and winter beds open in advance of the planned date. This is currently being supported from slippage on other unscheduled care investment, but clearly adds further financial pressure.

3.8 To assess movements in cost, compared with movements in activity, Appendix 3 provides a summary of acute activity by speciality for the first nine months compared to activity for the same period last year.
4 Efficiency & Productivity

4.1 Slippage on LRP continues to be the key determinant of the financial position, contributing £4.2m to the year to date overspend. This represents a similar level to the year end forecast, therefore requiring an improvement in delivery in the final quarter.

4.2 Table 2 provides a summary of the in year position, with further detailed analysis of delivery against local targets and specific work streams set out in Appendix 4.

Table 2: Efficiency and Productivity 2013/14

<table>
<thead>
<tr>
<th>Current Year Target</th>
<th>April - December</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actuals</td>
</tr>
<tr>
<td>Local</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Work streams</td>
<td>(6,640)</td>
<td>(4,286)</td>
</tr>
<tr>
<td>Centrally held</td>
<td>(12,896)</td>
<td>(8,284)</td>
</tr>
<tr>
<td>Residual</td>
<td>(7,926)</td>
<td>(5,945)</td>
</tr>
<tr>
<td>Total</td>
<td>(27,832)</td>
<td>(19,275)</td>
</tr>
</tbody>
</table>

5 Waiting times

5.1 Expenditure on elective capacity to meet waiting times totalled £24.3m at the end of December, a movement of £3.2m in the month. Table 3 provides a summary:

Table 3: Expenditure on Elective Capacity

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outturn</td>
<td>Plan</td>
</tr>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Internal</td>
<td>7,905</td>
<td>12,679</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>12,081</td>
<td>12,546</td>
</tr>
<tr>
<td>Other Contractors</td>
<td>4,921</td>
<td>4,583</td>
</tr>
<tr>
<td>Other NHS</td>
<td>2,642</td>
<td>2,959</td>
</tr>
<tr>
<td>Total</td>
<td>27,549</td>
<td>32,767</td>
</tr>
</tbody>
</table>

5.2 Expenditure in December is slightly above forecast, with increased costs against both independent sector and other contractors. This reflects the introduction of additional short term capacity for a number of specialties out with plan; initial review of the amended usage suggests that this position can be managed within the existing forecast.

5.3 Internal capacity spend continues in line with previous months although there remains a requirement to reduce use of external capacity to offset the expected increased spend as recruitment impacts in the final quarter. This, along with the impact of elective cancellations due to unscheduled care bed pressures in the early part of January, is the key risk the forecast which is currently being updated.
6 **Property & Asset Management**

6.1 The forecast cost of the in year programme is £50m, of which £26.6m has been incurred to the end of December 2013. The programme for the year is shown in Appendix 5 and is discussed in more detail in the separate Property and Asset Management Investment update being presented to the Committee.

7 **Year End Forecast**

7.1 The year end forecast review process has now been completed, confirming that the financial plan target of breakeven remains achievable, however the shortfall of £1.7m identified will require concerted management action through a combination of; local recovery plans; increased delivery of LRP; management of allocations; and slippage in investments.

7.2 Further detail is given in Appendix 6 which shows operational units forecasting a baseline overspend of £2.9m with unachieved LRP of £4.0m. Whilst the waiting time forecast is currently being revised, indications are that this will be in line with the current estimated position.

8 **Risk Register**

8.1 The risk register has been reviewed to assess whether there is an increased risk to the delivery of financial targets for 2013/14. Taking account of the identified additional flexibility it has been decided to leave the risk rating at medium.

9 **Health and Other Inequalities**

9.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

10 **Involving People**

10.1 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.

11 **Resource Implications**

11.1 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  
22 January 2014  
susan.goldsmith@nhslothian.scot.nhs.uk

**List of Appendices**

Appendix 1: NHS Lothian Income and Expenditure Summary December 2013  
Appendix 2: NHS Lothian Summary by Operational Unit December 2013
Appendix 3: NHS Lothian Summary of Acute Activity December 2013
Appendix 4: NHS Lothian Property and Asset Management Investment Programme Summary December 2013
Appendix 5: NHS Lothian Efficiency and Productivity Summary December 2013
Appendix 6: NHS Lothian Year End Forecast 2013
### NHS Lothian Income & Expenditure Summary December 2013

**APPENDIX 1**

<table>
<thead>
<tr>
<th>Income</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from other health systems</td>
<td>(152,014)</td>
<td>(116,020)</td>
<td>(117,167)</td>
<td>1,147</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(56,821)</td>
<td>(43,308)</td>
<td>(43,309)</td>
<td>1</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,504)</td>
<td>(2,213)</td>
<td>(2,182)</td>
<td>(31)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(1,918)</td>
<td>(1,438)</td>
<td>(1,438)</td>
<td>(0)</td>
</tr>
<tr>
<td>Other income</td>
<td>(47,705)</td>
<td>(39,751)</td>
<td>(40,661)</td>
<td>910</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td>(260,962)</td>
<td>(202,730)</td>
<td>(204,757)</td>
<td>2,027</td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,361,703)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>(1,622,665)</td>
<td>(202,730)</td>
<td>(204,757)</td>
<td>2,027</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Dental Staff</td>
<td>213,004</td>
<td>157,103</td>
<td>154,630</td>
<td>2,473</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>349,606</td>
<td>258,784</td>
<td>258,522</td>
<td>261</td>
</tr>
<tr>
<td>Allied Healthcare Professional</td>
<td>58,174</td>
<td>42,865</td>
<td>42,626</td>
<td>239</td>
</tr>
<tr>
<td>Support Services / Other</td>
<td>56,124</td>
<td>41,188</td>
<td>42,508</td>
<td>(1,321)</td>
</tr>
<tr>
<td>Health Science Services</td>
<td>35,680</td>
<td>26,519</td>
<td>25,501</td>
<td>1,019</td>
</tr>
<tr>
<td>Personal &amp; Social / Therapeutic</td>
<td>25,581</td>
<td>19,180</td>
<td>17,878</td>
<td>1,302</td>
</tr>
<tr>
<td>Management/Admin Staff</td>
<td>87,466</td>
<td>63,885</td>
<td>63,166</td>
<td>719</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td>825,634</td>
<td>609,523</td>
<td>604,831</td>
<td>4,693</td>
</tr>
<tr>
<td>Non-Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>100,307</td>
<td>72,525</td>
<td>73,118</td>
<td>(593)</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>77,944</td>
<td>59,142</td>
<td>59,532</td>
<td>(400)</td>
</tr>
<tr>
<td>Equipment</td>
<td>23,918</td>
<td>20,599</td>
<td>22,288</td>
<td>(689)</td>
</tr>
<tr>
<td>Other Non Pays</td>
<td>66,147</td>
<td>58,390</td>
<td>59,532</td>
<td>(1,141)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>126,334</td>
<td>93,559</td>
<td>95,366</td>
<td>(1,807)</td>
</tr>
<tr>
<td>GMS</td>
<td>120,332</td>
<td>85,734</td>
<td>85,758</td>
<td>(23)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4,581</td>
<td>3,185</td>
<td>3,230</td>
<td>(45)</td>
</tr>
<tr>
<td>Property/Transport</td>
<td>50,699</td>
<td>35,629</td>
<td>37,079</td>
<td>(1,450)</td>
</tr>
<tr>
<td>Ancillary / Admin Costs</td>
<td>171,085</td>
<td>64,894</td>
<td>62,825</td>
<td>2,069</td>
</tr>
<tr>
<td><strong>Total Non-Pay</strong></td>
<td>743,347</td>
<td>493,658</td>
<td>500,181</td>
<td>(6,523)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>1,568,982</td>
<td>1,103,181</td>
<td>1,105,012</td>
<td>(1,831)</td>
</tr>
</tbody>
</table>

**SUB TOTAL CORE BASELINE POSITION** | (53,683) | 900,451 | 900,255 | 196 |

**LRP**

<table>
<thead>
<tr>
<th>LRP</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>non recurring central funds</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>SUB TOTAL CORE POSITION</strong></td>
<td>(60,960)</td>
<td>896,295</td>
<td>900,255</td>
<td>(3,960)</td>
</tr>
</tbody>
</table>

**NHS Lothian Non Core Position**

| Depreciation & Capital Grants | 54,001 | 26,417 | 21,917 | 4,499 |
| Revenue Funded Capital Schemes | 0 | 0 | 4,499 | (4,499) |
| Impairments, Provisions & Donated Depreciation | 6,959 | (675) | (675) | 0 |
| **TOTAL NHS LOTHIAN CORE/NON CORE POSITION** | | | | |

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>922,036</td>
<td>925,996</td>
<td>(3,960)</td>
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# NHS Lothian Expenditure Summary December 2013

## Unscheduled Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Infirmary Edinburgh Site</td>
<td>67,579</td>
<td>50,669</td>
<td>52,209</td>
<td>(1,539)</td>
<td>(1,122)</td>
<td>(417)</td>
</tr>
<tr>
<td>Western General Hospital Site</td>
<td>57,525</td>
<td>43,204</td>
<td>43,878</td>
<td>(674)</td>
<td>(609)</td>
<td>(66)</td>
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<td>St Johns Hospital Site</td>
<td>18,040</td>
<td>13,494</td>
<td>14,082</td>
<td>(588)</td>
<td>(550)</td>
<td>(38)</td>
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<tr>
<td>LUHS AHP Services</td>
<td>14,576</td>
<td>11,011</td>
<td>11,105</td>
<td>(94)</td>
<td>(76)</td>
<td>(18)</td>
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**Total Unscheduled Care:** 157,721

## Scheduled Care

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<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women Children &amp; Neuroscience</td>
<td>98,874</td>
<td>73,153</td>
<td>72,231</td>
<td>922</td>
<td>901</td>
<td>22</td>
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<tr>
<td>Surgical Services Directorate</td>
<td>169,912</td>
<td>128,369</td>
<td>129,529</td>
<td>(674)</td>
<td>(609)</td>
<td>(11)</td>
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<td>Clinical Services</td>
<td>158,745</td>
<td>117,377</td>
<td>117,679</td>
<td>(302)</td>
<td>(9)</td>
<td>(293)</td>
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**Total Scheduled Care:** 427,531

## CHPs/CHCP/PCCO

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<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh CHP</td>
<td>305,616</td>
<td>226,237</td>
<td>227,104</td>
<td>(868)</td>
<td>(868)</td>
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<td>East Lothian CHP</td>
<td>72,016</td>
<td>112,062</td>
<td>112,740</td>
<td>(678)</td>
<td>(667)</td>
<td>(11)</td>
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<td>Midlothian CHP</td>
<td>51,266</td>
<td>37,566</td>
<td>37,542</td>
<td>24</td>
<td>27</td>
<td>(3)</td>
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<tr>
<td>West Lothian CHP</td>
<td>112,543</td>
<td>80,970</td>
<td>80,719</td>
<td>250</td>
<td>250</td>
<td>0</td>
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<tr>
<td>Primary Care Other</td>
<td>(10,703)</td>
<td>(14,977)</td>
<td>(14,976)</td>
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**Total CHPs/CHCP/PCCO:** 530,738

## Facilities and Consort

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<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
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</thead>
<tbody>
<tr>
<td>Facilities Management</td>
<td>84,079</td>
<td>60,578</td>
<td>61,795</td>
<td>(1,217)</td>
<td>(1,324)</td>
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<td>Consort</td>
<td>46,531</td>
<td>33,400</td>
<td>33,184</td>
<td>216</td>
<td>118</td>
<td>98</td>
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**Total Facilities and Consort:** 130,610

## Corporate Budgets

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<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>514</td>
<td>381</td>
<td>399</td>
<td>(18)</td>
<td>(18)</td>
<td>(1)</td>
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<tr>
<td>Communications</td>
<td>1,143</td>
<td>828</td>
<td>811</td>
<td>17</td>
<td>17</td>
<td>(0)</td>
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<tr>
<td>Ehealth</td>
<td>29,000</td>
<td>22,237</td>
<td>22,332</td>
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<td>(95)</td>
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<tr>
<td>Finance &amp; Capital Planning</td>
<td>9,706</td>
<td>7,571</td>
<td>7,332</td>
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<td>239</td>
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<tr>
<td>Human Resources</td>
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<td>7,036</td>
<td>7,113</td>
<td>(77)</td>
<td>(32)</td>
<td>(45)</td>
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<tr>
<td>Medical Director</td>
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<td>1,063</td>
<td>988</td>
<td>75</td>
<td>75</td>
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<tr>
<td>Nursing</td>
<td>7,599</td>
<td>403</td>
<td>119</td>
<td>283</td>
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<td>Pharmacy</td>
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<td>9,311</td>
<td>9,198</td>
<td>113</td>
<td>158</td>
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<td>Planning</td>
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<td>(240)</td>
<td>(383)</td>
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<td>Public Health</td>
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<td>4,141</td>
<td>4,000</td>
<td>140</td>
<td>146</td>
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<tr>
<td>Other</td>
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**Total Corporate Budgets:** 85,684

## UHS/PC & SS Divisional

<table>
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<tr>
<th>Service</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
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</thead>
<tbody>
<tr>
<td>Corporate - Divisional</td>
<td>(31,453)</td>
<td>(25,447)</td>
<td>(25,442)</td>
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<td>Corporate Services UHS</td>
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<td>2,727</td>
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<td>(54)</td>
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**Total UHS/PC & SS Divisional:** (27,594)

## Strategic Budgets
<table>
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<tr>
<th>SLAs/UNPACs/NCA</th>
<th>12,638</th>
<th>9,499</th>
<th>10,667</th>
<th>(1,168)</th>
<th>(1,168)</th>
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</thead>
<tbody>
<tr>
<td>Income from other health systems</td>
<td>(1,428,384)</td>
<td>(71,731)</td>
<td>(71,984)</td>
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<td>254</td>
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<tr>
<td>Property &amp; Asset Management</td>
<td>40,844</td>
<td>29,078</td>
<td>29,087</td>
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<td>(8)</td>
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<td>Programmes</td>
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<td>4,715</td>
<td>3,534</td>
<td>1,180</td>
<td>1,184</td>
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<td>Provisions &amp; Claims</td>
<td>8,970</td>
<td>4,129</td>
<td>3,695</td>
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<td>435</td>
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<td>Research &amp; Development</td>
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<td>4,760</td>
<td>4,760</td>
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<td>(0)</td>
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<tr>
<td>Reserves &amp; Uncommitted Allocations</td>
<td>19,396</td>
<td>307</td>
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<td>307</td>
<td>2,922</td>
<td>(2,615)</td>
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<td>(1,328,417)</td>
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<td>(20,242)</td>
<td>999</td>
<td>3,617</td>
<td>(2,618)</td>
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<tr>
<td>TOTAL</td>
<td>(23,728)</td>
<td>983,809</td>
<td>987,773</td>
<td>(3,964)</td>
<td>198</td>
<td>(4,156)</td>
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<td>0</td>
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<tr>
<td>Offset by release of provisions and reserves</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
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<td>Non Recurring Central Funds</td>
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<td>1,300</td>
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<td>0</td>
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<tr>
<td>(23,728)</td>
<td>983,809</td>
<td>987,773</td>
<td>(3,964)</td>
<td>198</td>
<td>(4,156)</td>
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</tr>
<tr>
<td>AME / DEL / Other</td>
<td>23,048</td>
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<tr>
<td>TOTAL</td>
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<td>-------------</td>
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<td>------------</td>
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<tr>
<td><strong>CLINICAL SERVICES</strong></td>
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</tr>
<tr>
<td>Clinical radiology</td>
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<tr>
<td>Dermatology</td>
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<td>115</td>
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<td>Ear, nose &amp; throat (ent)</td>
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<td>3,713</td>
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<td>369</td>
<td>352</td>
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<td>863</td>
<td>956</td>
<td>999</td>
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<td>843</td>
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<td>4,893</td>
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<td>663</td>
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<td>804</td>
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<td></td>
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<tr>
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<tr>
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<td>Geriatric medicine</td>
<td>1,597</td>
<td>1,627</td>
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<td>168</td>
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<td>Infectious diseases</td>
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<tr>
<td>Rehabilitation medicine</td>
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<td>111</td>
<td>4</td>
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<tr>
<td><strong>WOMEN CHILDREN &amp; NEUROSCIENCE</strong></td>
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<td>666</td>
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<td>Count1</td>
<td>Count2</td>
<td>Mean1</td>
<td>Mean2</td>
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<td>Median2</td>
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<td>--------</td>
<td>--------</td>
<td>-------</td>
<td>-------</td>
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<td>---------</td>
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<td>Midwifery</td>
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<td>Obstetrics</td>
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<td>RHSC sub-total</td>
<td>15,791</td>
<td>15,522</td>
<td>1,780</td>
<td>1,719</td>
<td>1,720</td>
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</table>
| **TOTAL**         | **35,997** | **35,821** | **3,914** | **3,830** | **3,955** | }

- Count1 and Count2: Counts of different categories.
- Mean1 and Mean2: Average values of different categories.
- Median1 and Median2: Median values of different categories.
### APPENDIX 4

**NHS Lothian Efficiency & Productivity – December 2013/14**

<table>
<thead>
<tr>
<th>WORKSTREAM</th>
<th>Current Year Target</th>
<th>April - December</th>
<th>Target</th>
<th>Actuals</th>
<th>Slippage</th>
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<tr>
<td>Facilities &amp; Infrastructure</td>
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<td>(693)</td>
<td>(825)</td>
<td>(132)</td>
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<td>(954)</td>
<td>(740)</td>
<td>(214)</td>
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<td>Management &amp; Administration</td>
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<td>(536)</td>
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<tr>
<td>Pharmacy Redesign</td>
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<td>(52)</td>
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<tr>
<td>WCN</td>
<td>(275)</td>
<td></td>
<td>(206)</td>
<td>(173)</td>
<td>(33)</td>
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<td>Flow &amp; Capacity Management</td>
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<td></td>
<td>(97)</td>
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<td>(97)</td>
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<td>Edinburgh Rehabilitation Bed Redesign</td>
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<td></td>
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<td>-</td>
<td>(184)</td>
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<td>Enhanced Recovery</td>
<td>(300)</td>
<td></td>
<td>(225)</td>
<td>-</td>
<td>(225)</td>
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<tr>
<td>Review in Interventions of Limited Clinical Value</td>
<td>(500)</td>
<td></td>
<td>(329)</td>
<td>(18)</td>
<td>(311)</td>
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<td>Outpatients</td>
<td>(1,537)</td>
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<td>(1,015)</td>
<td>-</td>
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<td>Prescribing</td>
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<td>(2,803)</td>
<td>(154)</td>
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<td>Procurement</td>
<td>(1,248)</td>
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<td>(936)</td>
<td>(560)</td>
<td>(376)</td>
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<td><strong>TOTAL</strong></td>
<td><strong>(12,896)</strong></td>
<td></td>
<td><strong>(8,284)</strong></td>
<td><strong>(5,817)</strong></td>
<td><strong>(2,467)</strong></td>
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<table>
<thead>
<tr>
<th>LOCAL</th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tr>
<td>Edinburgh CHP</td>
<td>(811)</td>
<td></td>
<td>(443)</td>
<td>(639)</td>
<td>(196)</td>
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<td>East Lothian CHP</td>
<td>(406)</td>
<td></td>
<td>(205)</td>
<td>(194)</td>
<td>(11)</td>
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<td>Mid Lothian CHP</td>
<td>(54)</td>
<td></td>
<td>(49)</td>
<td>(51)</td>
<td>2</td>
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<tr>
<td>West Lothian CHCP</td>
<td>(186)</td>
<td></td>
<td>(123)</td>
<td>(123)</td>
<td>-</td>
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<tr>
<td>Primary Care Other</td>
<td>(28)</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Estates &amp; Facilities</td>
<td>(343)</td>
<td></td>
<td>(200)</td>
<td>(273)</td>
<td>73</td>
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<td>Corporate Areas</td>
<td>(601)</td>
<td></td>
<td>(364)</td>
<td>(223)</td>
<td>(141)</td>
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<td>University Hospital Services</td>
<td>(3,740)</td>
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<td>(2,726)</td>
<td>(1,679)</td>
<td>(1,047)</td>
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<td>Strategic Budgets</td>
<td>(471)</td>
<td></td>
<td>(176)</td>
<td>(173)</td>
<td>(3)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>(6,640)</strong></td>
<td></td>
<td><strong>(4,286)</strong></td>
<td><strong>(3,355)</strong></td>
<td><strong>(931)</strong></td>
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</tbody>
</table>

**Residual held**

| Residual held                                       | (7,926)              |                  | (5,945) | (5,945) | -        |
| Residual                                            | (370)                |                  | (760)   | -       | (760)    |

**TOTAL**

| (27,832)                                           | (19,275)             |                  | (15,117)| (4,158) |          |
### INCOME

<table>
<thead>
<tr>
<th>Source</th>
<th>MYR Forecast £k</th>
<th>Agreed Programme £k</th>
<th>Expenditure to month 9 £k</th>
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</thead>
<tbody>
<tr>
<td>SGHD Specific Funding</td>
<td>26,231</td>
<td>26,232</td>
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<td>SGHD Formula Allocation</td>
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<td>25,349</td>
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<tr>
<td>Other Sources of Funding</td>
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<td>3,304</td>
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<td><strong>TOTAL SOURCES</strong></td>
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<td><strong>54,886</strong></td>
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### EXPENDITURE

#### Capacity & Unscheduled Care

<table>
<thead>
<tr>
<th>Project</th>
<th>MYR Forecast £k</th>
<th>Agreed Programme £k</th>
<th>Expenditure to month 9 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>1,830</td>
<td>1,830</td>
<td>1,864</td>
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<tr>
<td>Radiotherapy Phase 9</td>
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<td>0</td>
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<tr>
<td>Radiotherapy - Other</td>
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<td>16</td>
<td>16</td>
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<tr>
<td>RIE Additional Beds &amp; Decant</td>
<td>4,307</td>
<td>4,307</td>
<td>1,814</td>
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<td>Continuing Care Redesign</td>
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<td>1,377</td>
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<tr>
<td>WGH Expansion of Ward 58</td>
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<td>0</td>
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<tr>
<td>Day Surgery Redesign</td>
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<td>0</td>
</tr>
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<td>St John's Hospital MRI</td>
<td>959</td>
<td>959</td>
<td>68</td>
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<td>Renal Review - WGH</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Labour Ward/ Maternity Unit (SJH)</td>
<td>764</td>
<td>764</td>
<td>605</td>
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<tr>
<td>Burns Unit (SJH)</td>
<td>241</td>
<td>241</td>
<td>210</td>
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<tr>
<td>Autism/Learning Disability Residential Support Service</td>
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<td>200</td>
<td>0</td>
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<td>** комфортность**</td>
<td><strong>9,193</strong></td>
<td><strong>9,693</strong></td>
<td><strong>5,274</strong></td>
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#### Investment in Primary Care Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>MYR Forecast £k</th>
<th>Agreed Programme £k</th>
<th>Expenditure to month 9 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>2,991</td>
<td>2,991</td>
<td>2,179</td>
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<tr>
<td>Gullane Medical Centre</td>
<td>1,995</td>
<td>1,995</td>
<td>1,612</td>
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<tr>
<td>West End Medical Practice</td>
<td>3,235</td>
<td>3,235</td>
<td>2,091</td>
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<tr>
<td>Firrhill/Muirhouse/Blackburn</td>
<td>1,216</td>
<td>856</td>
<td>67</td>
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<tr>
<td>Ratho Health Centre Satellite</td>
<td>63</td>
<td>63</td>
<td>21</td>
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<tr>
<td>Tranent</td>
<td>655</td>
<td>655</td>
<td>291</td>
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<td><strong>9,795</strong></td>
<td><strong>6,262</strong></td>
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#### Major Service Redesign/Redevelopment

<table>
<thead>
<tr>
<th>Project</th>
<th>MYR Forecast £k</th>
<th>Agreed Programme £k</th>
<th>Expenditure to month 9 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>7,184</td>
<td>7,184</td>
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<td>Lothian Asset Management Strategy</td>
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<td>108</td>
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<td>Royal Edinburgh Hospital</td>
<td>932</td>
<td>2,732</td>
<td>724</td>
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<tr>
<td>Greenbank Centre REH</td>
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<td>470</td>
<td>451</td>
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<tr>
<td>REH Orchard Clinic</td>
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<td>0</td>
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<td>East Lothian Community Hospital</td>
<td>77</td>
<td>77</td>
<td>78</td>
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<tr>
<td>Pharmacy Aspectic Unit WGH</td>
<td>132</td>
<td>132</td>
<td>22</td>
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<tr>
<td><strong>Major Service Redesign/Redevelopment</strong></td>
<td><strong>8,944</strong></td>
<td><strong>10,754</strong></td>
<td><strong>4,011</strong></td>
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#### Invest to Save

<table>
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<th>Agreed Programme £k</th>
<th>Expenditure to month 9 £k</th>
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</thead>
<tbody>
<tr>
<td>Laboratory Equipment</td>
<td>412</td>
<td>412</td>
<td>235</td>
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<tr>
<td>Microbiology Automation</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Invest to Save</strong></td>
<td><strong>412</strong></td>
<td><strong>412</strong></td>
<td><strong>235</strong></td>
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#### Compliance

<table>
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<th>Expenditure to month 9 £k</th>
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</thead>
<tbody>
<tr>
<td>GDP dental premises</td>
<td>1,000</td>
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<td>Endoscopy RIE</td>
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<td>103</td>
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<tr>
<td>Endoscopy WGH</td>
<td>243</td>
<td>243</td>
<td>98</td>
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<tr>
<td>Community Dentistry Decontamination</td>
<td>482</td>
<td>482</td>
<td>462</td>
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<td><strong>Compliance</strong></td>
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<td><strong>2,123</strong></td>
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<td>Rolling Programmes</td>
<td>2011/12</td>
<td>2012/13</td>
<td>2013/14</td>
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<td>--------------------------------------------------</td>
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<tr>
<td>RIE Lifecycle Costs</td>
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<td>4,620</td>
<td>4,674</td>
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<td>Projects under £250k</td>
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<td>2,300</td>
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<td>892</td>
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<td>995</td>
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<td>4,834</td>
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<td>109</td>
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<td>Purchase of Items for Cancer Treatments</td>
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<td>NSD Funded Schemes</td>
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<td>Detect Cancer Early</td>
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<td>Teenage Cancer Trust, WGH</td>
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<td>Other Donations</td>
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<td></td>
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<td>Completing Schemes</td>
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<td><strong>50,631</strong></td>
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<td>Total expenditure</td>
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<td></td>
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<tr>
<td>Total (over)/ under commitment</td>
<td><strong>4,163</strong></td>
<td><strong>(519)</strong></td>
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# NHS Lothian Year End Forecast 2013/14

<table>
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<td>£k</td>
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<td>Edinburgh CHP</td>
<td>(868)</td>
<td>(1,076)</td>
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<tr>
<td>East Lothian CHP</td>
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<td>(734)</td>
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<tr>
<td>Midlothian CHP</td>
<td>27</td>
<td>(17)</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>250</td>
<td>(147)</td>
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<td>Clinical Services</td>
<td>(8)</td>
<td>(630)</td>
</tr>
<tr>
<td>Royal Infirmary Edinburgh Site</td>
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<td>(2,131)</td>
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<tr>
<td>St Johns Hospital Site</td>
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<td>(714)</td>
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<td>Surgical Services Directorate</td>
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<td>Western General Hospital Site</td>
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<td>(822)</td>
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<td>Women Children &amp; Neuroscience</td>
<td>900</td>
<td>907</td>
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<td>AHP Services</td>
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<td>Corporate - Divisional</td>
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<tr>
<td>Primary Care Other</td>
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<td>Corporate Services</td>
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<td>(649)</td>
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<tr>
<td>Strategic Services</td>
<td>2,317</td>
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<tr>
<td><strong>Operational Position before LRP</strong></td>
<td>(1,103)</td>
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<td><strong>LRP unachieved</strong></td>
<td>(4,157)</td>
<td>(4,114)</td>
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<td><strong>Total Operational Position</strong></td>
<td>(5,260)</td>
<td>(6,978)</td>
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<td>Waiting Times</td>
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<td>Provisions and reserves</td>
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<td>Non Recurring Central Funds</td>
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<td><strong>Total</strong></td>
<td>(3,960)</td>
<td>(1,717)</td>
</tr>
</tbody>
</table>
SUMMARY PAPER - DEVELOPING THE ROYAL VICTORIA HOSPITAL

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Services as Astley Ainslie and Corstorphine Hospital require improved environments.</td>
<td>3.1</td>
</tr>
<tr>
<td>Current risks include compromises to fire safety, Infection Control and patient experience.</td>
<td>3.1</td>
</tr>
<tr>
<td>Following appropriate engagement with patients and their families, some of these services could transfer into the refurbished Royal Victoria Hospital.</td>
<td>3.3</td>
</tr>
<tr>
<td>Any transfer to the RVH is dependant on the cessation of use for patients with delayed discharge.</td>
<td>3.4</td>
</tr>
</tbody>
</table>

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27 January 2014
DEVELOPING THE ROYAL VICTORIA HOSPITAL

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board agree to the continued re-development of the Royal Victoria Hospital and note the benefits the refurbished facilities will have in terms of patient safety, quality of healthcare and patient experience.

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

2 Recommendations

The Board is recommended to:

2.1 Agree to transfer services, some clinical services, currently based at Astley Ainslie and Corstorphine Hospital, into more up-to-date premises which offer improved safety, quality and patient experience.

3 Discussion of Key Issues

3.1 The Board is aware of ongoing discussions about the suitability of sites such as Astley Ainslie Hospital and Corstorphine Hospital for the provision of high-quality, safe and effective patient care, in particular relating to Infection Control and fire risk. While a range of services continue to make use of these sites, and efforts continue to ensure that these are safe and clinically appropriate for patients, the ongoing refurbishment and upgrading of the Royal Victoria Hospital presents new opportunities for the transfer of these services.

3.2 The refurbished wards on the Royal Victoria Hospital site allow for patients to be cared for in single rooms or 4- or 6-bedded bays, with modern hygiene and toilet facilities. The site also benefits from its proximity to the adjacent Western General Hospital and there is ongoing investment in wider site works such as car parking and security.

3.3 The Board’s approval is sought in order to transfer those services currently on other sites (such as those mentioned in paragraph 3.1 above) which would benefit from transfer to the newly refurbished and upgraded Royal Victoria Hospital. Any such transfer will be preceded by full engagement with patients and their families. These plans will be subject to external scrutiny as appropriate, including by the Scottish Health Council and Scottish Government.
4 Key Risks

4.1 Transferring services into more up-to-date and high quality settings as proposed would result in reduced risks related to Healthcare Acquired Infection (HAI) and improved patient and staff safety. Reducing the provision of services on peripheral sites will have a longer term positive impact on financial risk.

4.2 Use of space in RVH is dependant on a reduction of patients with delayed discharges to release the space.

5 Risk Register

5.1 The proposal will have a positive impact on the risk of HAI (Corporate Risk 1076) by providing healthcare services to patients in more appropriate and upgraded clinical facilities.

6 Impact on Inequality, Including Health Inequalities

6.1 This proposal seeks approval for services to be transferred to the Royal Victoria Hospital site. Specific plans for individual services – where there is detailed information about the diversity of patients, staff and families – will be subjected to Rapid Impact Assessment according to Board policy.

7 Involving People

7.1 Specific plans to transfer services are subjected to full engagement with patients, families and other stakeholders including the Scottish Health Council and Scottish Government. All proposals will follow NHS Lothian’s comprehensive Organisational Change Policy and Procedure for staff and volunteers.

8 Resource Implications

8.1 The resource implications of any transfer will be managed within revenue budgets. The costs of the RVH are managed within the Unscheduled Care budget. Failure to reduce the number of patients waiting for discharge will compromise the financial plan for 2014/15.

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27 January 2014
This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

- The Board is recommended to agree to receive the four draft Integration Plans on 3 December 2014 for approval to consult with parties as prescribed by Scottish Government.  
  1.1
- The previous proposal to submit Integration Plans to the NHS Board on 2 April does not fit with the legal process for the Bill and the subsequent requirement by Scottish Government to then consult on the draft regulations and guidance  
  2.1
- The timeline for consultation and submitting final Integration Plans to Scottish Government for approval will not be known until the publication of the Regulations in October 2014.  
  2.3
- NHS Lothian is still committed to establishing Integration Joint Boards as early as possible.  
  2.5
- A revised timeline is now proposed, and included in table 1.  
  3.3

Jamie Megaw
Strategic Programme Manager
27 January 2014
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INTEGRATION PROCESS AND MILESTONES
PUBLIC BODIES (JOINT WORKING)(SCOTLAND) BILL

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board agrees to receive the four draft Integration Plans in December 2014 for approval to consult with parties as prescribed by Scottish Government.

1.2 This work supports NHS Lothian to achieve Corporate Objective 4: To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements.

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

2 Recommendations

2.1 Note and agree that the previous proposal to submit Integration Plans to the NHS Board on 2 April does not fit with the legal process for the Bill and the subsequent requirement by Scottish Government to then consult on the draft regulations and guidance.

2.2 Agree that the Integration Plans will be submitted to the NHS Lothian Board on 3 December 2014 for approval to consult but recognise that this is dependent on the legal process for the Bill and may change if the Bill does not move on to the statute book by November 2014.

2.3 Understand the timeline for consultation and submitting final Integration Plans to Scottish Government for approval will not be known until the publication of the Regulations in October 2014.

2.4 Support the work in each Integration Joint Board area and across Lothian to develop the draft content of the Integration Plans from April 2014 to November 2014 and the content of the Strategic Commissioning Plans which will be informed by the Regulations and Guidance from Scottish Government.

2.5 Agree that NHS Lothian is still committed to establishing Integration Joint Boards as early as possible. The initial goal of 1 April 2015 may not be possible and the start date may need to move to June or July 2015 depending on the process identified above. None of which are in the gift of NHS Lothian and its partners to control.
3 Discussion of Key Issues

3.1 The Public Bodies (Joint Working) (Scotland) Bill is anticipated to move on to the statute book around November 2014. The timing is dependent on the completion of due parliamentary process.

3.2 A paper was previously presented to the NHS Lothian Audit and Risk Committee on 9 December 2013. This paper was titled ‘Integration: Process and Update’. It described a timeline for development and submission of Integration Plans. Subsequent to the Audit and Risk Committee meeting there has been informal communication from Scottish Government. This has confirmed that the previous ambition in NHS Lothian to consult on the Integration Plans over the summer 2014 will not meet the requirements on consultation stipulated in the Bill because the regulations will not have been published to instruct Health Boards on how to undertake consultation. The legal requirement to consult on the Integration Plans is described in section 6 of the Bill - before submitting the integration plan for approval…the local authority and the Health Board must jointly consult – (a) such persons or groups of persons appearing to have an interest as may be prescribed, and (b) such other persons as the local authority and Health Board think fit.

3.3 A revised timeline is now proposed (table 1) where the NHS Lothian Board commits to developing the required four Integration Plans for Lothian and to submit draft Integration Plans to the NHS Board meeting on 3 December 2014 for approval to consult. Approval from the relevant Local Authority is also required before consultation can commence.

3.4 In preparing the integration plans the Local Authority and Health Board must have regard to the integration planning principles and the national health and wellbeing outcomes.

3.5 The regulations published by Scottish Government in October/November 2014 will describe what consultation is required prior to the final Integration Plans being approved by the Health Board and relevant Council and then submitted to Scottish Government for approval.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Action in Lothian</th>
<th>Legal Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014</td>
<td>Content of the draft Integration Plans is developed by a local group working in each Integration Joint Board with lead officers from directorates in NHS Lothian working to ensure consistency where possible in the four plans.</td>
<td>Bill enacted</td>
</tr>
<tr>
<td>October 2014</td>
<td>Regulations produced by Scottish Government and consultation completed</td>
<td></td>
</tr>
<tr>
<td>November 2014</td>
<td>Bill moves onto statute book</td>
<td></td>
</tr>
<tr>
<td>December 2014</td>
<td>Health Boards and Local Authorities can consult on the content of Integration Plans.</td>
<td></td>
</tr>
</tbody>
</table>

3 December 2014: NHS Lothian Board meeting. Integration Plans presented for approval for consultation. The relevant Council
| Dates to be confirmed | After consultation is completed Health Boards and Local Authorities revise and submit Integration Plans to Scottish Government for approval. The timeframe for this stage will be informed by the regulations published by Scottish Government |

4 **Key Risks**

4.1 There is a risk that the Board and its Partners fail to submit agreed integration plans that satisfy the Scottish Government requirements to agreed timescales resulting in a failure to meet its legal responsibilities.

5 **Risk Register**

5.1 The risk described in section 5.1 has been included on the NHS Lothian Corporate Risk Register.

6 **Impact on Inequality, Including Health Inequalities**

6.1 The four Integration Plans will undergo impact assessments prior to submission to the Board in December.

7 **Involving People**

7.1 The Board will follow the consultation processes as required by the law and Government direction.

8 **Resource Implications**

8.1 The NHS Lothian Finance Directorate is leading work on the financial aspects of integration plans, with regard to the developing Scottish Government guidance in this area.

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Strategic Programme Manager  
21 January 2014  
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This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
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<th>Summary</th>
</tr>
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<tbody>
<tr>
<td>3.1</td>
<td>This proposal is part of the continuing work to review and strengthen the Board’s system of corporate governance. Many of the Board’s risks are associated with acute functions, however, there is no governance committee providing specific oversight of these functions in the way that CHP Sub-Committees/CHCP Board do for their functions. Consequently, the detailed governance scrutiny that would normally be conducted by a committee is to some extent being performed by the Board.</td>
</tr>
</tbody>
</table>
| 3.2   | The Board Chairman and the executive directors recommend the attached terms of reference for a new committee, which aims to deliver the following benefits:  
- It will allow the Board agenda to be re-balanced to considering strategic matters, and any exceptional items referred to it by committees;  
- It will support the Healthcare Governance Committee, the Staff Governance Committee, and the Finance & Resources Committee in discharging their remit and arriving at a conclusion on their assurance needs. This is particularly true for the Healthcare Governance Committee which has an extensive remit and a long list of assurance needs.  
- It will provide additional focus on patient safety and quality of care within the acute services, which is appropriate given the Board’s risks and its developing risk appetite. | |
| 3.3   | The Committee will report directly to the Board. | |

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24 January 2014  
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CREATION OF THE ACUTE HOSPITALS COMMITTEE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board agrees to establish the Acute Hospitals Committee, and approve the attached terms of reference. This will support the following Board Corporate Objectives: 1- Management Culture; 2- Waiting Times Recovery Plan; 3- Unscheduled Care Performance; 6 - Improve Patient and Staff Safety; 7 - Implementation of the Patient Centred Collaborative; 8- Live within Available Financial Resources; and 10- Robust System of Performance Management.

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

2 Recommendations

2.1 Agree that the Acute Hospitals Committee be established.

2.2 Review and approve the proposed terms of reference for the Acute Hospitals Committee.

2.3 Agree the Committee membership as set out in the Terms of Reference.

3 Discussion of Key Issues

3.1 This proposal is part of the continuing work to review and strengthen the Board’s system of corporate governance. The creation of an Acute Hospitals Committee initially arose from a discussion at the Risk Management Steering Group. Many of the Board’s risks are associated with acute functions, however there is no governance committee providing specific oversight of these functions in the way that CHP Sub-Committees/ CHCP Board do for their functions. Consequently the detailed governance scrutiny that would normally be conducted by a committee is to some extent being performed by the Board.

3.2 There are a number of benefits to creating this new Committee:
- It will allow the Board agenda to be re-balanced to considering strategic matters, and any exceptional items referred to it by committees;
- It will support the Healthcare Governance Committee, the Staff Governance Committee and the Finance & Resources Committee in discharging their remit and arriving at a conclusion on their assurance needs. This is particularly true for the Healthcare Governance Committee which has an extensive remit and a long list of assurance needs.
• It will provide additional focus on patient safety and quality of care within the acute services, which is appropriate given the Board’s risks and its developing risk appetite.

3.3 The Committee will report directly to the Board. However the Committee will prepare its own statement of assurance needs by drawing from the assurance needs of the Healthcare Governance Committee, the Staff Governance Committee and the Finance & Resources Committee. The Committee will communicate regularly with these other committees. The Committee will also routinely receive minutes of other groups so as to inform the conduct of its business. The terms of reference set this out.

3.4 The Board Chairman and the executive directors reviewed the draft terms of reference on 13 December 2013, and agreed that it should be recommended to the Board.

4 Key Risks

4.1 The broad fundamental risk is that the Board’s systems of corporate governance are not fit for purpose. This can lead to weaknesses in systems of internal control or poor performance not being detected, and the inability of Board members to fully discharge their responsibilities.

5 Risk Register

5.1 The Board’s Corporate Risk Register already contains a number of risks that are pertinent to the remit of this committee.

6 Impact on Inequality, Including Health Inequalities

6.1 A Rapid Impact Assessment was performed on 9 January 2014. The proposal to create the Committee was welcomed, and it was agreed that it applies to all population groups (rather than affecting any particular groups).

6.2 Overall the approach will strengthen the Board’s processes for meeting the assurance needs on equality issues. The fourth annual audit of rapid impact assessments (for the 2012 calendar year) showed that “acute & clinical” accounted for 25 of the 86 completed rapid impact assessments (RIAs) throughout NHS Lothian. It is reasonable to expect acute services to account for a larger proportion of RIAs. The creation of this Committee is an opportunity to pull up the standard of decision-making within acute services by making the consideration of equalities issues more systematic.

6.3 The Rapid Impact Assessment generated the following recommendations for the Committee (once established) to take forward:

• The Committee should make attending to equality duties one of its early priorities within its Statement of Assurance Needs. A simple measure is to ensure that all Committee papers have the “Impact on Inequality, Including Health Inequalities” section completed.
• Based on the current level of completion of rapid impact assessments, it is recommended that compliance with equalities duties be added to the Acute
Hospitals Risk Register. Once the Committee is assured that impact assessments are being completed when required and to a satisfactory standard, it can recommend that the issue is taken off the risk register.

7 Involving People

7.1 This is not applicable to this paper.

8 Resource Implications

8.1 The Board secretariat function will provide the secretarial support to this committee. A committee with clear terms of reference that uses a statement of assurance needs is more likely to make better use of its time, and channel its efforts to those areas that clearly need attention. This new committee aims to assist in improving the efficiency and effectiveness of the Board’s system of governance.

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15 January 2014
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List of Appendices

Appendix 1: Terms of Reference of the Acute Hospitals Committee (15 January 2014)
DRAFT TERMS OF REFERENCE OF THE ACUTE HOSPITALS COMMITTEE AS AT 15 JANUARY 2014

Remit:

The Committee is to provide governance oversight of the clinical and non-clinical functions (required to make these hospitals operational and fit-for-purpose) that are provided within the following hospitals:

- Royal Infirmary of Edinburgh
- Western General Hospital
- Royal Victoria Hospital
- Liberton Hospital
- St John’s Hospital
- Lauriston Building (excluding the Edinburgh Dental Institute, which is in the remit of the West Lothian Community Health and Care Partnership)
- Princess Alexandra Eye Pavilion
- Royal Hospital for Sick Children
- Any non-NHS facility that has been engaged to provide additional capacity for functions that would otherwise have been provided in one of the above hospitals.

Functions that are excluded from this Committee’s remit are:

- Primary care contracting with independent contractors (GPs, dentists, ophthalmologists and pharmacists)
- Any other clinical or care function that is within the remit of the Community Health Partnership Sub-Committees or the West Lothian Community Health and Care Partnership Board (or their successor bodies)

The Committee shall discharge its remit by addressing the three elements of the Board’s system of corporate governance; Assurance Needs, Performance Management and Risk Management.

Assurance Needs (Internal Control and Quality)

The Committee’s assurance needs should address the following key areas:

- The quality and safety of clinical services, and their contribution towards reducing harm.
- Compliance with the NHS Scotland Staff Governance Standard.
- Efficient and effective use of resources.

The Committee shall develop a comprehensive list of the functions and services within its remit. The Committee shall then develop its Statement of Assurance Needs so as to satisfy the assurance needs of the Healthcare Governance Committee, Staff Governance Committee, Finance & Resources Committee, and the Audit & Risk Committee.
Once the Statement of Assurance Needs is developed, it shall be used to inform the following aspects of the Committee’s work:

- Commission and receive reports from management and other sources in order to arrive at an opinion on each assurance need.
- Where the Committee concludes that the assurance provided is less than “satisfactory”, seek confirmation from management that the issue is on the appropriate risk register, and an action plan is in place.
- Seek assurance that all relevant Board policies, procedures, protocols etc are implemented as intended.
- Follow-up on any areas that require further management action.
- Report any areas of concern to other relevant Board Committees, or the Board itself.

**Performance Management (Outcomes)**

- Receive and review regular reports on the delivery of relevant operational performance targets, corporate objectives, and outcomes, e.g. waiting times, unscheduled care performance, contribution to HEAT targets.
- Receive and review regular reports on patient and staff safety, quality of care, patient experience, and staff experience.
- Receive and review regular reports on the delivery on efficiency & productivity targets, and overall financial control.
- Investigating areas where performance is less than what is required, and understanding the contribution of the hospital functions to that performance result.
- Where the performance is off trajectory, seek confirmation from management that the issue is on the appropriate risk register, and an action plan is in place to get to the required level of performance on a sustainable basis.
- Where the causes or solutions to an issue lies beyond the functions in the remit of this Committee, to refer the matter to the appropriate committee or the Board itself.

**Risk Management**

- Regularly receive and review the relevant risk registers and develop a clear understanding of the risks.
- Seek assurance that there is a process to ensure that all existing and emerging risks are identified, properly assessed and scored, and recorded on the risk registers.
- Seek assurance that risk is being managed within the Board’s Risk Appetite and Tolerances, and that the exposure to risk is reduced as a consequence of risk management activities.

**Relationship to Other Groups/ Committees**

In the interests of the Committee being informed of all matters pertinent to its remit and for these matters to be assessed holistically, the Committee shall routinely receive the minutes of the following:
University Hospital Services Clinical Management Group  
Scheduled Care senior management team  
Unscheduled Care senior management team and Unscheduled Care Board.  
Local Partnership Forum  
Health & Safety Committees within University Hospital Services sites  
Any other groups that the Committee thinks fit.

This will not disturb the established relationships between the above and the committees/groups/directors that they already report to. The above groups shall be providing minutes to the Acute Hospitals Committee in addition to where they normally send their minutes and/or chair’s report.

A chart illustrating the relationships is at the end of these terms of reference.

The Committee may refer or highlight issues to other Board committees or groups or directors, so as not to duplicate governance activities. Similarly the Committee may have issues referred to it by the chairs of other committees.

Lothian NHS Board has a Strategic Planning Committee and an established process for the review and approval of capital business cases. The Committee will require directors to keep it appraised on any strategic or capital developments in Board strategy which may have a bearing on the Committee’s remit.

**Membership**

The Board will make all appointments with due regard to the current membership of CH(C)Ps sub-committees/board, or any subsequent integration joint monitoring committee/integration joint board that may be established in the future.

The Committee will consist of three non-executive Board members (one of whom shall be the Employee Director), the Medical Director and the Nurse Director. A non-executive Board member shall chair the Committee. All Board members shall have the right of attendance and have access to papers.

The following people shall routinely be invited to attend the meeting: Director of Unscheduled Care; Director of Scheduled Care; Director of Finance (or nominee); Director of Human Resources & Organisational Development (or nominee); Director of Strategic Planning, Performance Reporting and Information; Medical Director-University Hospital Services; Medical Director- Patient Safety and Quality Improvement; and Deputy Director of Nursing.

Joint Directors of Health and Social Care / Chairs of Health and Social Care Partnerships will be invited to attend as required to report on progress associated with delayed discharge, patient pathways, demand management etc.

**Frequency of Meetings**
Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. In any event, meetings shall normally be held six times a year, in advance of full Board meetings, to allow a report to be submitted to the following full Board meeting.

**Quorum**

No business shall be transacted at a meeting of the Committee unless at least two non-executive members are present. Any non-executive Board member may deputise for a non-executive member of this Committee.

**Reporting Arrangements**

The Committee will report to the Board by means of submission of minutes and a summary from the chair of the Committee to the next available Board meeting.

The Committee shall also share the output from work on its Statement of Assurance Needs with other governance committees, so as to inform the conclusions of those committees on the NHS Lothian position on assurance needs.
NHS Lothian Acute Hospitals Committee Structure

NHS Lothian Board

* Finance & Resources Committee
* Healthcare Governance Committee
* Acute Hospitals Committee
* Staff Governance Committee
* Healthcare Governance Committee
* Clinical Management Group
* Management Teams
* Scheduled & Unscheduled Care Senior Management Groups
* Site Based Health & Safety Groups

Notes
1. * Governance Committees
2. Dotted lines/arrows – exchange minutes for information purposes
3. Solid lines/arrows – bodies directly communicate with each other to carry out their role
4. Board committees can request direction to respond to enquiries at any time