NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 22 MAY 2013
TIME: 9:30 A.M. - 12:00 P.M.
VENUE: BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

AGENDA

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Lead Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Members of the Public and the Press</td>
<td></td>
</tr>
<tr>
<td>Apologies for Absence</td>
<td></td>
</tr>
<tr>
<td>1. Minutes of the Previous Meeting of Lothian NHS Board held on 24 April 2013</td>
<td>BH *</td>
</tr>
<tr>
<td>2. Matters Arising (9:35am - 9:55am)</td>
<td></td>
</tr>
<tr>
<td>2.1. Paediatric and Neonatal Staffing</td>
<td>DF *</td>
</tr>
<tr>
<td>2.2. Medical Staffing Risk Assessment Update</td>
<td>DF/AB *</td>
</tr>
<tr>
<td>3. Policy &amp; Strategy (9:55am - 10:20am)</td>
<td></td>
</tr>
<tr>
<td>3.1. Strategic Clinical Framework and 2020 Route Map</td>
<td>AMcM *</td>
</tr>
<tr>
<td>3.2. Corporate Objectives 2012/13 and 2013/14</td>
<td>AMcM *</td>
</tr>
<tr>
<td>3.3. Strategic Planning - Next Steps</td>
<td>AMcM *</td>
</tr>
<tr>
<td>4. Unscheduled Care - Linking the Strategic Clinical Framework with Delivering Sustainable, Quality and Safe Care for Patients (10:20am - 10:50am)</td>
<td>MH/PG *</td>
</tr>
<tr>
<td>5. Performance Management (10:50am - 11:15am)</td>
<td></td>
</tr>
<tr>
<td>5.1. Waiting Times Progress and Performance</td>
<td>DF *</td>
</tr>
<tr>
<td>5.2. Performance Management</td>
<td>AMcM *</td>
</tr>
</tbody>
</table>

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

For further information please contact Peter Reith, ☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
6. Governance (11:15am - 11:40am)

6.1. Quality Report
6.2. Healthcare Associated Infection Update

7. Other Items (11:40am - 11:50pm)

7.1. Proposed Revision to the Terms of Reference of the Audit & Risk Committee
7.2. South East Scotland Research Ethics Committees
7.3. Communications Received

8. Committee Minutes for Adoption (11:50am - 12:00pm)

8.1. Audit & Risk Committee - Minutes of the Meeting held on 2 April 2013
8.2. Finance & Resources Committee - Minutes of the Meeting held on 17 April 2013
8.3. Edinburgh Shadow Health & Social Care Partnership - Minutes of the Meetings held on 11 January, 15 February & 15 March 2013
8.4. West Lothian Health & Care Partnership Sub-Committee - Minutes of the Meeting held on 28 March 2013

9. Date, Time and Venue of Next Meeting: Wednesday 26 June 2013 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

10. Resolution to take items in closed session

Dates of Meetings in 2013: 24 July 2013
No August Meeting
25 September 2013
23 October 2013
27 November 2013
No December Meeting
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 24 April 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 & Organisational Development); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Mrs M Hornett (Nurse Director) and Professor A K McCallum (Director of Public Health & Health Policy).

Non-Executive Directors: Mrs S Allan (Chair from item 2.4); Mr M Ash; Mr J Brettell; Dr M Bryce; Councillor D Grant; Councillor R Henderson; Professor J Iredale; Mr P Johnston (Chair until item 2.4); Mrs J McDowell; Mrs A Meiklejohn; Councillor F Toner; Mr G Walker; Mr G Warner; Dr R Williams and Mr R Wilson.

In Attendance: Mr J Forrest (Director, West Lothian Community Health & Care Partnership); Mr A Jackson (Associate Director of Planning, for item 7); Professor A McMahon (Director of Strategic Planning, Performance Reporting & Information); Mr D A Small (General Manager, East & Midlothian Community Health Partnership); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications & Public Affairs).

Apologies for absence were received from Mr B Houston, Ms K Blair, Mr P Gabbitas, Ms A Mitchell, Councillor C Johnstone and Mr A Joyce.

Chairing of Meeting: The Chief Executive advised that Mrs S Allan (Vice Chair) was running slightly late and the Board agreed that Mr P Johnston should chair the meeting until such time as the Vice Chair arrived.

Declaration of Financial and Non-Financial Interest

Mr Johnston 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. Mr Johnston declared an interest on agenda item 7 in his role as a Non Executive Board Member on NHS Healthcare Improvement Scotland. The Board agreed that it would be appropriate for Mr Johnston to remain in the room during the debate on this item.

1. Minutes of the Meeting Held on 27 March 2013

1.1 The minutes were approved as a correct record subject to the following amendment: Minute 171.6 to read Dr Williams rather than Mr Wilson.
2. **Matters Arising**

2.1 **Paediatrics** - The Medical Director advised the Board he would report on the position in respect of rotas as well as providing an update on recruitment.

2.2 The Board noted the paediatric rota at the Royal Hospital for Sick Children was compliant. A challenge around the neonatal rota at the Simpson Memorial Maternity Pavilion was being covered by using internal locum’s with the position further improving once the neonatal fellow was in post. The Medical Director reported significant issues were being experienced at the Paediatric Intensive Care Unit at the Royal Hospital for Sick Children as a consequence of medium term sickness absence. It was noted that 2 fixed term appointment post had been advertised to help to mitigate this position. It was noted in response to Councillor Toner that there were no significant issues with rotas at St Johns Hospital, with good cover in place over the summer period.

2.3 The Medical Director updated on positive progress with the recruitment of Consultant Paediatricians, Specialist Paediatric Doctors, the Neonatal Fellowship and advanced practitioner posts. It was reported a proactive approach was being taken to horizon scan for future service gaps although it was important to recognise some rotas remained fragile.

2.4 Mrs Allan, Vice Chair assumed the Chair and Mr Johnston stepped down.

2.5 The Medical Director, in response to concerns raised by Councillor Toner, outlined the proactive steps being taken to avoid a summer closure of limited services at St Johns Hospital advising that over July additional staff would be in place with the rota being sustained on a mixed economy basis with the rota becoming more robust as staff developed into their posts. It was reported in response to Councillor Toner that previous difficulties around providing holiday cover for 2 key members of staff had been addressed. The Medical Director advised if all of the Fellowship posts were appointed to this would fill the middle grade gap with the key issue thereafter being around the retention of staff.

2.6 The Medical Director advised in respect of one appointed member of staff who was not currently GMC compliant that the person would be carefully supervised for 4 weeks to ensure skills were fit for purpose. This situation had arisen because of issues around limited availability of information.

2.7 Mrs McDowell commented she would have welcomed a paper on this item commenting verbal reports to the Board should be on an exception basis rather than the rule. The Medical Director explained the logic of providing the verbal report and undertook to provide written updates in future. The Chief Executive reminded the Board that medical staffing was reflected in the Risk Register which it had been agreed would come before the Board on a quarterly basis.

2.8 The Board commented on the need to learn lessons from the paediatric position and to apply these elsewhere in order to mitigate other potential downstream service pressures.
2.9 The Chief Executive advised that medical staffing was generally recognised as a risk and there were different factors in play between medical and nursing recruitment. He commented a key issue in respect of medical staffing was the propensity for specialist working. He reminded the Board of the work that had been commissioned at his request by the South East and Tayside Planning Group (SEAT) on Medical Workforce Planning and this would be discussed later in the day in private session.

2.10 Professor Iredale commented from a University perspective that the intake of students would be undertaken on the basis of providing excellence of service provision and would not be quota based. He reported that junior doctor numbers were determined by Government. The Board noted that Professor Iredale and the Chief Executive had given evidence to the Greenaway Review of the shape of training and that the issues discussed at the Board meeting had surfaced during that evidence.

2.11 **Risk Workshop** – The Corporate Services Manager would circulate details of the dates for the Risk Appetite and Tolerance Board Workshop.

3. **Chairs Introductory Comments**

3.1 **Appointment of Chair** - The Vice Chair advised that Mr Brian G Houston had been appointed as Chair of Lothian NHS Board although he had been unable to attend the current meeting because of previous commitments.

3.2 **Dr Charles Winstanley** - The Vice Chair advised a formal Board dinner would be held on 9 May to recognise the considerable contribution made to NHS Lothian by Dr Winstanley over his 6 years as Chair of the Board. She hoped as many Board members as possible would attend the dinner.

4. **Committee Minutes for Adoption**

4.1 **Healthcare Governance Committee - Minutes of the meeting held on 2 April 2013** – The Board adopted the minutes.

4.2 The Board noted the spiritual care and bereavement update and the importance of end of life care. The Healthcare Governance Committee was also focused on patient experience feedback and the need where appropriate for this to be discussed in a timely way at Board level.

4.3 **Staff Governance Committee - Minutes of the meeting held on 20 March 2013** – The Board adopted the minutes.

4.4 The Board agreed whilst it was important to remain in step with Scottish Government Policy around the Francis Report it also required to be seen to be sufficiently forensic around what was happening within its own services. The importance of identifying internal areas of vulnerability and addressing these irrespective of work being undertaken elsewhere was discussed. The Medical Director advised quality improvement teams had been asked to consider respective services and report back by the end of May in order to inform a fuller paper to the June Board meeting.
4.5 The Chief Executive reminded the Board that at the previous meeting he had reported on debate held by the Scottish Chief Executives Group around the Francis Report. At the meeting the Scottish Government and Chief Executives had a clear sense of the importance of the Francis Report recognising whilst many of the recommendations related to the English NHS specifically there were significant issues to be addressed in Scotland. The Scottish Government view had been they were keen to identify key areas of the Francis Report that they would like to sponsor further work around and although this would not be exhaustive it provided Boards with a baseline against which to work from.

4.6 Dr Bryce suggested each Board member should be responsible for applying forensic scrutiny in this area and that Non Executive Board members might want to be active within their respective committees in undertaking this work. It was noted that the work around the Francis Report needed to link with work around the values statement.

4.7 The Board agreed that the June Board Workshop Seminar would focus on the Francis Report.

4.8 East Lothian Community Health Partnership Subcommittee - Minutes of the meeting held on 28 February 2013 - The Board adopted the minutes.

4.9 The Board noted the debate around the joint commissioning of the older people strategies. It was reported that previously raised issues about attendance at meetings was being addressed and was currently work in progress.

4.10 Mr Small undertook to brief Dr Williams outwith the meeting on the Lanfine Unit and the necessary approval process. Mr Ash stressed no decision on the unit had been made at the meeting held on 28 February 2013.

4.13 West Lothian Community Heath and Care Partnership Board – Minutes of the meeting held on 22 January 2013 - The Board adopted the minutes.

4.14 Mr Walker welcomed the discussion on Single Handed General Practitioners and questioned whether risks were identified and addressed on a Lothian wide basis. The General Manager of the East and Midlothian CHP advised single handed practices by definition were a risk and this was shared with other CHP colleagues with the risk register attempting to define and mitigate the risk. The Board was assured the risk was not in terms of the quality of treatment provided to patients but around the impact on patients if the practice lost its practitioner.

5. **Quality Report**

5.1 The Medical Director advised that the report updated the Board on the standard quality measures and that the May report would focus on clinical effectiveness measures in Mental Health.

5.2 The Board noted work in progress around the need to improve NHS Lothian’s processes for notification, investigating and learning from suicides and potential
suicides including an internal review and a recent approach from the Healthcare Improvement Scotland (HIS) Suicide Reporting System Team.

5.3 The Medical Director reported that the number of cardiac arrest calls in October, November, and December 2012 had stabilised. As previously stated at the Board meeting, the October figures had been due to increases in cardiac arrest calls at St Johns Hospital and the Western General Hospital. The November increase had been predominantly due to calls from the Royal Infirmary of Edinburgh. The Board were advised there was normally an increase in calls at this time of year. It was noted work continued to improve on the situation.

5.4 The Medical Director advised as previously reported that the Francis Report remained at the forefront of work and would be reported on further at the June Board meeting. It was noted that the Government south of the border had produced an initial response to the report.

5.5 Mr Brettell advised he remained concerned about processes around the collection of data and response times in respect of complaints as well as the management of priorities. It was noted at the previous Board meeting it has been agreed to report quarterly to the Board on complaints. The June paper would focus on quality, staffing issues, complex complaints and the general increase in complaints. The Board noted that the NHS Lothian increase in complaints reflected a similar trend in the rest of the public sector particularly because of easier access to the complaints process through social media and email.

5.6 The Director of Communications & Public Affairs advised issues had been raised and discussed with the complaints team through a positive development session. The Chief Executive reported that he and the Director of Communications & Public Affairs had met with the Scottish Public Services Ombudsman who had confirmed the increase in complaints across the public sector in general. It was noted there was a need to look at the NHS Lothian position to determine whether this was as a result of a societal phenomenon or a Lothian unique situation. It was reported in respect of response times that the new focus was on resolving the complaint to the complainants satisfaction. The importance of meeting the 3 day acknowledgement target was emphasised as this confirmed to complainants that the organisation was in receipt off and addressing their concern. Work was underway to investigate the possibility of replicating the ‘early resolution front end model’ introduced by the Ombudsman’s office.

5.7 The Vice Chair advised she was aware that in exceptional circumstances the Chief Executive had met with families and she felt this sent an important message. She stressed complaints was a resource for the organisation to consider and if the Board was working in partnership then it was reasonable to expect people to hold the Board to account.

5.8 Mr Walker commented from his memory NHS Lothian had never achieved complaints targets and he questioned whether sufficient resources were being applied. In addition he felt issues often got slowed down in a process that was not fit for purpose and suggested there might be mileage in triaging complaints. He also questioned what progress had been made by the Medical Director around readmission rates.
5.9 The Medical Director advised in respect of readmission rates he was looking at random sets of notes using a structured template and would report back on the outcomes to the Board in July once the position had been discussed at the Healthcare Governance Committee in June. Mr Wilson commented his perception was that the position had worsened over previous months and not stabilised as had been reported.

5.10 Mr Walker commented whilst he welcomed the considerable improvement in the report he felt it would further benefit from better trend analysis over time quoting the waiting times report as an example. The Medical Director advised that in line with the Francis report recommendations the format of the quality report would be reviewed in totality as issues about upward reporting had been identified as a specific issue.

5.11 The Director of Human Resources & Organisational Development acknowledged the points made about the complaints process and suggested as a first step the review of processes should be undertaken which would in turn inform whether additional staff resource was required or whether the team could work differently. He advised that the June report to the Board would discuss the issues raised at the Board meeting.

5.12 Mrs McDowell commented that the report suggested that, since July / September 2012 and the subsequent reporting quarter, complaints numbers had reduced whilst compliance targets had significantly worsened and she found the explanation of staff absence within the complaints team as difficult to accept. The Director of Human Resources & Organisational Development advised he and his colleagues accepted the current performance level was not acceptable. He commented that the response provided in respect of sickness absence had been an honest answer which had led to discussions with the team and the subsequent development sessions being arranged.

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

6. Healthcare Associated Infection Update

6.1 The Director of Public Health & Health Policy provided her regular update on Healthcare Associated Infection to the Board advising that the *staphylococcus aureus bacteraemia* target had not been met. The reasons for the increase in numbers was being looked at and appropriate lessons would be learned. Healthcare Improvement Scotland had confirmed that they were seeing an increase in the number of people admitted into hospital with infections. It was noted that full year data was now available and this would inform issues that needed to be addressed.

6.2 The Board noted that the *clostridium difficile* target had been met although there were continuing problems with *norovirus* that were being addressed. The Board noted that the Executive lead for healthcare associated infection had transferred to the Nurse Director as it was important to embed this work into routine operational business. The Nurse Director advised in respect of the absence of data for the
Royal Victoria Hospital that this was because there had been no infections and this was good news.

6.3 Mr Brettell questioned whether there was any correlation between hospitals with lower hand hygiene compliance levels and those with higher rates of healthcare associated infection noting that the Director of Public Health & Health Policy had previously stated the differences in hand hygiene compliance levels were statistically insignificant. The Director of Public Health & Health Policy commented the two issues were not inconsistent although instances could occur by chance. It was noted however that good hand hygiene was one of the best ways of controlling infection. The Vice Chair commented she would welcome seeing data in respect of Public Hand Hygiene Compliance.

6.4 The Board agreed the recommendations in the circulated paper.

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

7.1 The Nurse Director advised that the purpose of her report was to update the Board on the Royal Infirmary of Edinburgh Inspection Report and NHS Lothian’s action plan in response to this. She reminded the Board that in a previous inspection at the Royal Infirmary of Edinburgh significant concerns had been raised and that the current report recognised the improvements made although it was import not to be complacent. She commented that the key focus should be about caring for all patients in a dignified way even when the system was under pressure and that in that regard work was underway to improve the care provided.

7.2 The Nurse Director in response to a comment about the apparent lack of timescales or outcomes in the action plan advised that work was in place to address these issues particularly through the wider Vulnerable Peoples Action Plan which was updated on a regular basis. She confirmed that where specific actions were identified that leads, timescales and outcomes had been identified.

7.3 Dr Bryce commended the reported improvements commenting that some of the work moving forward would need to look at recommendations around pressure sores care. She reported in her capacity as Chair of the Clinical Governance Committee she had sought assurance from the Chair of the Staff Governance Committee that staff training was in place to ensure compliance with policies as she felt this was a proxy around how issues were addressed across the system. The Nurse Director recognised the difficult balance between service provision and training and advised that a lot of the work around the Vulnerable Peoples Action Plan was about taking training into the work environment in a variety of innovative ways. She commented educational work and resources for staff were being put in place although this was a significant task across the acute and community sector.

7.4 Mr Wilson commented in respect of the Francis Report that he would like to see external reports cross referenced to the Francis Report. The Nurse Director reported from a nursing perspective this work had already commenced prior to the Francis Report issuing.
7.5 Mr Walker questioned in respect of Francis how the Board would know it had proper staff levels and staff mix in place. The Nurse Director advised currently the Board would not have this information although a lot of work had been done over the previous few months which would culminate in a report being brought to the Board or a Board Development Session to provide reassurance based on benchmarked data.

7.6 The Chief Executive referred the Board to the recent media debate and the Royal Collage of Nursing’s comments about nurse staffing levels. He reminded the Board that NHS Lothian was now a net recruiter of nurses partly because of the need to open beds to increase capacity to deal with waiting times and unscheduled care issues. He advised targeted investment had commenced in some front door areas.

7.7 The Director of Human Resources & Organisational Development in response to Dr Bryce’s comments about training advised he and the Employee Director would agree with the Staff Governance Committee how to address these points. Thereafter he and the Nurse Director would bring back an update report to a future Board meeting.

7.8 The Board agreed the recommendations in the report and that the Nurse Director would arrange for time to be set aside for further discussion.

8. Waiting Times Progress and Reporting

8.1 The Medical Director advised performance continued to improve. The number of inpatients waiting over 12 weeks had dropped by two thirds on the level of 6 months previously and over 1900 less than at its peak in 2011. The Board noted 97 of those waiting over 12 weeks were for procedures excluded from the treatment time guarantee. The remaining 233 were predominantly waiting for complex operations that could only be undertaken in NHS Lothian.

8.2 The Medical Director advised the challenge moving forward was to sustain capacity for elective services whilst meeting the treatment time guarantee.

8.3 The Board noted the positive position in respect of outpatients and endoscopy waits and that further continued improved performance was anticipated.

8.4 The Board noted the progress being made in reducing the number of patients waiting longer than the national targets and standards.

9. Performance Management

9.1 The Director of Strategic Planning, Performance Reporting & Information advised that the performance paper had been revised following the NHS Lothian March Board where it had been agreed that from 1 April only the 16 HEAT targets plus the standards on Delayed Discharge and Cancer Waiting Times and Stroke Performance would be included. It was noted other waiting times and performance information on waiting times and unscheduled care would be addressed under separate reports.
9.2 The Board received specific reports in respect of cancer (62 day and 31 days); accident and emergency waiting lists; delayed discharges; children and adolescent mental health services and psychological therapies.

9.3 It was reported in response to a question about the impact on vulnerable patients in respect of access to Child and Adolescent Mental Health Services (CAMHS) and psychological therapies that the CAMHS 18 week wait was a maximum target with there being a desire to shorten this. The Director of Strategic Planning, Performance Reporting & Information advised in respect of psychological therapies that this was a service that people needed almost instant access to and that work was underway on the baseline information with the ambition being to move staff and resources to meet and grow capacity in the areas where it was required.

9.4 The Vice Chair commented that the Edinburgh Patient Public Forum regularly expressed concern about the lengths of wait in this area. Mrs Meiklejohn commented that in East Lothian a redesign exercise has been undertaken which would be rolled out across NHS Lothian and would help to mitigate the current position.

9.5 It was agreed that future reports to the Board should provide further narrative in the comment box in respect of performance areas which were either amber or red.

9.6 The Director, West Lothian Community Health & Care Partnership advised in respect of delays that West Lothian patients would not suffer any delays irrespective of the campus in which they were treated as social work staff followed patient journeys.

9.7 The Chief Executive commented there was a tendency to correlate delayed discharge with poor performance around 4 hour waits. He advised he had asked management teams to identify where delays actually existed with the results confirming that internal processes were as important as delayed discharges and were often at the heart of the problem along with capacity. He advised that having the granularity of data allowed resources to be targeted. The Chief Executive commented given the positive performance around delayed discharges in West Lothian it would be important to look and learn from that model.

9.8 Mr Walker commented he was concerned that the performance report was lacking focus and was being used as a tick-box exercise. He felt there was an argument moving forward to have focus on a specific area in the report such as delayed discharges supported by trajectories for improvement where actions were off target. The Director of Strategic Planning, Performance Reporting & Information advised that the Board has previously agreed that delayed discharge performance should be reported under the wider performance report and undertook to give consideration on how best to present the report in future.

9.9 The Board agreed the recommendations in the circulated paper and the future proposed developments around the paper and noted the generally positive performance.

10.1 The Director of Finance advised that an underspend of £0.477m had been achieved for the year ended 31 March 2013 compared with the forecast breakeven position reported since the midyear review. The position encompassed a base line underspend of £4.164m offset by unachieved efficiency savings of £3.717m.

10.2 The Board noted of the net underspend of £2.6m that £2.2m had been used to reduce the level of brokerage received from the Scottish Government for waiting times leaving an underspend of £0.445m to carry forward into the next financial year.

10.3 The Director of Finance advised that these outcome figures were subject to confirmation by External Audit.

10.4 The Director of Finance advised that there had been a significant capital programme delivered in-year including £5m of additional backlog maintenance as well as the purchase of medical equipment as a consequence of slippage on the Royal Hospital for Sick Children / Department of Clinical Neurosciences programme.

10.5 The Director of Finance provided further detail around predicted staff underspends and the breakdown of waiting times spend between the public and private sector. The Chief Executive commented in respect of waiting times that the strategy had been to simultaneously develop two approaches. The first of these had been to clear the backlog and get patients treated as quickly as possible. It was noted as the backlog reduced the system would have a better indication of what the internal recurring capacity required to be. He reminded the Board that it would take some time to build up internal capacity and during that period there would continue to be a need to use private sector capacity. The Board noted a report would be brought back to a future meeting detailing tranche two capacity investments. The Medical Director commented work was underway to look at different ways of working as well as the provision of staff over the coming years.

10.6 Mr Walker commented on the importance of the Board recognising how good a financial outturn position had been delivered and congratulated the Director of Finance and her staff on this stellar achievement in a year that had contained significant challenges.

10.7 The Board noted the achievement of financial targets for the year 2012/13, subject to external audit review.

11. Unscheduled Care Briefing for March 2013

11.1 The Nurse Director commented that the system continued to experience difficulty in achieving the target for 4 hour A & E waits and commented although attendance was down with admissions stable there was evidence of an increase in the age of patients, the complexity of their conditions as well as an increase in the length of stay for this patient group.
11.2 The Board noted that norovirus continued to be an issue in the Royal Infirmary of Edinburgh and Liberton and this resulted in significant delays in patient flow as Liberton was effectively the gateway out of the Royal Infirmary of Edinburgh.

11.3 The Nurse Director advised that the 7 day flow was being looked at in order to move patients through the system and that discussions continued with CHPs and others around reducing admissions into the acute sector. It was noted that the winter debrief had been undertaken and that planning was already underway for the onset of the next winter.

11.4 The Nurse Director in respect of the acute sector advised that management structures had changed to a site management team focus with a view to the holistic management of all site issues and this linked to the ongoing integration agenda. It was noted that work on wards 109 and 209 and the admission unit was progressing.

11.5 Mr Brettell commented that over the previous 18 months the level of performance in this area had not been satisfactory even prior to the impacts of winter. He commented that the report made no mention of key actions and timescales and he felt the Board needed this information. The Nurse Director commented that a draft trajectory graph was available with a view to returning performance to the 95% target level. She commented that the complex nature of issues and the interplay between these was a particular challenge, particularly at a time when the system did not have enough beds.

11.6 The Chief Executive commented that although the enormity of addressing the waiting times issue should not be lost that the unscheduled care position was much more difficult to resolve particularly as the impact of demographic and population changes became apparent along with the challenges of dealing with a significantly older population. The Chief Executive commented that the Board Development Seminar scheduled for 1 May 2013 was a critical touch point as one of the questions the Board would have to address would be how much extra capacity could be achieved on the 3 key acute sites and to what timescale.

11.7 Mr Brettell commented that the Board needed to see strategic options from management based on logical assumption in order for the Board to review the action plan to address the unscheduled care position.

11.8 Dr Bryce commented that workforce solutions always appeared to be medical or nursing based and questioned whether there were solutions that could be provided by other groups of staff. The Nurse Director advised additional investment had been made in AHPs and other staff groups including support staff. The Director of Strategic Planning, Performance Reporting & Information advised part of the solution should be about delivering capacity in primary care and the third sector.

11.9 The Director of Public Health & Health Policy commented there were ways of improving the way people were cared for when they arrived in the acute sector. She advised in primary care there had been an increase in emergency appointments because of the impact of the economic crisis. She commented there was also an economic gradient in the use of unscheduled care services.
11.10 The Chief Executive commented he understood the Board’s desire for an action plan and trajectories. He advised there was no quick fix solution and there was a need for the Board to set out a number of strategic markers. He reminded the Board that it had recently approved the Clinical Framework Strategy and this would be a touchstone document moving forward. It was agreed that a paper would come to the Board detailing the actions in hand and projected trajectory to return to the 95% target.

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

12. Single Outcome Agreement

12.1 The Director of Strategic Planning, Performance Reporting & Information provided the Board with an update and overview of engagement by NHS Lothian in the development of the refreshed single outcome agreement within each Community Planning Partnership in Lothian. He commented that the timescale for submission of the single outcome agreements had been deferred until June and in that regard he would be happy along with CHP General Managers to engage further in order to develop the final proposals for agreement by the Board.

12.2 Mr Ash commented that there was a need to ensure that different sectors engaged in the single outcome agreement properly through the Community Planning Partnership process. He commented that some Community Planning Partnerships did not have Board member representation and felt this was a concern. The CHP General Manager for East & Midlothian advised that work was underway to resolve this position and he would provide Mr Ash with detail outwith the meeting.

12.3 Councillor Henderson welcomed the circulated paper commenting that in the past the Community Planning Partnership model had not been effective and had functioned on an information sharing basis rather than taking actions although this position was now changing. He agreed with the points made by Mr Ash about process although he felt this would evolve and improve going forward. He stressed that issues around welfare reform and employability etc could only be achieved in partnership and success in this area would have a downstream impact on the unscheduled care agenda.

12.4 The Director of West Lothian CHP Partnership Board advised in West Lothian over the previous 8 years engagement had been undertaken on a multiagency basis with a subcommittee focussing on outcomes. He advised that the West Lothian Single Outcome Agreement had been upheld as an exemplar. He advised within West Lothian single outcome agreements were embedded in the performance agenda.

12.5 The Board agreed that the Director of Strategic Planning, Performance Reporting & Information would progress further work around the finalisation of the single outcome agreements offline.
13. Corporate Objectives

13.1 The Director of Strategic Planning, Performance Reporting & Information provided the Board with details of progress made in delivering NHS Lothian’s corporate objectives for 2012/13 and invited agreement of the final proposed set of corporate objectives for 2013/14. He commented that the circulated paper also highlighted minor updates to the Strategic Clinical Framework to take account of Scottish Government priorities. He advised that the corporate objectives were now aligned to the Strategic Clinical Framework.

13.2 The Board noted that NHS Scotland had developed a route map to the 2020 vision for Health and Social Care which had recently been shared with Boards. The Director of Strategic Planning, Performance Reporting & Information advised that the NHS Lothian Strategic Clinical Framework approved by the Board in February had been crossed checked with 12 priority key deliverables in the route map and he was confident that the NHS Lothian position mirrored the national position.

13.3 Mrs McDowell commented in respect of the 2012/13 corporate objectives that there were gaps in reporting and performance and that the paper did not provide an analysis of whether individual objectives had been met. She felt there were also issues around timing and whether objectives had been achieved. She felt the report was not comprehensive enough to provide the Board with assurance that the corporate objectives had been achieved.

13.4 The Chief Executive commented that the intention was that the colour coding contained within the report would confirm whether objectives had been achieved or not at a glance and that draft objectives had previously been considered by the Board with any suggested changes having been incorporated. The Director of Strategic Planning, Performance & Information accepted that there were some areas of performance that would be capable of containing subtleties that needed to be further explained.

13.5 Mrs McDowell commented if objectives had not been completed to the deadline then it should be reflected as a red achievement status and provided an example within the paper where this would apply.

13.6 Mr Walker commented that he agreed with Mrs McDowell and Mr Wilson that there was not sufficient time to consider the paper in the necessary level of detail at the current meeting. He commented he felt that it would be more appropriate to discuss this early in a future agenda.

13.7 The Chief Executive commented that virtually every corporate objective had been referenced in previous Board meetings and assured the Board that these were not taken lightly.

13.8 Mrs McDowell commented that as the end of the year had passed she felt there was a need to pause and look at what had been achieved as well as what needed improvement. It was agreed that an update report on the corporate objectives would be provided to the May Board meeting.
13.9 The Chief Executive commented that this paper represented the basis for the annual review. Mr Walker commented that unlike in previous years there was a need for Non Executive Board Members to receive early notice of the date and venue of the Annual review meeting.

13.10 The Vice Chair commented that the Cabinet Secretary was seeking views on the future format of the annual review process to include better engagement with Non Executive Directors and members of the public.

13.11 The Board agreed to receive an update report at the May Board meeting.

14. **Shadow Health & Social Care Partnership Board Memberships**

14.1 The Board agreed appointments to the Shadow Health & Social Care Partnership Boards for East Lothian, Edinburgh and Midlothian subject to the spelling of Mrs McDowell’s name being corrected.

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

15.1 The Director of Human Resources & Organisational Development commented that this was the equivalent paper to the Midlothian one considered at the previous meeting. He advised he had met the Chief Executives of both East and Midlothian Council and secured agreement around the contents of job descriptions. He commented that he had met the Human Resources Departments of both authorities and that process issues had been agreed.

15.2 The Director of Human Resources & Organisational Development advised the equivalent paper had gone to the East Lothian Council meeting the previous day and had been approved. If NHS Lothian also approved the paper this would complete the governance process. It was noted if the paper and arrangements were approved it was the intention to have people in post by the middle of May.

15.3 Councillor Grant confirmed that the East Lothian Council approval of the paper had been unanimous.

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

16. **Communications Received**

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

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

17.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 22 May 2013 in the Boardroom Waverley Gate, 2 - 4 Waterloo Place Edinburgh.
18. **Invoking Standing Order 15.2**

18.1 The Vice Chair sought permission to invoke standing order 15.2 to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke standing order 15.2.
PAEDIATRIC AND NEONATAL STAFFING

1. Purpose of the Report

1.1 The purpose of this report is to provide an update on paediatric and neonatal workforce issues in NHS Lothian.

2. Recommendations

2.1 Note the actions that are being taken to manage these issues.

2.2 Approve the actions underway to mitigate the risks associated with the current shortages in paediatric and neonatal staffing.

3. Discussion of Key Issues

3.1 Gaps in middle grade registrar rotas caused by maternity leave, less than full-time training and out of programme training currently affect all paediatric and neonatal rotas in Lothian (as well as Borders and Fife) including the neonatal intensive care unit at RIE, the paediatric intensive care unit at RHSC, general and speciality paediatric rotas at RHSC and the paediatric and neonatal service at St John’s. From August 2013 there will be no middle grade trainees allocated to the paediatric and neonatal unit at St John’s or Borders for out of hours work.

3.2 The Community Child Health Service is facing staffing shortages now and in coming months mostly due to retirements and difficulties in recruiting. This service provides most of the medical input into child protection concerns in Lothian. In particular, over the summer there will be no consultant based in West Lothian. In addition recruitment to the post of Designated Doctor for child protection in Lothian has been unsuccessful on two occasions.

3.3 Recruitment within paediatrics and neonatology in recent months comprises

3.3.1 One consultant paediatrician based at St John’s. There are out of hours resident shifts in the job plan (in addition to two other consultants and an associate specialist who also work in this way).

3.3.2 One specialty doctor in paediatrics based at St Johns with out of hours resident shifts in the job plan.

3.3.3 Four clinical fellows in paediatrics who will be based at St John’s. These doctors are from Myanmar and start dates are dependent on meeting the requirements of the General Medical Council and the UK Border Agency.

3.3.4 One clinical fellow in neonatology based at RIE.

3.3.5 Two Advanced Neonatal Nurse Practitioners who will be based at RIE.

3.3.6 Recruitment to two further clinical fellow posts based at RIE and two based at RHSC is underway.

3.3.7 This recruitment is in addition to two consultant paediatricians and three consultant neonatologists recruited in 2012 to support services across Lothian.
3.4 Access to less than full time training for new applicants is currently being granted at a minimum of 0.8 of full time rather than the previous 0.5 or 0.5 of full time.

3.5 Each of the paediatric and neonatal units is dependent on a combination of internal locums (all), external agency locums (St John’s) and consultants undertaking resident middle grade out of hours shifts (St John’s and the paediatric intensive care unit at RHSC) (with the consequent impact on clinical activity the day before and the day after the out of hours shift) to produce workable rotas. Unless there are unforeseen developments we anticipate being able to cover all the acute rotas over the summer.

3.6 In the Community Child Health Service

3.6.1 We have implemented a redesign of medical input to child protection Interagency Referral Discussions with Police and Social work to take account of the staffing challenges.

3.6.2 Consultants in the Community Child Health Service based in Edinburgh, East and Midlothian have moved clinical sessions to provide consultant presence in West Lothian for over half the week pending successful recruitment.

3.6.3 We have recently recruited a consultant who will be based in West Lothian with a start date likely to be in the autumn.

3.6.4 We are optimistic that another appointment of a consultant based in West Lothian can be made of the summer with a start date in the autumn.

3.6.5 Child Protection Nurse Advisers are being trained to take on some of the child protection work but are not yet working independently.

3.7 The Scottish Government Health Department and NHS Lothian have commissioned and external Workforce Support Team to review measures taken so far, review the work underway and support the local management team in managing the staffing challenges.

3.8 The planning group chaired by the Director of Operations for Women, Children and Neurosciences NHS Lothian, Mrs Fiona Mitchell, meets fortnightly to assess the situation and operationally manage issues that develop.

4. Key Risks

The key risks are

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

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

4.3 Short notice staffing problems in a unit that are difficult to manage because of the tight rotas in every unit which affect the ability to deliver a safe service in that unit.

5. Risk Register

5.1 The risk associated with the paediatric and neonatal workforce is on the Board risk register.

6. Impact on Health Inequalities

6.1 An equality and impact assessment has not been undertaken.
7. Involving People

7.1 Planning for a public information campaign on the risks to paediatric and neonatal services in West Lothian is underway.

8. Resource Implications

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

8.2 The costs associated with locum use on all sites.

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

Dr Edward Doyle
Associate Divisional Medical Director
Women, Children and Neurosciences
8 May 2013
MEDICAL STAFF RISK ASSESSMENT UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on our medical staffing risk assessment work and to advise the Board on the plans and actions being taken to meet safely the needs of patients and quality standards.

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

2 Recommendations

2.1 Note the updated medical risk assessment position.

2.2 Recognise the variables and fragility of medical staffing in identified areas.

2.3 Contribute to the plans and actions being taken, agree the approach to clinical priorities and contingency planning and to receive regular progress reports at subsequent meetings.

3 Discussion of Key Issues

3.1 Background

3.1.1 The Board receives a monthly report on unscheduled care from the Nurse Director and the Joint Director of Health and Social Care. In previous reports to the Board the investment in the Emergency Medicine service at St John’s Hospital were set out.

3.1.2 In the November 2012 Board paper on unscheduled care the Board noted that Emergency Medicine medical staffing is integrated across all three Emergency Departments. The Board heard that the Joint Management Team had committed substantial additional investment in August 2012 to support the latest version of the Emergency Department Workforce Plan, to manage safely the national reduction in the number of Emergency Medicine trainees since 2011. The Board also noted that the full impact of the planned national reduction in trainees would be reached in August 2013.

3.1.3 The November Board paper also notified the Board of proposals to attempt to include trained GPs in the regular staffing overnight in the Emergency Department at St John’s Hospital, instead of trainee medical staff as part of the aim to move towards a sustainable trained workforce for service delivery, in line with approaches used elsewhere in Scotland. The plan also intended this group of staff to be supplemented by dedicated Emergency Nurse Practitioners. The plan set out that
the GPs who would work within the Emergency Department would be part of a tailored Emergency Medicine training programme, to enhance further their existing skills within the specialty, and ensure their continuous professional development. The GPs would be employed through the Lothian Unscheduled Care Service (LUCS) and be subject to an agreed governance framework.

3.2 Medical Workforce Risk Assessment

3.2.1 At the April Board meeting the Director of Human Resources and Organisational Development and Medical Director briefed the Board on the work being undertaken in Lothian and across the SEAT region in respect of Medical Workforce Risk Assessment.

3.2.2 The Medical Workforce Risk Assessment process is still a work in progress but it was noted that it had focused initially on a number of potentially vulnerable front door specialties and raised Emergency Medicine as a significant risk in relation to the reduction in trainee numbers and the potential impact on service delivery. Trainees are responsible for the delivery of the majority of out of hours work. Emergency Medicine was highlighted as the first “very high red risk” followed by Paediatrics, Obstetrics and Gynaecology, Vascular and Medicine for the Elderly. This has been noted on the corporate risk register and services are working on plans to mitigate against any risk to service delivery.

3.2.3 The rota sustainability score in the risk analysis highlighted Emergency Medicine as the top rated risk in relation to the correlation between impact and likelihood to happen. A score of 25 was assigned (the highest possible) with a potentially extreme impact on service delivery being combined with the scenario being assessed as almost certain to occur in the next three years.

3.3 Recruitment Situation

3.3.1 Over the past 18 months the Emergency Medicine service has attempted to recruit Speciality Doctors, Nurses, Consultants and most recently GPs. (Adverts attached at Appendix 1). The recruitment exercise was successful in appointing consultants which will extend the consultant presence in the department to 2300hrs. However less than half of the Specialty Doctor posts which were planned to cover the out of hours gap which was previously covered by trainees were filled. Appointments were made to all of the advertised nursing posts who will support the Triage area and time to first assessment.

3.3.2 The response to the advertisement to recruit GPs to cover the anticipated gap of 100 hours per week at St John’s (currently covered by trainees) which has arisen as a result of an inability to recruit Specialty Doctors has been quantitatively poor with only one applicant. This means further work is necessary to look at the medical staffing resource across NHS Lothian to maintain services.

3.3.3 Traditionally consultants in Emergency Medicine have not routinely worked overnight in the department, being on-call from home. This allows consultant staffing levels to be adjusted to ensure that there are sufficient senior medical staff present in the Emergency Department at times of peak activity. With the current number of consultants it may not be possible to staff Emergency Departments...
satisfactorily during peak hours if the consultant resource is utilised to work overnight.

3.4 Current Recruitment Investment

3.4.1 Over the past 10 months the Emergency Medicine service across NHS Lothian has made appointments above previous staffing levels of 6.5 wte consultant staff, 25 additional nurses and 3 Emergency Nurse Practitioners which represents additional planned investment of £2.4m.

3.5 Action Plan and Contingency Planning

3.5.1 A group of senior clinicians and senior managers has been established to agree an action plan and contingency arrangement.

3.5.2 The group includes the Director of Human Resources and Organisational Development, Nurse Director, Medical Director, Employee Director, Associate Medical Director, Clinical Director for Emergency Medicine, Clinical Director - LUCS, Clinical Director West Lothian CHCP, Joint Director - West Lothian CHCP - Head of Health West Lothian CHCP and the General Manager, East Lothian and Midlothian CHP’s as host of the LUCS service.

3.5.3 This group has already met and focussed on actions to ensure the maintenance of clinical services by a) ensuring most effective use of all existing resources across Lothian b) identifying and responding to reasons why GPs are not willing to apply for the posts c) identifying other potential ways of filling the gaps. The following list of actions can be seen as falling into these categories:

- Examine the job plans of all Emergency Medicine Consultants, in particular the number of programmed activities, the supporting professional activity/direct clinical care split, less than 12 session contracts. All of this aimed at maximising the current available staff resource and to explore shift working.
- Consider appointing GPs to the Emergency Medicine department at RIE (more support available) to allow a resource shift of Emergency Medicine medical staff to provide out of hours cover at St John’s Hospital.
- Make direct approaches to the current GP registrar group to encourage applications and agree support requirements.
- Consider the establishment of a rota for GPs (a mixed economy model) with Emergency Medicine/LUCS/Prison Healthcare to aid GP’s to retain their primary care skills for revalidation.
- Examine all avenues for pay and reward flexibility with the agreed terms and conditions of employment.
- Examine the potential inclusion of acute physicians as the trauma element is already filtered out of St John’s Hospital to the RIE.
- Examine the further development of Emergency Nurse Practitioners and Paramedics to cover minor injuries/musculoskeletal injury.
- Re-advertise as widely as possible existing vacancies.
- Examine the out of hour’s emergency services in NHS Borders and NHS Dumfries & Galloway which have GP involvement to see if any lessons can be learned.
- Develop a contingency plan in the event that any combination of the above points still leave gaps in service cover. This may require an extension of the
existing diversion strategy that has been safely operated for a number of years. Any such strategy will focus on ensuring that all patients are getting the right treatment in the most appropriate place and would enable the majority of out of hours patients to continue to be treated at St John’s.

4. **Context**

4.1 Emergency Medicine and the medical staffing of Emergency Departments is a pressure point for the NHS across the United Kingdom. The College of Emergency Medicine is warning that Emergency Departments are facing “unsustainable workloads” and the biggest challenge for over a decade. The recruitment of trainees is via a UK wide recruitment process which has not yet been completed for the August 2013 intake, but an estimation by the Post Graduate Dean has suggested the expected fill rate for these training slots will be between 32% and 41% depending on examination results.

4.2 In South East Scotland the number of core trainees will fall from 15 to approximately 13 in August 2013 and the number of Higher Specialist Trainees (middle grade staff) from 25 to approximately 14. This means that the number of trainees at St John’s will fall from 5 to 2 and at RIE from 12 to approximately 8.

4.3 Across the UK attendances at Emergency Departments continue to rise and the College reports a 50% increase from 10 years ago. The College argues that between 15% and 30% of patients turning up at an emergency department do not require urgent care and could instead be treated in non-emergency settings.

4.4 In the medium to longer term we need close collaboration between colleagues in primary and secondary care to redesign the service to ensure it is safe, of an appropriate quality, appropriately funded, and consistently provided 24/7 across all sites.

4.4.1 Maintaining safe Emergency Departments for patients that are acutely ill or injured is a top priority. The policy of diversion of patients from West Lothian with medical conditions such as surgical emergencies or major trauma to the RIE has worked successfully for many years. If there is a need to extend this policy because of medical staffing challenges, this will be explored although it is vital to note that the St John’s department itself will remain open 24/7.

4.4.2 There are approximately 20 attendees at RIE every hour between 1100 - 2200hrs. The average number of out of hours attendees per hour between 2300 - 0700hrs is 7 at RIE and 2 at St John’s. Approximately 30% of attendees on both sites are admitted.

4.5 Although it is essential that we have contingency plans developed to cope with this medical staffing risk, we will however leave “no stone unturned” in our efforts to maintain the existing service at St John’s Hospital if it is possible, as we have done thus far with paediatrics. If contingency plans are required to be put into action, the order of priority for medical staffing levels to be maintained will be according to the patients’ needs and the resources available on the site. The Royal Infirmary would be the first priority because it provides trauma and regional services such as interventional cardiology. The RIE Emergency Department is the largest department in Scotland and is supported by a comprehensive 24 hour radiology service.
Specialist paediatric emergency services at the Royal Hospital for Sick Children would also need to be maintained as it is also a tertiary regional provider.

5 Key Risks

5.1 Medical staffing is identified as one of the key risks on the Corporate Risk Register because of its potential impact on service delivery and the sustainability of services. Any change to the existing diversion strategy will impact on the already busy RIE.

6 Risk Register

6.1 The NHS Lothian risk register contains a ‘Medical Staffing’ risk. The multi-factorial risk assessments that have been carried out will be added to the risk register as and when they are completed. They will be reviewed and updated where necessary on a 6 monthly basis.

7 Impact on Inequality, Including Health Inequalities

7.1 The introduction of the medical workforce risk assessment process will not in itself have any implications in relation to inequality. A Rapid Impact Assessment will be carried out on any issues that may emerge as part of the process.

8 Involving People

8.1 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.

9 Resource Implications

9.1 The resource implications are not yet known.

David Farquharson
Medical Director
17 May 2013
David.farquharson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Job Adverts
NHS Lothian - University Hospitals Division

GP with a Special interest in Emergency Medicine
Reference: CG 397

Applications are welcome for the above permanent 6 posts based at St John's Hospital. 100 hours are available to be split between the successful candidates.

More detailed departmental and specialty information can be found in the job description available via email address / link below.

For an informal discussion please contact either Dr Dave Caesar, Consultant on 0131 242 1338 e-mail dave.caesar@nhslothian.scot.nhs.uk or Dr Sian Tucker, Consultant on 0131 537 9152 email sian.tucker@nhslothian.scot.nhs.uk.

For a job pack detailing the minimum requirements for this post and associated training and development opportunities, please visit www.medicaljobs.scot.nhs.uk or email medical.personnel@nhslothian.scot.nhs.uk. Please quote reference CG 397.

Closing Date: 4th May 2013
NHS Lothian - University Hospitals Division

Consultant
Emergency Medicine – 6 posts
Reference: CG 368

Applications are welcome for the above permanent, 40 hours full time posts based at either the Royal Infirmary of Edinburgh or St John's Hospital.

More detailed departmental and specialty information can be found in the job description available via email address / link below.

For an informal discussion please contact Dr Dave Caesar, Consultant on 0131 242 1338 e-mail dave.caesar@nhslothian.scot.nhs.uk

For a job pack detailing the minimum requirements for this post and associated training and development opportunities, please visit www.medicaljobs.scot.nhs.uk or email medical.personnel@nhslothian.scot.nhs.uk. Please quote reference CG 368.

Closing Date: 6th March 2013 noon

Interview Date: 18th March 2013
NHS Lothian - University Hospitals Division

Specialty Doctor
Emergency Medicine – 4 posts
Reference: CG 359

Applications are welcome for the above permanent, full time / part time posts based at the Royal Hospital for Sick Children & St John’s Hospital.

More detailed departmental and specialty information can be found in the job description available via email address / link below.

For a formal discussion please contact Dr Dave Caesar, Consultant on 0131 242 1338 e-mail Dave.Caesar@nhslothian.scot.nhs.uk.

For a job pack detailing the minimum requirements for this post and associated training and development opportunities, please visit www.medicaljobs.scot.nhs.uk or email medical.personnel@nhslothian.scot.nhs.uk. Please quote reference CG 359.

Closing Date: 23rd February 2013
REFERENCE NUMBER: SJH/2012/ENP6/5/R1

JOB TITLE: Emergency Nurse Practitioner x 3

GRADE: Band 6

LOCATION: St Johns Hospital

CONTRACT DURATION: Permanent

HOURS: 37.5

CLOSING DATE: 22 MAY 2013

SALARY SCALE: £25,528 - £34,189

Apply on-line www.jobs.scot.nhs.uk

**Please note – the e-mail address you provide on the application form will be used to communicate any further correspondence relating to this vacancy**

This post requires the post holder to have a PVG Scheme membership/record. If the post holder is not a current PVG member for the required regulatory group (i.e. child and/or adult) then an application will need to be made to Disclosure Scotland and deemed satisfactory before they can begin in post.
REFERENCE NUMBER: SJH/2012/ENP6/5

JOB TITLE: Emergency Nurse Practitioner x 3

GRADE: Band 6

LOCATION: St Johns Hospital

CONTRACT DURATION: Permanent

HOURS: 37.5

CLOSING DATE: 18th April 2013

SALARY SCALE: £25,528 - £34,189

Apply on-line www.jobs.scot.nhs.uk

**Please note – the e-mail address you provide on the application form will be used to communicate any further correspondence relating to this vacancy**

This post requires the post holder to have a PVG Scheme membership/record. If the post holder is not a current PVG member for the required regulatory group (i.e. child and/or adult) then an application will need to be made to Disclosure Scotland and deemed satisfactory before they can begin in post.
Director of Strategic Planning, Performance Reporting & Information

STRATEGIC CLINICAL FRAMEWORK AND 2020 ROUTE MAP

1 Purpose of the Report

1.1 The purpose of this report is to highlight minor updates to the Strategic Clinical Framework to take account of Scottish Government 2020 Route Map.

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

2 Recommendations

2.1 Note Scottish Government Route Map to the 2020 Vision for Health and Social Care.

2.2 Note the changes made to the Strategic Clinical Framework in line with the 2020 Route Map.

2.3 Note the draft communications plan for supporting the launching and embedding of the Strategic Clinical Framework.

3 Discussion of Key Issues

3.1 NHS Scotland has developed a route map to the 2020 vision for health and social care which has recently been shared with Board Chief Executives (see appendix 1). The NHS Lothian Strategic Clinical Framework approved by the Board in February has been cross-checked with the 12 priority key deliverables in the route map. While all 12 priority areas are already reflected in the Framework the following revisions have been made to reflect increased points of emphasis:

Priority: Care for multiple and complex illnesses
An action has been added to aim 2: “We will develop our models of care and responses to address the needs of people with complex and multiple morbidities.

Priority: Safe Care
"Safe" added to aim 3 to read: “Ensure that healthcare is evidence-based, incorporates best practice, and achieves safe, seamless and sustainable care pathways for patients

An action has been added to this aim: “Improving patient safety in all healthcare settings will continue to be a top priority, through our participation in the Scottish Patient Safety Programme.”
Priority: Primary Care
An action has been added to aim 1: "We will develop the role of primary care through a new primary care strategy and support primary care teams to respond to the needs of people with complex and multiple morbidities.

A copy of the revised Strategic Clinical Framework is attached at appendix 2. The draft Communications Plan is attached for information at appendix 3.

4 Key Risks

4.1 No risks are identified in the production of this paper and the revised Strategic Clinical Framework.

5 Risk Register

5.1 No risks are identified as a result of the paper itself and the revisions to the Strategic Clinical Framework. Individual actions and any need to place issues on the risk register will be considered as part of the Local Delivery Plan actions for implementing HEAT targets and standards and also the corporate objectives.

6 Impact on Inequality, Including Health Inequalities

6.1 All existing HEAT Targets and standards have been fully impact assessed as have many of the other targets within the set of objectives.

7 Involving People

7.1 Staff have been involved in the development of the Strategic Clinical Framework and the review of it against the newly published 2020 Route Map. Wider staff groups will be engaged and consulted with as a result of the Board signing off the Framework in February and the work that will now be undertaken in implementing it.

8 Resource Implications

8.1 Resource implications will be highlighted as this work progresses.

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13 May 2013
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Alex McMahon
Director of Strategic Planning
alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: A Route Map to the 2020 Vision for Health and Social Care
Appendix 3: Draft Communications Plan

2
APPENDIX 1

A ROUTE MAP TO THE 2020 VISION FOR HEALTH AND SOCIAL CARE

Introduction

This paper summarizes some of the excellent achievements which have been secured in recent years through a focus on improving quality in our health and care services, and reflects that these achievements are at least partially responsible for the high regard with which Scotland is held internationally.

However, over the next few years the demands for health and social care and the circumstances in which they will be delivered will be radically different. It is our job to ensure that we can continue to provide the high quality health and care services the people of Scotland expect and deserve into the future, securing the best possible outcomes for people from the care and support they receive. We must therefore collectively recognise and respond to the most immediate and significant challenges we face. These include Scotland’s public health record and level of inequalities, our ageing population, the increasing expectations arising from new drugs, treatments and technologies and the specific impact of inflation on the health service.

This paper sets out a new and accelerated focus on a number of priority areas for action in the form of a ‘Route Map’ to the 2020 Vision for Health and Social Care in Scotland. It has been designed to make measurable progress to the 2020 vision, with specific deliverables in 2013/14. The key features of the Route Map are that it:

- recognises the importance of the public service reform agenda as a framework for delivering the 2020 Vision for Health and Care;
- maintains the commitment to pursuing the 2020 Vision for Health and Social Care through a focus on improving quality at scale across Scotland (building on success e.g. Family Nurse Partnerships, Scottish Patient Safety Programme etc.);
- Pursues opportunities to work with other public sector and business partners to drive transformational innovation, providing growth in the Scottish economy;
- identifies particular areas for accelerated improvement and enhanced roles in unscheduled and emergency care, in primary care in services for people living with multi morbidities providing a whole system response to improve the patient pathway in order to reduce pressure on A&E departments;
- supports our commitment to shift the balance of power to, and builds up and on the assets of individuals and communities through a focus on achieving social change (more people able to care, volunteer etc.), support for the self-management of long-term conditions and personal action (drinking, exercise, diet and engagement) through working in partnership in CPPs and the new Integrated Health and Social Care Partnerships and
- Develops our strategy for engaging and empowering our workforce, providing our response in Scotland to addressing many of the issues raised by the Mid-Staffordshire/Francis Inquiry, and equipping them to work in an integrated way which reflects the different needs of different people and different places across Scotland.
The 2020 Vision for Health and Care in Scotland

'The Scottish National Health Service will be a publicly funded and publicly delivered health care service free to all our citizens. We will have a world-leading healthcare service where everyone is able to live longer and healthier lives at home, or in a homely setting. We will have a focus on reducing health inequalities, on prevention, anticipation and supported self-management. When hospital treatment is required, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.'

We must be bold enough to agree and pursue the key actions which will allow us to turn this 2020 vision into a reality. It is only by doing this that we will secure the health and social care services in Scotland that will best meet the needs of future generations, and demonstrate our ability to deliver a world leading high quality health and care service to the people of Scotland.

Our record of excellence

In Scotland we have considerable experience and success in delivering and improving high quality and sustainable healthcare services which is already recognised internationally as world-leading. In particular our record of successes include:

- legislation to ban smoking in public places,
- significantly reducing premature mortality from cancer, heart disease and stroke through a number of initiatives including most recently the high profile detect cancer early programme
- delivering enhanced patient safety with major reductions in levels of Healthcare Associated Infections (HAI)
- massively reducing waiting times and delayed discharge from hospital and
- effective management of a £12bn budget.

These and other successes are recognised internationally as innovative and aspirational both for what they have delivered to date and for their future scope and potential for improving health, health and social care in Scotland.

We have achieved these successes through working in partnership across Scottish Government, the wider public sector and with staff. Looking ahead, our model remains one of integration, collaboration, outcomes focus, values trust and innovation. We continue to categorically rule out the disruptive type of reforms and upheaval being put in place in NHS England and are committed to continuing to provide high quality health and social care to the people of Scotland that reflects the true values of the people delivering health and social care services in Scotland. Our recognition of the importance of local ownership of decision making and service delivery complements our unified system for governance and accountability in NHSScotland.
During the current spending review we have committed to protecting the health spending by giving a real terms resource increase recognising the very specific inflationary and service pressures facing the delivery of health and care services. Efficiency savings identified by territorial health boards amounting to over £1bn in the last 4 years have been retained by them and used to further enhance local services.

The Challenges

Over the next 10 years the proportion of over 75s in Scotland’s population – who are the highest users of health and care services - will increase by over 25%. By 2033 the number of people over 75 is likely to have increased by almost 60%. Over the next 20 years demography alone could increase expenditure on health and social care by over 70%. These challenges will augment the specific impact of inflation on health and care services. The impact of these and other pressures are demonstrated in the charts set out in Appendix 1.

Despite efforts to address the challenge of health inequalities in Scotland over recent years we have made very little progress. This remains a key priority area.

There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia. Estimates suggest that the number of people with dementia is set to rise from 71,000 to 127,000 within the next 20 years. If we do not dedicate resource to dementia there will be tremendous financial costs to the NHS and Social Services as well as the health and costs impact on carers. Compared with non-caregivers, carers of people with dementia are more likely to take prescribed medication, visit their GP and to report higher levels of stress and physical symptoms.

The 2020 Vision Route Map

The accelerated pursuit of the 2020 vision through the Route Map set out below, building and developing on our model for integrated health and social care delivery will demonstrate competency through our recognition as a world leader in high quality health and care services.

Public Service Reform

It is also important to confirm that the approach makes a vital contribution to our commitment to the 4 pillars of public service reform set out in our response to the Christie Report - reflecting our commitment to achieving outcomes which matter to the people of Scotland while ensuring the financially sustainability of our public services.

Working in partnership is fundamental to achieving progress in each of the priority areas – partnership across the NHS in Scotland, with local government, with the Third Sector, with industry, with central government and with people. This partnership approach is particularly vital for one of our three Quality Ambitions: that
all the services we develop and deliver are person-centred. The focus in the Route Map on developing the workforce and leadership capacity also makes an important contribution to the people pillar. The 2020 Route Map clearly identifies prevention as a priority area of activity around population health, but it is also fundamental to the approaches we will develop to improve care for people with multi-morbidities, and in support of older people through an integrated system. Finally, we will be driving improvement across the range of priority areas using the Framework for Improvement which has measurement and performance as one of its key features.

We continue to support the focus on performance across NHSScotland through the annual process of agreeing Board Local Delivery Plans with improved monitoring and assessment of outcomes. Ensuring that HEAT targets evolve to reflect the key priorities set out in the 2020 Route Map will make an important contribution, alongside a focus on supporting NHS Boards to strengthen their governance roles, and the commitment to work through Community Planning Partnerships and Integrated Health and Social Care Partnerships to ensure that SOAs properly reflect health and social care priorities and that local boards will be held to account for their effectiveness in the delivery of these priorities and for ensuring the effectiveness of CPPs generally.

The Route Map describes 12 priority areas for action for pursuing our 2020 vision for high quality sustainable health and social care services in Scotland in three domains; the quality of care, the health of the population and value and financial sustainability. These domains are often referred to as the ‘Triple Aim’. For each of these domains there will be a small number of priority areas for action, often building on existing work and all requiring focussed attention and acceleration.
1. Further improving the **quality of the care** we provide with a particular focus on:

- **Increasing the role of Primary Care** - There is now a strong consensus on the urgent need for an expanded role for primary care and general practice in particular. This is at the heart of our 2020 Vision, specifically focussed on keeping people healthy in the community for as long as possible and represents a critical prerequisite to tackling health inequalities and the challenges facing unscheduled care.

  **Key deliverables for 2013/14:**
  - Implementation of new GP contract with benefits fully explored and realised
  - 2020 Vision for expanded primary care developed
  - New Models ‘place-based’ primary care developed including a model for remote Primary Care implemented and evaluated

- **Integrating Health and Social Care** - Integration of adult health and social care is a key part of the Scottish Government’s commitment to public service reform in Scotland. We will continue to drive forward the widely endorsed commitment to integrating health and social care services in Scotland.

  **Key deliverables for 2013/14:**
  - Bill introduced to Parliament and gaining Royal Assent
  - Preparatory work with Health Boards, Local Authorities, third and independent sector partners and including development and delivery against new SOAs and the building of effective CPPs

- **Accelerating our programme to improve safety in all healthcare environments** - Building on the world-leading and recognised success of the Scottish Patient Safety Programme, we will continue the ground-breaking extension of this programme into primary care, maternity services, paediatrics and mental health, and will embark on the development of a new Scottish Patient Safety Index to accelerate our progress in driving down harm in acute care settings.

  **Key deliverables for 2013/14:**
  - Further increase in safety in Scottish Hospitals as measured by HSMR and HAI
  - New broader measure of safety developed to increase impact of improvement (SPSI)
  - Maternity, mental health and primary care safety programmes implemented with measureable improvement

- **Improving the way we deliver unscheduled and emergency care** - A new Expert Group has been established to identify and agree high impact actions to transform the way that unscheduled care is delivered with a focus on reducing the number of people who present at A&E departments through action in the community, in primary care and to improve the flow of patients out of A&E. Specific work will be done to improve services at weekends and out of hours in both urban and remote and rural areas
Key deliverables for 2013/14:

- Develop out of hospital Care as part of the National Unscheduled Care Action Plan
- Achieve a sustainable performance on 4 hour A&E waits by end of December
- Improve Patient Care in hospitals by increasing flow through the system

- People-powered health and care services – through the Patient Rights Act and ground-breaking work to develop more person-centred health and care services we will give the public a voice on their experiences to drive up the quality of care but also promote personal responsibility for health and wellbeing, and support self-management so that people are better able to maintain their health and to manage periods of ill health. This will include a focus on improving resources and support to people to help them navigate and understand the system, so that they become more involved and engaged in their healthcare.

Key deliverables for 2013/14:

- Person-Centred Health and Care Collaborative being implemented with measureable improvements locally in experience for patients, their carers and for staff
- Support and clear accessible information will be available to enable people and their carers to manage confidently at home and during times of transition

- Improving our approach to supporting and treating people who have multiple and chronic illnesses - will deliver improved outcomes for people living with multiple morbidities, including mental health conditions. We will consider the whole pathway of care with a focus is on people aged <65 years in areas of deprivation and high levels of health inequalities. This work will link closely with the work to expand the role of primary care, to improve unscheduled care, to put people at the centre and to integrate health and care services. Much of this work will require strong partnership working, and will be supported by Health and Social Care providers playing a full role in Community Planning Partnerships and the development of Single Outcome Agreements, and through the new Integrated Health and Social Care Partnerships.

Key deliverables for 2013/14:

- Key pressure points in the entire patient pathway for most commonly occurring combinations of chronic term illnesses will be identified and actions for address these will be agreed
- Through more detailed analysis of existing data, people will be identified as ‘at risk’ and anticipatory plans will be agreed
2. **Improving the health of the population** with a particular focus on:

- **Early years** - We will drive forward the Early Years Collaborative, breaking new ground in improvement methodology across the full range of public partners involved in a child’s early years, building on successes such as Family Nurse Partnerships and working on the ambition to make Scotland the best place for children to grow up.

**Key deliverables for 2013/14:**
- The world’s first national multiagency quality improvement programme will be implemented across partner organisations to give our children the best start in life

- **Reducing health inequalities** – We will refocus our efforts on health inequalities particularly in the context of benefits cuts which will impact most on those most at risk of ill-health. We will do this by targeting improvement resources into primary care in the most deprived areas of Scotland including staff and equipment such as tele-health facilities, learning from and rolling out successful initiatives such as the Deep-End Practices in Glasgow.

**Key deliverables for 2013/14:**
- There will be a new focus on targeting resources to the most deprived areas
- The successful approach developed in the ‘Deep-end’ GP practices will be rolled out more widely across relevant areas of Scotland reducing the risk of admission to hospital and improving outcomes for people in Scotland’s most deprived communities

- **Preventative measures on alcohol, tobacco, dental health, physical activity and early detection of cancer** - Despite significant improvement in health outcomes in recent years, Scotland continues to have a poor record of healthy life expectancy. Alongside the commitment to refocus energy on targeting health inequalities, we will continue to pursue a preventative agenda in partnership across the public sector, concentrating on tackling Scotland’s relationship with alcohol, smoking and increasing levels of physical activity. We will also continue to invest in the hugely important programme of work to increase the early detection of cancer. Once again, much of this work will require strong partnership working, and will be supported by Health and Social Care providers playing a full role in Community Planning Partnerships and the development of Single Outcome Agreements, and through the new Integrated Health and Social Care Partnerships.

**Key deliverables for 2013/14:**
- There will be a measurable increase in early detection of cancer across Scotland, and particularly in deprived areas resulting in better outcomes
- Implementation of new restrictions on tobacco advertising will result in a reduced rate of smoking amongst teenagers
3. Securing the value and financial sustainability of the health and care services we provide:

- Establish a vision for the health and social care workforce for 2020, and setting out a clear plan of actions which have immediate effect – We will take forward a major programme to work in partnership with staff, professional bodies, and unions to establish and agree a vision for the health and care workforce required to realise the 2020 vision. We will develop a detailed action plan with key deliverables which start to have a significant positive impact for staff and patients in 2013/14 and each year thereafter. One of the early actions will be a focus on workforce planning to ensure that we have the right people, in the right numbers in the right jobs.

**Key deliverables for 2013/14:**

- 2020 Vision for NHSScotland workforce published in June 2013 following extensive consultation
- Detailed action plan agreed to deliver 2020 Workforce vision through modernisation, leadership and management by Summer 2013

- Increase our investment in new innovations which both increase quality of care, and reduce costs and simultaneously provide growth in the Scottish economy - The new Innovation Partnership Board which has been established to take forward the joint Statement of Intent between Government, NHS and Industry will additionally be asked to oversee a new Innovation Fund which will be tested through 2 initial pilots before role out to scale. The approach is an ambitious one and aims to target high value fundraising through philanthropy, European funding, and assessing other models of fundraising.

**Key deliverables for 2013/14:**

- A new fund to provide pump-priming for innovative approaches in healthcare will result in more small/medium Scottish companies working with NHS Scotland to develop and test solutions which improve the quality of care and contribute to Scottish economic growth
- A new procurement portal will be established to encourage small/medium enterprises and other partners, including Third Sector, to work with NHSScotland

- Increase efficiency and productivity through more effective use of unified approaches coupled with local solutions and decision making where appropriate - We will fully implement the Efficiency and Productivity Portfolio of action at scale, including a specific focus on implementing shared services where possible and appropriate, reducing drug costs through a single programme management focus on prescribing savings, which better coordinates both the national and local work in this area and optimise the use of management information to highlight areas for improvement.
Key deliverables for 2013/14:
- A review of national services to NHSScotland will be carried out with recommendations to increase shared services and to achieve further contributions to the shift required of resources from management to front line services, where this does not negatively impact on quality of care.

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<thead>
<tr>
<th>Route Map to the 2020 Health and Social Care Vision for Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Triple Aim</strong></td>
</tr>
<tr>
<td>Person Centered</td>
</tr>
<tr>
<td>Safe</td>
</tr>
<tr>
<td>Primary Care</td>
</tr>
<tr>
<td>Care for Multiple and Chronic Illnesses</td>
</tr>
<tr>
<td>Effective</td>
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<tr>
<td>Health of the Population</td>
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<tr>
<td>Prevention</td>
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<tr>
<td>Value and Sustainability</td>
</tr>
<tr>
<td>Efficiency and Productivity</td>
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<td></td>
</tr>
</tbody>
</table>
Our Health, Our Future
NHS Lothian Strategic Clinical Framework
2013 – 2020
# Contents

Introduction ................................................................................................................. 1
The vision for health and healthcare in Scotland ....................................................... 2
The NHS Lothian context – challenges and opportunities ......................................... 3
Our strategic aims ......................................................................................................... 5
Addressing our immediate priorities ......................................................................... 13
The process we will adopt ............................................................................................ 14
Appendix ....................................................................................................................... 15
Introduction

We have developed this strategic clinical framework to underpin NHS Lothian’s approach to deliver Scotland’s vision for achieving sustainable, quality health care services and deliver a healthier future for everyone.

This framework sets out the principles we will embrace in planning and delivering services and care in Lothian, and identifies how, through integrated working with partners and redesigning services around and with people, we will promote good health and deliver safer, more effective and person-centred healthcare.

It affirms our public service ethos based on social justice and valuing our workforce, and our role in public service reform as a socially responsible organisation promoting equality and protection for the most vulnerable in society.

It is clear that future models of delivering health and healthcare will need to be different and we will be engaging staff, patients and stakeholders in this whole system programme of change and redesign.

We want to embed a culture of continuous improvement to ensure our staff can fully contribute to achieving the best possible health and healthcare based on evidence and best practice.

Starting with our most pressing challenges around waiting times and access to optimal care and support for vulnerable groups including the very young and the very elderly, we need to develop integrated care pathways to ensure that services are consistently high quality, efficient and safe.

This approach will drive the development of our workforce and the use of our financial and capital assets to ensure that everything we do delivers value for patients and the public.
The vision for health and healthcare in Scotland

The Cabinet Secretary for Health, Wellbeing and Cities set out a statement of intent for delivery of health and healthcare in September 2011. This recognised the need for health care to be delivered in radically different ways if NHS Scotland is to continue to provide high quality services in the context of significant challenges. These challenges include Scotland’s public health record, its changing demography and the economic environment.

The Scottish Government’s vision for health care is that by 2020:

• everyone is able to live longer healthier lives at home, or in a homely setting
• we will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management
• when hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
• whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
• there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Scotland’s vision for health promotion and public health remains focused on:

• developing a fairer society and reducing inequalities in health
• addressing the needs of disadvantaged groups
• promoting health in all policies and prioritising prevention, for example by ensuring children get the best start in life.
The NHS Lothian context – challenges and opportunities

Our framework sets out the principles and themes we will adopt in NHS Lothian to deliver the Cabinet Secretary’s vision for achieving sustainable quality healthcare services, which will deliver a healthier future for everyone.

There are specific challenges which we need to address and which mean that we need to change how we operate:

• between 2011 and 2020 the population of Lothian is predicted to increase by 9.3%, from 846,104 to 925,207. The greatest increase with be in the over 75 age group, which will increase by 22.2% over the same period

• the Lothian population aged 0-15 years is also growing, with a projected 14.6% increase in the number of children and young people by 2030

• while the overall health of our population is improving, evidenced by reductions in deaths from coronary heart disease and stroke, there remains a fivefold socioeconomic gradient in the rate of premature death from heart disease. In addition, the risk of multiple morbidity increases with increasing age and lower socioeconomic status. The overall incidence of cancer is expected to rise by 1.4% per annum, and the prevalence of dementia to increase by 70% over the next 20 years. Issues such as obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol present significant public health challenges and are often closely associated with long term conditions such as cardiovascular disease and diabetes

• despite some good progress, inequalities remain in health outcomes across different social groups in Lothian and people in our poorest communities continue to die younger and live less healthy lives

• the shape of our workforce is changing. There will be fewer doctors overall and where doctors skills are needed in specialist areas of care, these may need to be provided on fewer sites to ensure that services are safe. There are however opportunities to develop and use the skills of many staff groups and professional disciplines more effectively

• The global economic downturn means that real terms growth in health spending is not expected to return to the level of 2009/10 until 2025, so we have to deliver better health and healthcare while making best use of limited public resources.
Key principles of our planning framework are therefore to:

- ensure services are safe, clinically effective and person-centred
- focus on prevention and early intervention to help people keep well and anticipate care needs
- take a whole system approach to planning and managing integrated pathways of care working with partner agencies in local authorities and voluntary sector
- reduce unnecessary variation in the way patients are cared for
- deliver services with the appropriate mix of staff skills, ensuring viable clinical staff rotas
- reduce spend on property and buildings as hospital stays reduce to release money for direct patient services
- consider the continued use of active treatments which have not been shown to extend the length of life or improve quality of life
- identify services that are not sustainable in longer term and proactively plan a new way of delivering care
- make sure we stop procedures and treatments which add no clinical value
- maximise the opportunities for use of new technologies to support health and healthcare.
Our strategic aims

We have identified six strategic aims to ensure we can deliver safe effective and person-centred health and social care to meet the needs of the people of Lothian:

1. prioritise prevention, reduce inequalities and promote longer healthier lives for all
2. put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
3. ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
4. design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
5. involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
6. use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively.

The specific areas of focus and the actions we will pursue to achieve each of these aims are described in more detail in the following pages.

Aim 1

Prioritise prevention, reduce inequalities and promote longer healthier lives for all

Everyone should have the same opportunities to enjoy good health as a matter of fairness. The NHS provides health care to everyone free at the point of need and has a role to play in:

- providing services designed to prevent future illness
- taking opportunities to provide advice and support to people to help them to take care of their own health
- working with partners to promote the health and well being of communities and the whole population.
On average, people who are better off have better health than those who are less well off. Social inequalities in health are widest between the most well off and the least well off, with people living in poverty more likely to die at a younger age and to have more than one illness than the rest of the population. Health inequalities are an example of social injustice.

Health services play an important role in improving the health of all people as society changes, but more can be done to make sure the NHS improves health outcomes for people at higher risk of ill health, particularly for people living in hard-pressed circumstances. Care needs to be taken to make sure that changes to the health service do not benefit only those who are better off and unintentionally maintain or increase health inequalities.

We have identified five key actions which must be in place to prioritise prevention, to promote longer healthier lives for all, and to ensure that we reduce inequalities in health:

- we must make sure health services deliver high quality care to the whole population. We will measure the way people use health services and the health outcomes for different population groups. This will help us make sure services are working well for everyone
- we will tailor services and health interventions to people who are at highest risk of ill health to prevent illness where possible and reduce socioeconomic differences in health
- we will strengthen the role of clinical services in preventing illness and supporting people who have health problems to access the help and support they need to maintain their well being and social and economic welfare. For example developing the role of the NHS in pathways which support employability and retention of employment and access to welfare rights advice
- our primary care services are central to identifying the majority of people who are at highest risk of ill health while they are still healthy. We will work with GPs and other community health professions to offer evidence based interventions, identify and reduce risk, and make the most of contacts with patients as opportunities for prevention and health promotion
- We will develop the role of primary care through a new primary care strategy and support primary care teams to respond to the needs of people with complex and multiple morbidities
- We will work closely with local authorities and other agencies to address the social determinants of health, to make sure people have the best chance of living a healthy life and that places they live are designed to promote good health.
Aim 2

Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care settings

Working with our partners in local authorities and the voluntary sector, through health and social care partnerships we will integrate care delivery so that services are organised around the needs of the patient/client.

We will jointly plan our new models by looking at the needs of the local population and work with local authorities and other partners to meet health and social care needs and improve health outcomes.

We will provide more and better care at home and in community settings, supporting individuals to stay at home for as long as possible.

Partnerships will deliver 24/7 community responses including integrated elderly care teams to prevent the negative impact of avoidable admissions to hospital.

We will develop our models of care and responses to address the needs of people with complex and multiple morbidities.

Partnerships will work together to ensure families have access to tailored programmes of support, such as the Family Nurse Partnership, to give every child the best start in life.

We will also work in partnership with other key stakeholders, including those in the private sector where appropriate.
Aim 3

Ensure that healthcare is evidence-based, incorporates best practice, and achieves safe, seamless and sustainable care pathways for patients.

Care will be designed on the basis of evidence-based pathways and care bundles, ensuring staff have the appropriate skills needed to deliver these.

We will pro-actively manage the care of those patients with the most complex needs. This will mean putting in place systems to ensure that care plans are delivered and coordinated across settings, including multi-disciplinary case conferences to plan jointly with patients and carers.

We will encourage and support patients and clinical staff to develop anticipatory care plans.

We will develop standardised care protocols which support collaboration among health and care professionals, ensure equitable access to best practice and reduce unnecessary variation in the care patients receive.

Patient information will be shared with relevant professionals in real-time along pathways to support timely clinical decisions.

Improving patient safety in all healthcare settings will continue to be a top priority, through our participation in the Scottish Patient Safety Programme.

Using evidence, we will identify best practice and adopt it as an innovative learning organisation. We will continuously assess and improve our performance at individual, care condition and organisation level through transparent information sharing and learning discussions across care settings.

We will plan with other health boards how care pathways for those using our regional cancer services can be developed to meet increasing patient numbers and changed care needs.

We will continue the development of the palliative care strategy to deliver care at home, in a hospice or in an appropriate hospital setting so that patients and families are fully supported in their final days.

Through our partnerships with further education institutions we will contribute to teaching, training, research and innovation, and maximise the healthcare benefits of collaborative working.
Aim 4

Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting.

We will work with the local community to enable people to make best use of the services of general practices, community pharmacies, out-of-hours primary care centres and the minor injury service, and reduce unnecessary attendance at emergency departments.

We will increase the focus on prevention, including raising awareness of health risk factors which allow people to anticipate health problems and develop anticipatory care plans to prevent or minimise their impact.

Patients’ emergency care needs will be met on an ambulatory basis rather than being admitted to hospital when possible, using agreed care pathways to enable rapid access to assessment, diagnosis, treatment and practical care and support at home.

When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm for most planned hospital care.

For those who do require inpatient care, admission and discharge to their home or community environment will be safe and timely, with no boarding, unnecessary delays or avoidable re-admission.

We will reduce the length of stay in hospital, including in our specialist treatment and rehabilitation facilities for many patients. Hospital teams will work with colleagues in community health and social services to ensure seven-day discharge from hospital.

Aim 5

Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families.

Care will be provided to the highest standards of quality, safety and equity, whatever the setting, with the person at the centre of all decisions.

We will reaffirm our core values, engaging with staff teams and with patients to develop, share and demonstrate our beliefs about what excellent quality care means for patients, carers and staff.
We will ensure stronger public involvement in the design and delivery of health services, and recognise the value that can be added by such participation.

As well as partnership input to designing our pathways of care, we will use patient experience and feedback to check the outcomes and impact.

We will encourage and support individuals to care for their own health through early identification of health issues, providing information and developing self-care plans for those with long term conditions.

We will encourage and support people of all ages to be able to participate positively to health and wellbeing in their local communities.

**Aim 6**

**Use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively.**

**People**

We will ensure that our management culture, organisational vision and values base support and engage all staff to contribute positively to the implementation of this strategic clinical framework within the ethos of public service.

As an employer we will ensure that our recruitment, retention and workforce development approaches are socially responsible and promote social justice and reduce inequalities.

We will engage fully with staff and their representatives across the care spectrum to maximise their contribution to delivering better services; this will include reviewing the balance of generalist versus specialist teams, facilities and services.

We will ensure service models are based on sustainable service capacity and workforce plans, withdraw from unsafe clinical staff rotas and redesign services to ensure high quality and safe care.

Professionals’ skills will be fully utilised with staff skills and roles developed and aligned to maximise effectiveness so that care is delivered by the most appropriate member of the team.

We will continue to work across regions and Scotland to ensure specialist skills and facilities are shared and developed, recognising our role as a regional centre for more specialist services.
Technology

Telehealth and telecare facilities will be coordinated across health and social care to enable remote access to care and monitoring, and support self-management, helping people to live independently at home.

We will always treat information about patients and their care confidentially, but appropriate sharing of information between health and care professionals and with patients themselves should be the norm. Information about patient history and treatment plans will be shared electronically with professionals involved, and the patient/client, to ensure best possible decisions.

The Clinical Portal being introduced will provide a simple and secure way for clinical professionals to review a patient’s medical information from multiple sources in a single, secure on-line location, assisting decision-making about care.

We will also develop a Patient Portal which will allow patients secure electronic access to information on their health and care and to information to support self care and involvement in decisions.

Value for public money

We will focus our funding where it has the biggest impact on people’s health and wellbeing and where appropriate disinvest in services of low clinical value.

We will manage our costs to be financially sustainable while maintaining or improving health outcomes through waste reduction, lean processes and enabling staff to work to their full potential.

Care pathways will be designed to reduce wasteful activities for patients and staff: unnecessary duplication of tests, appointments, recording of information; unnecessary waiting for patients; avoidable transfers and travel.

Buildings and Estates

We will look at the physical space and land that we own and make decisions, based on clinical need, on opportunities to safely move off sites, reducing land and property running costs, reducing our environmental impact and releasing funding to be invested in other services.

We will continue a programme of primary care premises development providing accessible community-based healthcare facilities.
Less hospital inpatient care may mean we need fewer hospital beds, with those that we do need provided in appropriate and fit for purpose accommodation.

We will continue to have three acute hospital sites at the Royal Infirmary of Edinburgh, St John’s, Livingston and the Western General Hospital, reviewing what services are delivered at each as we redesign care pathways.

We will develop a new Royal Hospital for Sick Children and Department of Clinical Neurosciences on the Royal Infirmary of Edinburgh site at Little France.

We will review the future model for delivery of specialist rehabilitation services in hospital and the community.

We will re-develop the Royal Edinburgh Hospital site as a shared campus for mental health and other related services such as learning disability, brain injury and acquired brain injury and neurological conditions.

We will develop a new model of care for community hospital services in East Lothian.

We will review the future of some of our smaller sites such as the Astley Ainslie Hospital, Corstorphine Hospital and Liberton Hospital, which provide a less than optimal setting for patient care in terms of privacy, dignity and safety, as we modernise the facilities and locations in which the care of older people is provided.

We will ensure that our sites contribute to the development of a healthy built environment that they contribute to delivering Scotland’s targets for sustainability and support the local economy.
Addressing our immediate priorities

NHS Lothian is facing particular and immediate challenges to ensure that we are able to provide treatment to patients within an acceptable length of time, and we are taking action to provide additional short term capacity for planned care. Access to responsive and timely unscheduled care particularly for older people is also an area where we know there is a need to do better.

Our initial priorities will therefore be:

- integrated older people’s care pathways focusing on care and support for frail/elderly patients with complex needs
- consistency of care for older people with complex needs accessing high volume elective surgical pathways such as urology and orthopaedics
- improved condition-specific pathways associated with long term conditions such as CHD, stroke, respiratory diseases, diabetes.

We are already working closely with our local authority partners to develop new models of care and put in place plans to ensure we can jointly meet the care needs of our population. Our response to the Government’s proposals on the integration of health and social care, and local joint commissioning plans for older people and children’s service plans, are fully aligned with the aspirations this framework sets out for improved health and healthcare for the people of Lothian.
The process we will adopt

We need to engage staff, patients and other partners to develop new ways of working across integrated pathways for major patient groups and conditions over the next 3-5 years.

Whole system redesign teams will be established with a long term remit and a continuous improvement ethos to plan and implement changes to how care is delivered. Each team will be led by front-line health and social care practitioners with voluntary sector, patient and carer input, supported by health and social care partnerships to:

- systematically review our major clinical care pathways across care settings
- use research evidence, best practice guidance, and staff and patient experience
- design, implement and sustain improved service delivery outcomes
- develop effective primary care, secondary care and social care interfaces
- deliver joined-up care for patients.

Priority areas of focus for teams will be:

- identifying the target (high risk) populations through analysis of patient level data
- setting up enabling processes e.g. access to specialist consultation, protocols and pathways
- allocating resources to deliver care at the right time and in the right location to best meet needs
- using real-time reporting and tracking and shared information to monitor patient progress.

Corporate resources and systems will be aligned to support these service teams, including organisational development, health information analysis, e-health, lean process improvement and quality improvement teams. Teams will have access to a programme of education and support from redesign experts.

Alongside taking steps to improving our services as a priority, we are working with our staff to create the more positive and supportive organisational culture that is essential to achieve our aims. Through affirming our vision and shared values with staff, and developing leadership capability at all levels, we will ensure that staff are able to contribute fully to delivering better health and healthcare.
Appendix

NHS Lothian Clinical Strategy Engagement Events

- Strategic Planning Directorate
- Public Health and Health Policy Directorate
- UHD Senior Management Team
- Clinical Strategy Event – public/patient (x2)
- Area Clinical Forum
- East Lothian CHP Sub Committee (x2)
- Lothian Partnership Forum (x2)
- Allied Health Profession meeting
- Staff Governance Committee
- Clinical Board
- Informatics Board
- Service Redesign Committee
- Lothian Area Division of Psychiatry
- Directorate Governance Group
- Pharmacy Senior Management Team
- Carers Action Midlothian
- Lothian Cancer & Planning Implementation Group
- Lothian Faith Group
- Primary Care Forward Group
- Lothian Area Pharmaceutical
- Lothian Area Medical Committee
- Nurse Directors Meeting
- West Lothian CHCP sub-committee
- Edinburgh CHP sub-committee
- Carers of West Lothian
- Managed Clinical Network representatives
- West Lothian Community Planning Partnership
- East Lothian Community Planning Partnership
- Health Promotion Department
- The Grand Rounds – RIE
- Lothian Psychology Committee
- Edinburgh Partnership Board
- Midlothian Partnership Board
- Corporate Management Team
- Midlothian CHP sub-committee
- Edinburgh Health & Social Care SMT
- Edinburgh Joint Board of Governance
Our Health, Our Future

NHS Lothian Strategic Clinical Framework 2013 - 2020

Communications Plan
1. Introduction

The purpose of this document is to set out the communications plan for launching and embedding NHS Lothian’s Strategic Clinical Framework.

The Framework was agreed by the Lothian NHS Board at its meeting in February 2013 and will now underpin all of NHS Lothian’s activities and our approach to delivering Scotland’s vision for achieving sustainable quality health care services and a healthier future for everyone.

The Framework will be linked to NHS Lothian’s corporate objectives and the developing vision and values to provide staff with a comprehensive package of principles, guidance and direction for the provision of services and care in Lothian.

This package will be presented to stakeholders as our long term vision for service delivery.

Separate communications plans will be developed for the implementation of service developments and change as a result of the Framework being introduced.

It is important to have a co-ordinated approach to internal and external communications, including all media relations, in order to ensure consistency of approach and communication of key messages.

2. Communications Objectives

- To establish the Strategic Clinical Framework as a reference document within the organisation ensuring that all plans, developments and changes to services can be linked back to the Framework and underlining principles
- To ensure staff understand the important role the Framework plays in shaping our services for the future
- To encourage staff to contribute positively to the implementation of the Framework
- To ensure staff understand the links between the vision and values, the corporate objectives and the Framework
- To raise awareness among all key stakeholders of the key principles and strategic aims of NHS Lothian’s planning Framework
To ensure that communication and consultation around service re-design is linked to the framework.

3. Key Messages

- Providing safe, clinically effective and person-centre care is our priority

- The demographics of our population are changing and, in order to provide sustainable, quality healthcare for the people of Lothian, we will need to do some things differently in the future

- The Strategic Clinical Framework is a tool to ensure that services across Lothian are planned and shaped with the same core principles - it comprises ten principles for planning and six strategic aims

- The Framework takes account of the challenges that we need to address, including an increase in the over 75 age group, inequalities in health across different social groups and the increase in multiple morbidity as a result of these factors, as well as changes to the workforce and the continued limited public resources in the current economic climate

- The Framework will help us live our values, deliver our vision and support us in achieving our corporate objectives through the efficient and effective use of the resources we have – skilled people, technology, buildings and equipment.

- Partnership and key stakeholders, including patient representatives, have been involved and engaged in shaping and developing the Framework

- Developing the Framework has identified three initial priorities:
  - integrated older people’s care pathways
  - consistency of care for older people with complex needs
  - improved condition specific pathways for long term conditions
4. Target Audiences

The initial communications will mostly be directed at staff. This will help embed the Framework into the internal planning and service re-design processes.

External communications will focus on the long term vision and how the framework will help NHS Lothian achieve this.

Individual communication and engagement plans will be developed for service re-design and development projects as required. These will be tailored to meet the needs of the specific stakeholders for the service.

**Internal audiences**
NHS Lothian staff:
- JMT
- CMTs
- Senior Managers
- Frontline staff

Health and Social Care Partnerships

**External audiences**
Councillors
MSPs and MPs
Local authorities
Patients
Carers
Members of the public
Voluntary sector and community groups
Scottish Government Health Department
Media

5. Communications Action Plan

In order to achieve the objectives of the communications plan a range of activities has been proposed, as listed below. The detail and timescales for communications activity will be agreed and finalised by the Strategic Planning Communications Sub Group.
Internal Communications
Connections article
Dedicated section on the NHSL intranet
Team Brief article
Managers Brief
Standard presentation
Big Picture events
Q&A sessions
Case studies

External Communications
Health Link article
Dedicated section on the NHSL website
Social Media messages
Briefings for MSPs, Scottish Government, Councillors.
Media activity

7. Evaluation

Evaluation of the communications activities will be based on the outcome of the measurable communications objectives. This will be through feedback from staff and the strategic planning team who will be supporting departments to apply the framework. Awareness and use of the Framework, the principles and strategic aims will also be assessed through the Investors in People assessment process.

Media relations can be evaluated through the amount of coverage, its tone and position in publications.

ENDS
CORPORATE OBJECTIVES 2012/13 AND 2013/14

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note and discuss as appropriate the progress made in delivering NHS Lothian’s Corporate Objectives for 2012-13, and to agree the final proposed set of Corporate Objectives for 2013-14.

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

2 Recommendations

2.1 Note and provide any comment on the achievement against NHS Lothian’s Corporate Objectives for 2012-13 as set out in the narrative and the actual performance as set out in Appendix 1.

2.2 Agree the set of proposed Corporate Objectives for 2013-14 as set out in Appendix 2.

2.3 Note that the corporate objectives for 2013/14 are aligned to the six key aims of the Clinical Strategy Framework.

2.4 Note that for the first time two new team objectives for the Executive Directors have been set on ensuring patient and staff safety and delivery of high quality patient care.

2.5 Note that there is also the inclusion of an objective on communications which will look at internal and external communications and to support the delivery of the key messages related to the ‘Values work’ and also the Strategic Clinical Framework.

2.6 Note that individual Executive Directors objectives are aligned to these corporate objectives and were taken to the Remuneration Committee on 9 April.

3 Discussion of Key Issues

3.1 NHS Lothian’s Corporate Objectives for 2012-13 comprised 57 actions. Appendix 1 details progress against each.

3.2 Significant progress has been made against the 2012/13 objectives and these are highlight within the appendix by either a red or green status. Red being that we have not achieved or met the timeline and green that we have met the target and or the timeline.
3.3 The proposed Corporate Objectives for 2013-14 comprise 50 actions, which include the revised HEAT targets and standards for 2013-14.

3.4 The 13/14 corporate objectives build on the 2012/13 objectives as many of the objectives relate to programmes of work that need to be developed or progressed over several years.

**Progress in respect of objectives and actions for 2012/13:**

3.5 To note that not every objective or action is being highlighted within this report as all of these objectives and actions have been reported to the Board and its committees during the course of 2012/13.

3.6 The Board agreed and signed off our new Strategic Clinical Framework in February 2013. In doing so this will allow the management team to progress a range of actions including reviewing the model(s) of care that NHS Lothian and its partners need to deliver in order to meet the future demands forecast through the growth in our population and the need to review our clinical services, the need for redesign and co-location of services.

3.7 During 2012/13 significant work has been undertaken, aligned to our ‘review of the organisations culture’. This work has also been aligned to the development of the Strategic Clinical Framework and is set out through the development of a set of ‘values’ for the organisation. This has involved engagement and consultation with around 3000 members of NHS Lothian staff. This is an important exercise as it means that the final set of values will have been influenced directly by over 10% of our total staff. Board members as well as Area Clinical Forum and Area Partnership Forum colleagues will be participating in a session on this topic on 6 June.

3.8 During the course of 2012/13 NHS Lothian addressed a significant waiting times agenda. During the course of the year the Treatment Time Guarantee was also introduced and we have been working to ensure that we comply with this legal requirement. During the year we reduced the number of patients waiting over 12 weeks for outpatients from 4418 in April 2012 to 2426 in March 2013 and for inpatients from 2000 in April 2012 to 330 by March 2013. In order to achieve this we have had to utilise the private sector as well as the Golden Jubilee Hospital. During 2013/14 we will review our use of the private sector and how we can build up internal capacity to repatriate a lot of activity that we had to send to the private sector.

3.9 Workforce pressures were a key issue during 2012/13 and in particular the issues relating to medical paediatric cover at St John’s Hospital. Significant investment has gone in to recruiting both specialty doctors and nurses to support the service on this site and these actions have been reported to the Board on a monthly basis.

3.10 NHS Lothian’s performance on a range of waiting times and access targets varied during the course of the year. Our performance on 31 day and 62 day cancer performance dropped and at one point we fell below the 95% target for 62 days. Since the beginning of 2013 our weekly, monthly and quarterly performance has been sustained above 95% for both. Undertaking the discipline of weekly breach analysis and learning from these and taking corrective actions around how patients
are passed through the system and decision points have helped to improve performance.

3.11 Our performance in respect of meeting the 4 hour, and 12 hour Accident and Emergency targets is not as we would have wished over the course of the year. Over recent weeks we have seen our performance in respect of 4 hours improve, both within the Royal Infirmary and across the other three acute hospital sites. However during the performance year we have hovered around 88% against the 98% target. ‘Flow’ through our health and social care systems was not as we would have wished and during December and January we saw 63 and 75 people delayed longer than 12 hours within our A&E and assessment areas.

3.12 Our performance on this has improved and by comparison during April we only experienced 9 people waiting longer than 12 hours, however we would not wish to see any 12 hour waits and it is our ambition to work towards 12 hour waits being ‘never’ events. NHS Lothian was not the only Board that experienced significant difficulties through the year and in particular over the winter period. A number of other Boards also experienced unprecedented numbers of people waiting longer than 4 and 12 hours and very few Boards achieved the 98% target.

3.13 The Scottish Government have now changed the target from 98% to 95% and upgraded it back from a standard to a target, with delivery against this to be achieved by September 2014. At which point the target will be elevated back to 98%.

3.14 Through the Nurse Director and the Joint Director, Edinburgh and the Unscheduled Care Group that they jointly chair they will oversee a range of developments which will improve our performance. These include new step down and care home beds; additional nursing and medical staff at the front door of the Royal Infirmary of Edinburgh and St John’s Hospital and improvements around patient transportation and wider models of care within the community.

3.15 Our performance in the delivery of stroke care is an area of concern and we continue to experience problems, many of which are aligned to the wider unscheduled care pressures but also noticeably the continued pressure that having norovirus has had on our bed availability both within stroke units but also more generally. We did not achieve the 90% target for all stroke patients being admitted to a stroke unit within a day of admission by March 2013. Indeed our performance in March has dropped to 46% and we are now putting a range of actions in place to prevent any further deterioration in this performance, such as protecting stroke beds, a new consultant commencing in July and additional nursing posts and weekly breach analysis. The latter being important as this was one of the actions that assisted us in improving our cancer care performance.

3.16 The number of people recorded as delayed in our system has improved year on year but not has much as we would want it to and we have not been able to achieve the position where by we have no one people delayed longer than 28 days. This is a key area of improved for us and will sit alongside our actions in unscheduled care as the main pressure points are around the Royal Infirmary of Edinburgh and the Western General and within the Edinburgh Council area. We are also looking to prevent admission to hospital where possible and appropriate. One development will be the creation of ‘step up’ beds and further development around community
led responses such as the Consultant lead team who GP’s can contact and ask for advice from in order to try and manage patients better at home (COMPASS) and better use of our day hospitals are amongst the actions that we are taking.

3.17 Many of the metrics and targets above mean that our response to the pressures of winter was not as we might have expected given the planning that was undertaken between us and our council partners. Norovirus was a significant issue this winter, indeed it started in October 2012 and even now in May 2013 continues to have a significant effect on our capacity and ability to deliver care and treatment, particularly on the Royal Infirmary and the Liberton Hospital sites. Planning for ‘winter 2013/14’ has now commenced and we will continue to look for primary and community based responses as well as any additional beds that may be required for surge during times of high demand on our hospital systems.

3.18 However during 2012/13 we did achieve delivery of the substance misuse target i.e. 90% of patients were assessed and treated within 3 weeks of referral. We achieved 93.1% by March 2013.

3.19 During the year we continued to meet the target on the number of alcohol brief interventions that were required to be delivered. Indeed we have now trained over 604 professionals across NHS Lothian and other partnerships to deliver these interventions. Smoking cessation was another good area of performance for NHS Lothian. We are showing through our performance that we have achieved the reduction in the number of people smoking and did so by December 2012, three months ahead of the target date.

3.20 Integration between adult health and social care has been a key theme during 2012/13 and we have progressed this agenda to the point that we have agreed shadow partnership arrangements in West Lothian and Edinburgh and we have agreement to establish shadow arrangements and to progress to appointing Joint Directors in East and Midlothian. Within health we have agreed to change the alignment of the functions within the Royal Edinburgh Hospital to the Edinburgh partnership as well as the lead responsibility for in-patient beds for learning disability and substance misuse. These services are also now exploring ways of improving how they are integrated at a community level. We are also progressing the discussion with Edinburgh Council in relation to a separate children’s partnership that could be in shadow form by April 2014. West Lothian already includes children’s services in their partnership.

3.21 We have constantly reviewed the way in which we bring information to the Board and we now take monthly reports on waiting times, healthcare associated infection and quality, unscheduled care and the reporting of our performance against HEAT targets. During the year we have said that we will review the way in which information is presented within these reports and changes have been made to the Quality and the Performance reports.

3.22 One area of our business continuity and emergency planning that was seriously tested out during 2012/13 was in respect of the Legionella outbreak. This required a multidisciplinary response to ensure that the public health and health protection response was as effective as it could be. We have received recognition by Scottish Government and others for our handling at the point and post outbreak.
3.23 Progress continues to be made in implementing the Boards strategies in sexual health and HIV as well as mental health and well-being. Work on the next stages of the learning disability and the physical and complex care strategies as well as the children and young people’s strategies will be brought to the board in 2013/14 as 2012/13 was there final year. In doing so a reflection on achievements achieved will be provided.

3.24 Although we achieved financial balance and indeed an under spend of circa £600K we had a shortfall of £12m in recurring savings which will be addressed in 2013/14.

3.25 Staff sickness although reported as red was a significant achievement for NHS Lothian in that we were only just above the target of 4%. NHS Scotland performance was 4.8% and we were 4.29%.

4 Key Risks

4.1 Risks associated with the delivery of HEAT targets and standards are detailed within the draft Local Delivery Plan Risk Management Plan which is also being discussed at the February Board. Other performance indicators are reported to the Board on a regular basis through a range of Board papers and updates.

5 Risk Register

5.1 Once approved, the proposed Corporate Objectives for 2013-14 will be linked directly to and where appropriate placed on the corporate risk register and will also be closely monitored by the Risk Management Steering Group.

6 Impact on Inequality, Including Health Inequalities

6.1 All existing and new HEAT Targets and standards for 2013/14 have been fully impact assessed as have many of the other targets within the set of objectives.

7 Involving People

7.1 Staff across the organisation are involved in the development and the subsequent delivery of corporate objectives and this is evidenced through team based and individual objectives.

8 Resource Implications

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

Moray Paterson
Business Manager
10 May 2013
moray.paterson@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning

List of Appendices

Appendix 1: NHS Lothian Corporate Objectives 2012-13
Appendix 2: NHS Lothian Corporate Objectives 2013-14
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>OBJECTIVE 1: DEVELOP THE NHS LOTHIAN CLINICAL STRATEGY TO PROVIDE A FRAMEWORK FOR SERVICE REDESIGN ACROSS THE ORGANISATION</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a clinical framework to support the redesign of clinical services which will meet the changing needs of our population and which are available to all of them who may benefit. Adopt evidence based best practice and models of health care which focus on patients and clients to ensure that we achieve the best outcomes for our population, using tool such as LEAN as appropriate.</td>
<td>March 2013</td>
<td>AMcM</td>
<td>Framework was signed off at the Feb Board meeting. Strategic Planning Group established and will oversee the development of future strategies and implementation. Modernisation Team/Improvement Support is aligned to this work</td>
<td>🟢</td>
</tr>
<tr>
<td>Design and implement phased changes to roles and working patterns to deliver the future service models.</td>
<td>Ongoing</td>
<td>AMcM</td>
<td>Work programme has been developed, and was taken to the March Planning Group in advance of the 1st May Board Seminar.</td>
<td>🟢</td>
</tr>
</tbody>
</table>
### OBJECTIVE 2: FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing / October 2012</td>
<td>DF / SG</td>
<td>Weekly waiting times meeting chaired by the Chief Executive monitoring progress towards reducing the backlog of patients requiring out patient/day case/in patient treatment. Senior operational managers meet every Friday morning to review the implementation of Demand and capacity plans to ensure that there are sustainable solutions to meet the 12 week Treatment Time Guarantee and 18 week Referral To Treatment Target. Financial budgets agreed. Tranche two investments are currently being considered.</td>
<td>🟢</td>
</tr>
<tr>
<td>Ongoing</td>
<td>DF</td>
<td>Weekly monitoring of both 31 &amp; 62 day treatment times continue. Latest monthly review shows performance above 95% for both standards.</td>
<td>🟢</td>
</tr>
</tbody>
</table>

Continue to develop capacity plans and supporting financial plans to support the delivery of national access targets across all specialities, working with the Scottish Government Team to put plans in place which are sustainable, including the 12 weeks treatment time guarantee (TTG) for inpatient and day case treatment coming into effect from 1 October 2012; and for delivery of the 90% composite target for 18 week Referral to Treatment across appropriate specialities.

Continue to deliver the Scottish Government standard for 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>Start Date</th>
<th>Responsibility</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a Performance Management System to ensure quality and transparent data is routinely reported to appropriate Board Committees.</td>
<td>March 2013</td>
<td>AMcM/SG</td>
<td>Following approval of the committee structure, the Corporate Governance &amp; Value for Money Manager and Associate Director of Analytical Services have started to meet with Chairs and Executive Leads to review each committee’s information needs. In particular, the Corporate Governance &amp; Value for Money Manager is using a Board Assurance Map model to set out the main assurance topics for the Board and indicate the various sources of assurance, with sources categorised into:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- First Line of Defence – management controls and reporting;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Second Line of Defence – Board and committee oversight; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Third Line of Defence — independent review or regulatory oversight.</td>
</tr>
<tr>
<td>OBJECTIVE 3: TO PROMOTE AND ENSURE THAT ALL EMPLOYEES ARE SUPPORTED Appropriately IN LINE WITH STAFF GOVERNANCE POLICIES WITHIN NHS LOTHIAN</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>Details</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Complete the Critical Incident investigation in regard to Waiting Times and follow up actions as appropriate.</td>
<td>AB</td>
<td>The Critical Incident Investigation completed its work and reported its findings to Scottish Government Health Department and the Board. Following the report, a number of staff were subject to disciplinary processes.</td>
<td>☀</td>
</tr>
<tr>
<td>Complete the review of management culture within NHS Lothian and follow up actions as appropriate.</td>
<td>CHAIR /CE</td>
<td>This is a two year project and will take on board the 5x5x5 values work. To date 3000 staff have been engaged in this work, and a Board Seminar is being organised for 6th June.</td>
<td>☀</td>
</tr>
<tr>
<td>Refresh and implement the HR&amp;OD Strategy, in light of findings from recent investigation(s) and reviews.</td>
<td>Ongoing AB /CE</td>
<td>A revised HR&amp;OD Strategy was taken to the Nov 2012 Board and agreed.</td>
<td>☀</td>
</tr>
<tr>
<td>NHS Boards to achieve a sickness absence rate of 4%.</td>
<td>Ongoing AB</td>
<td>Staff sickness although reported as red was a significant achievement for NHS Lothian in that we were just above the target of 4%. NHS Scotland performance was 4.8% and we were 4.3%.</td>
<td>☀</td>
</tr>
</tbody>
</table>
### OBJECTIVE 4:
**FURTHER DEVELOP WORK RELATING TO NHS LOTHIAN UNSCHEDULED CARE IN ORDER TO SUPPORT THE ORGANISATION TO ACHIEVE REQUIRED STANDARDS OF PATIENT CARE**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013</td>
<td>AMcM</td>
<td>Delayed discharges are still above the trajectory to meet this target. The March figures where that 27 people were delayed longer than 28 days: Edinburgh – 23 East – 2 Mid – 2 West - 0</td>
<td>🟥🟥🟥</td>
</tr>
<tr>
<td>Ongoing</td>
<td>AMcM</td>
<td>Winter Business Continuity Plan delivered and being implemented as per the plan. NHS Lothian along with other Boards did not achieve our desired performance on 4 and 12 hours and delays during the winter period. This year winter planning will be embedded within the operational management. A winter de-brief took place on the 6th March.</td>
<td>🟥🟥🟥</td>
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</tbody>
</table>
## NHS Lothian – Corporate Objectives 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop work to support the delivery of the HEAT standard - 98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.</td>
<td>Ongoing</td>
<td>MH</td>
<td>This remains a challenge but an agreed action plan is now in place and is being driven forward through both the Joint Management Team and the Unscheduled Care Group. March performance was 88% against a 98% target.</td>
</tr>
<tr>
<td><strong>Objective 5:</strong> Drive forward the work on the integration of health and social care</td>
<td><strong>Timing</strong></td>
<td><strong>Lead CMT Member</strong></td>
<td><strong>Comments</strong></td>
</tr>
<tr>
<td>Continue to drive forward the Integration of Health and Social Care as directed by SG guidance.</td>
<td>Ongoing</td>
<td>AMcM</td>
<td>Significant progress made and NHS Lothian and council partners are at the forefront of this agenda in Scotland. Shadow arrangements in place in WL/Edinburgh and will be in place in East Lothian and Mid in April/May this year. Staff engagement underway, partnership agreements being developed, initial services being reviewed are Learning Disabilities; Mental Health; Complex Care; Substance Misuse; Prisons; Health Promotion. Next tranche are Dentistry, Children and aspects of acute care during 13/14.</td>
</tr>
</tbody>
</table>
NHS Lothian – Corporate Objectives 2012/13

<table>
<thead>
<tr>
<th>Objective 6: Implement Programmes of Governance and Efficiency to Ensure Quality Whilst Improving Patient Safety and Patient Experience</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
</table>
| Implement the Quality Improvement Strategy. | March 2013 | DF | A 1-year update on the implementation of the Quality Improvement Strategy (2011-14) was reported to the Board in July 2012. There have been sustained improvements in:  
  - HSMR and Adverse Event Rate (see below under SPSP)  
  - 20% reduction in Falls with Harm  
  - Reduction in medication errors. Many of the key measures have been incorporated into the Quality Report which is reported at every Board meeting. | |
<table>
<thead>
<tr>
<th><strong>NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to implement the Scottish Patient Safety Programme to deliver reductions in standardised hospital mortality rate (HSMR) and in adverse events recorded.</td>
<td>March 2013</td>
</tr>
<tr>
<td>Continue to improve patient experience through “Delivering Better Care”.</td>
<td>March 2013</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

| Ensure robust arrangements are in place for both emergency planning and business continuity in order to support the management of major incidents. | Ongoing | AKM / AMcM | Active participation in SCG at strategic and tactical level 27 exercises to test NHS Lothian and multiagency response to CBRN scenarios, major incidents (e.g. Hogmanay), communications in emergencies, etc. Debriefing for 7 incidents undertaken. Pandemic plan updated - reflects UK guidance – getting ready to exercise and produce additional supporting material as required. The NHS Lothian Emergency Planning Strategic Advisory Group (EPSAG) ensures that the needs for emergency planning at a strategic level, in conjunction with the requirements of a Category 1 responder under the Civil Contingencies Act, (2004) are identified and addressed across NHS Lothian. |
NHS Lothian ensures that this can happen by close working between the Director of Public Health and the Director of Planning, Performance Reporting and Information.

NHSL Business Continuity Management (BCM) programme continues to link into Scottish Government guidelines and frameworks to ensure arrangements are current and robust.

Formalised reassurance protocols are in place to ensure individual business areas are compliant with the BCM programme, along with triggers of escalation if required. Particular focus is given to plan maintenance and exercising on an annual basis.

The corporate risk is now removed for BCM, due to controls in place and the evaluation of the effectiveness of the said processes.
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<p>| Ensure robust arrangements are in place to manage communicable disease outbreaks and healthcare associated infection with targeted plans in place to deliver continued reduction in rates of healthcare associated infection (this includes the HEAT Target). | Ongoing | AKM | The Health Protection Team dealt with 88 incidents during the year, including 37 cold chain incidents and 13 Tuberculosis incidents. The large outbreak of Legionella during June 2012 required a multidisciplinary response by the whole of the Public Health department led by the Health Protection Team. NHS Lothian and IMT debriefs have been held and the final report for the outbreak is with the Central Legal Office for final sign-off. Response commented on favourably by SG and internationally. Follow up studies are being analysed, interim report was published and rapid publication in peer reviewed literature produced. IMT won Team of the Year at Celebrating Success awards. | NHS Lothian achieved the CDI Heat Target for 2012-13 as there were a total of 261 Episodes during the year. There are new targets from April 2013 for a further reduction of CDI so NHS Lothian should continue the good work that has been done so far. This includes, pursuing targeted actions in areas where new approaches are needed to drive down antibiotic use and to prevent infections, particularly recurrent infections. |</p>
<table>
<thead>
<tr>
<th>Risk Management arrangements reviewed regularly by both Healthcare Governance &amp; Risk Management Committee at bi-monthly meeting and by Audit committee.</th>
<th>Quarterly</th>
<th>DF</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Risk Management Steering Group has been established, chaired by the Chief Executive. As part of a review of governance committees at the Board, Risk Management now reports through the Audit &amp; Risk Committee as a standing item. The Corporate Risk Register was reported to the Board in January 2013 where it was agreed that it should be reported on a quarterly basis.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective Description</th>
<th>Start Date</th>
<th>Responsible</th>
<th>Status / Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop the complaints function to ensure single point of access, pro-active response and learning across the organisation as well as meeting targets to ensure a timely response.</td>
<td>March 2013</td>
<td>SW</td>
<td>A review has taken place on the future shape of the Complaints Department to ensure it is meeting the needs of the organisation as set out in this objective.</td>
</tr>
<tr>
<td>Ensure robust systems are in place to manage Freedom of Information requests within the guidelines.</td>
<td>Ongoing</td>
<td>AB</td>
<td>There are robust systems in place to manage FOI requests, and we comply with these guidelines.</td>
</tr>
<tr>
<td>Complete the action plan for the Equality &amp; Human Rights Scheme 2010-13, and develop future equality &amp; diversity objectives in order to meet legal requirements and ensure that the patient experience is as equitable and safe as possible for all individuals.</td>
<td>March 2013</td>
<td>AB</td>
<td>COMPLETE</td>
</tr>
</tbody>
</table>
### NHS Lothian – Corporate Objectives 2012/13

| Refresh / renew the involving people strategy, taking account of the requirements of the Patient’s Rights Act, to ensure the involvement and communication with our patients and communities. | March 2013 | MH | Agreement reached with the Improving peoples Experience Group IPEG, the Involving People’s group InVG and the Volunteers steering group that an interim approach would be taken during 2013 with a new plan to be in place from 2014 onwards that would reflect the changes in structure within NHS Lothian (site models) and reflect both the integrated agenda and the drive of the national Person centred health and social care programme. A draft position paper in progress and key individuals to meet at a planning workshop in June. |
# NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

## OBJECTIVE 7:
ENSURE APPROPRIATE STAFFING ARRANGEMENTS ARE IN PLACE ACROSS NHS LOTHIAN AS REQUIRED, INCLUDING MEDICAL STAFF, NURSING, AHPS AND OTHERS

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013</td>
<td>DF / SG</td>
<td>At a national level the further reductions have been paused in a number of specialties. The NHS Lothian 2013 financial plan includes provision for key areas where there are medical workforce pressures; Emergency Medicine, O&amp;G and Paediatrics. This funding is in place to enable these areas to recruit to both medical and non-medical replacements. The Nurse Director is undertaking a scoping exercise to determine the demand for advanced practice roles. A medical workforce risk assessment process is currently underway within all service/specialties, this will profile risk within the Trained, Training and Non-medical replacement workforces. The assessments will then be used to highlight and address areas of high risk.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing AB Model developed, risk matrix being implemented</td>
</tr>
</tbody>
</table>

Manage the national phased reduction in overall doctors in training numbers through workforce and financial planning and alternative professional role development.

Ensure robust workforce planning models continue to be developed to support service redesign across the system.
### Objective 8:
**Continue to Develop Standards of Care for Both Older People Service and Mental Health Services**

<table>
<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2016</td>
<td>CH(C)P GMs</td>
<td>The four partnerships have worked consistently over the last year, using the Change Fund investments to enhance community supports and services. Improvements associated with on-going pathway redesign, including those for older people with mental health problems, and the national standards for older people in acute care. At Nov 2012 – average 42%  East – 57%  West – 33.6%  Mid – 41%  Edinburgh – 31.4%</td>
</tr>
</tbody>
</table>
NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Continue to develop and take forward the implementation of four change plans in relation to the development of intermediate care services for older people.</th>
<th>March 2013</th>
<th>CH(C)P GMs</th>
<th>All Change Fund plans are being implemented. Mid term reviews have been conducted across all partnerships/plans. Discussions now about future areas of investment and these will take place through corporate and local change fund plan groups. Primary and community based responses are the main focus of this investment as are hospital based services to assist the patent pathway and ‘flow’ management. There are two more years of funding till March 2015.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to improve care for older people in acute care in line with national standards and HIS Inspection Regime</td>
<td>March 2013</td>
<td>MH</td>
<td>Vulnerable peoples Steering Group established in August 2012. New programme of education has been developed and now available. Resource Packs available during February. Dementia champions now in place and a further cohort being recruited to.</td>
</tr>
<tr>
<td>Continue with the first phase of implementation of the NHS Lothian Mental Health and Wellbeing Strategy 2011-15.</td>
<td>March 2013</td>
<td>AMcM</td>
<td>Implementation of the strategy is well progressed. Significant work on driving the actions forward and the redevelopment of the Royal Edinburgh Hospital is underway. Work on tackling issues related to social justice; inequalities; needs of those in prison and also wider work on psychological therapies and dementia are progressing well.</td>
</tr>
</tbody>
</table>
**NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13**

<table>
<thead>
<tr>
<th>OBJECTIVE 9: ENSURE THE CAPITAL PROGRAMME IS DELIVERED WITHIN A ROBUST FINANCIAL PLANNING AND GOVERNANCE FRAMEWORK</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to work with Consort to deliver the required service as stipulated under the service legal agreement, ensuring compliance with all aspects of the agreement.</td>
<td>Ongoing</td>
<td>SG / AB</td>
<td>Consort performance is managed in line with our Partnership Agreement. Review of Efficiency of soft FM services underway.</td>
<td></td>
</tr>
<tr>
<td>Continue to drive forward the Reprovision of the RHSC &amp; DCN projects.</td>
<td>Ongoing</td>
<td>SG</td>
<td>Project now progressing and procurement process underway. 3 bidders being evaluated. Still on track to be operational by 2017.</td>
<td></td>
</tr>
<tr>
<td>Continue to develop the business plan for the Reprovision of the Royal Edinburgh Hospital.</td>
<td>Ongoing</td>
<td>DS / SG</td>
<td>Programme infrastructure now established. Outline bed numbers and capital costs revised. First phase to focus on mental health related services and the second on learning disabilities.</td>
<td></td>
</tr>
<tr>
<td>Work closely with partner agencies in developing the proposed bio quarter adjacent to RIE site.</td>
<td>Ongoing</td>
<td>SG/ DF</td>
<td>The Director of Finance and Medical Director are working with colleagues to develop an Edinburgh Bioquarter business plan. This will involve highlighting aspirations for the clinical service from an NHS point of view, research, undergraduate/postgraduate training and the links with the University.</td>
<td></td>
</tr>
<tr>
<td>Continue to take forward other capital projects across the organisation as agreed as part of the Capital Plan.</td>
<td>Ongoing</td>
<td>SG</td>
<td>Ongoing – variety of capital projects now in development and construction. A capital Investment Plan is in place which goes through the Capital Investment Group.</td>
<td></td>
</tr>
</tbody>
</table>
# NHS Lothian – Corporate Objectives 2012/13

<table>
<thead>
<tr>
<th>Objective 10: Financial Balance</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure a robust financial planning and governance framework is in place, encompassing both capital and revenue, to support NHS Lothian's strategic objectives, to deliver financial balance, and which manages risk in relation to the economic position.</td>
<td>March 2013</td>
<td>SG</td>
<td>Financial balance achieved for 12/13.</td>
<td>![Green]</td>
</tr>
<tr>
<td>Ensure the Efficiency &amp; Productivity Programme delivers the required recurring savings for 2012/13, and progress is made on detailed, deliverable plans for 2013/14 and beyond</td>
<td>March 2013</td>
<td>SG</td>
<td>Efficiency &amp; Productivity Delivery 2012/13 – shortfall of £12m but plans for 2013/14 incorporate this and fully developed plan now in place for 13/14.</td>
<td>![Red]</td>
</tr>
<tr>
<td>Develop the Integrated Resource Framework as a financial planning tool and to support wider management decision making, particularly in relation to the integration agenda.</td>
<td>March 2013</td>
<td>SG / AMcM</td>
<td>The Integrated Resource Framework now has 3 years of Health and Social Care Data, and is being tested out within specific programme areas, before a final decision is taken to invest system-wide.</td>
<td>![Green]</td>
</tr>
</tbody>
</table>
## OBJECTIVE 11: 
**CONTINUE TO DRIVE FORWARD THE PUBLIC HEALTH AGENDA**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>AKM</td>
<td>5717 Keep Well health checks were completed against a target of 4800 and the phased ‘roll-out’ of ‘Keep Well’ approach in Primary Care is moving forward. Work on resource allocation with Director of Finance will support practices in highest deprivation areas to maintain additional services required to meet need. Locality clinics established in areas where practices have small numbers of eligible individuals, programme established for prisoners – 65 new checks (Edinburgh and Addiewell), 26 in Willow (v vulnerable women) and 140 reviews of high risk individuals. Evaluation programme is positive and clinical data recorded in primary care records to support continuity of care is in line with good practice.</td>
</tr>
</tbody>
</table>

Improve health inequalities and health deprivation by providing better access to services and resources to meet the needs of the most vulnerable groups through the following:
- Embedding Keep Well by 2015 –to be in place by 2013
- Eradicating measles and rubella – September 2013
- Complying with best practice in relation to information governance
- Improving the health of the population by reducing premature death, disability and distress
- Providing high quality universal services, targeted and tailored services for individuals and communities with greater levels of need and working with partners to address the social determinants of health
- Developing and testing measures designed to measure and evaluate improvements in the health of the population and reductions in health inequalities.
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

| | Plans for action to minimise risk of home-grown measles and rubella outbreak have been developed and agreed by JMT. Around 10,000 ten to seventeen year olds in Lothian need to be immunised if we are to avoid being affected by the current (April ’13) measles outbreak in England and Wales. WHO revised the target dates for evidencing elimination of home-grown measles and rubella - 2013 is now the first performance review point. The revised target year to evidence delivery is 2017. |
| | The Fair Warning process is an example of action taking place to improve information governance practices and embed best practice across all NHSL staff. Information governance risks will be recorded on the corporate risk register and reviewed regularly. |
| | We continue to improve the health of the population and work with partners to address the social determinants of health on a number of fronts. This work is encapsulated in the WHO ten essential Public Health Operations (2012): |
**OBJECTIVE 12:**
**ACHIEVE REQUIRED HEAT TARGETS AND STANDARDS AS EXPECTED WITHIN THE STATED TIMESCALES BY THE SCOTTISH GOVERNMENT**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2015</td>
<td>AKM</td>
<td>Baseline analysis regarding socioeconomic gradient in stage at presentation, treatment completion and ongoing engagement with services is being used to develop priorities for improvement and change. Breast cancer pilot established and programme of work underway to increase capacity for diagnosis and treatment. Awareness raising exercise in breast cancer increased referrals by 80% with some increase in investigations but no increase in cancers detected. Bowel campaign focuses on increasing uptake of screening. Regarding targets and local trajectories for the three cancers, these are still to be agreed with the Scottish Government. ISD continues to work on this for all Boards as this is not routine data and it is proving difficult to count.</td>
<td>🟢</td>
</tr>
<tr>
<td>March 2015</td>
<td>AMcM</td>
<td>Have agreed definitions and reporting. On track for delivery. As at March 2013, performance against the 80% target across all 5 quintiles is above 80%.</td>
<td>🟢</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>March 2014</th>
<th>AKM</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve oral health by providing preventative interventions: ensure at least 60% of 3 and 4 year olds in each SIMD quintile have fluoride varnishing twice a year by March 2014.</td>
<td>March 2014</td>
<td>AKM</td>
<td>Latest figures in January 2013 show that in the year from Oct 2011 to September 2012 a total of 25.4% of registered 2-5 year-old children in Lothian received one fluoride varnish application. Mainland Boards range from 11.0% to 32.7%. In the same time period, 4.8% of registered 2-5 year-old children in Lothian received two fluoride varnish applications. Mainland Boards range from 1.8% to 7.0%.</td>
</tr>
<tr>
<td>Deliver agreed completion rates for child healthy weight intervention programme through combined approach of prevention and treatment (NHS Lothian is required to deliver 1,475 interventions by March 2013 reaching a cumulative total of 2,268 by March 2014).</td>
<td>March 2014</td>
<td>AKM</td>
<td>Over the period July to Dec 2012 interventions were delivered to a total of 348 overweight and obese children (provisional figure yet to be validated by Scottish Government). We are currently recruiting additional schools to take part for the final weeks of 2012/13 and start 2013/14. Funding to deliver these additional programmes has been identified within Public Health budgets. Arrangements have been made to perform the measurements in as sensitive and confidential way as possible to minimise potential harm. With this plan in place we would expect to meet or exceed the target by March 2014.</td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target Achieved Details</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver smoking cessation services to support the reduction in the number of people smoking by 2014 (NHS Lothian is required to reach 4,836 successful quits by March 2013 reaching a cumulative total of 7,011 by March 2014).</td>
<td>Target achieved. Smoking cessation amongst the 40% most deprived within-Board SIMD areas over the period 2011/12 to 2013/14 was targeted to be 7,011. This target was reached by September 2012. We are on trajectory to achieve the 2011-14 target.</td>
<td>☑️</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Objective</th>
<th>Due Date</th>
<th>Responsible</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver an 18 weeks referral to treatment waiting time for Psychological Therapies from December 2014.</td>
<td>December 2014</td>
<td>AMcM</td>
<td>Initial work in East/Midlothian now being rolled out on the back of the publication of the demand, capacity and queue work completed. Strategic plan developed. Mental health is under the TTG and therefore we are addressing reporting as well as ensuring definitions are clear. eHealth support is ensuring a migration from PIMS to Trak by March 2014 captures all the information needs aligned to meeting this target and other information needs within mental health systems.</td>
</tr>
<tr>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>March 2013</td>
<td>AMcM/AKM</td>
<td>March 13 figures show NHS Lothian performance at 93.1% against a target of 90% of new patients beginning treatment within 3 weeks of referral.</td>
</tr>
<tr>
<td>Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15 (NHS Lothian will reach the target of 4,971 by March 2013, 4,799 by March 2014 and 4,629 by March 2015).</td>
<td>March 2015</td>
<td>AMcM</td>
<td>The trajectory for emergency bed days for those 75+yrs continues to rise above NHS Lothian’s agreed stretch target but actions through the unscheduled care and change fund will assist in this being delivered by 2015.</td>
</tr>
<tr>
<td>Improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.</td>
<td>March 2013</td>
<td>MH</td>
<td>Not on trajectory because of Unscheduled Care flow. Current March 2013 position was 46% against target. Action plan now in place.</td>
</tr>
</tbody>
</table>
Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.

<table>
<thead>
<tr>
<th>March 2013</th>
<th>AKM</th>
<th>SAB: SAB target by 31/03/2013 = 0.26 cases per 1000 Acute Occupied Bed Days (213 episodes). There were 255 episodes during the year so NHS Lothian did not achieve the SAB HEAT Target for 2012-13.</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2014</td>
<td>MH / PG</td>
<td>C.Diff. CDi target by 31/03/2013 = 0.39 per 1000 Total Occupied Bed Days (326 episodes). NHS Lothian achieved the CDI Heat Target for 2012-13 as there were a total of 261 Episodes during the year.</td>
</tr>
<tr>
<td>Support shifting the balance of care by achieving a 2% reduction in the rates of attendance at A&amp;E between 2009/10 and 2013/14 (NHS Lothian will achieve a rate of 1,944 by March 2013 and 1,95%934 by March 2014).</td>
<td></td>
<td>In December 2012, NHS Lothian's performance continued to be 5% above the trajectory for accident and emergency attendances. Total number was 17,699 attendances. Work to redesign the St John’s Hospital Primary Assessment Area standard operating procedures will, where appropriate, direct patients out of an admitted pathway into an ambulatory care pathway, therefore reducing the number of A&amp;E attendances recorded in the future. This has been notified to ISD and Scottish Government and there was an annual review of T10 on the 5th March. The T10 workstream will now sit within the unscheduled care group.</td>
</tr>
<tr>
<td>HEAT STANDARDS</td>
<td>Status</td>
<td>Achievements</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
<td>Ongoing</td>
<td>DS Annual Survey, NHS Lothian was at 80% against the 90% target</td>
</tr>
<tr>
<td>Maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources.</td>
<td>Ongoing</td>
<td>AMcM Lothian sits at approx 60% patients on the register above the initial target.</td>
</tr>
<tr>
<td>NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three established settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td>Ongoing</td>
<td>AMcM/AK M NHS Lothian has led the ABI programme on behalf of partners in the 3 Lothian ADPs. The HEAT standard has been achieved and by December 12,793 ABIs had been delivered. The ABI implementation team has trained an additional 604 professionals in 2012/13 to deliver ABIs in a number of organisations including Lothian and Borders Police, Lothian and Borders Fire Brigade, HMP Edinburgh, HMP Addiewell, Local Authorities and Higher Education establishments in Lothian.</td>
</tr>
</tbody>
</table>
| Support the implementation of the Palliative Care strategy to achieve a shift in the balance of care in respect of place of death (local targets):  
  - Decrease the proportion of deaths occurring in Acute Hospitals from 42.3% of all Lothian deaths (2008 baseline) to 38% by 2015  
  - Increase the proportion of deaths occurring in community residential settings from 34.4% of all Lothian deaths to 38.8% by 2015. | March 2015 | AMcM Performance in relation to deaths occurring within the acute hospital setting has increased. We are currently reviewing this target and actions required to support this as we see this as a quality and dignity issue. |
## OBJECTIVE 1
TO TRANSFORM THE MANAGEMENT CULTURE OF THE ORGANISATION

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that the major performance challenges around waiting times, unscheduled care and finance are tackled with an open, participative and approachable management style.</td>
<td>Ongoing, by March 14</td>
<td>All</td>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>Endorse and further develop the work on vision and values as part of the Management Culture review.</td>
<td>June 13</td>
<td>AMcM/AB</td>
</tr>
</tbody>
</table>
# NHS Lothian – Corporate Objectives 2013/14

## Objectives Relate to Aims 2 and 4 Within the Strategic Clinical Framework

**Objective 2:** To plan and deliver the waiting times recovery plan to clear the backlog of patients and develop recurring demand/capacity equilibrium

<table>
<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>JUNE 13</td>
<td>DF/AMCM</td>
<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>
</tr>
<tr>
<td>MARCH 14</td>
<td>AMCM</td>
<td>Ensure comprehensive monthly performance monitoring to the NHS Board on performance against targets, recovery plan and waiting times management compliance.</td>
</tr>
<tr>
<td>ONGOING</td>
<td>SG</td>
<td>Ensure the delivery of a sustainable financial framework to support recovery and maintain performance thereafter.</td>
</tr>
<tr>
<td>JUNE 13</td>
<td>AMCM</td>
<td>Ensure delivery of the comprehensive system of compliance monitoring of waiting times systems including real-time scrutiny of changes made on TRAK.</td>
</tr>
<tr>
<td>JUNE 13</td>
<td>AMCM</td>
<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>
</tr>
</tbody>
</table>
NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 3: TO IMPROVE UNSCHEDULED CARE PERFORMANCE</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
</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>AMcM/MH</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/MH/AMcM</td>
</tr>
<tr>
<td>Achieve sustained improvement of performance towards the 98% 4 hour access standard, reduction in boarding and eradication of 12-hour trolley waits.</td>
<td>Dec 13</td>
<td>PG/MH/ALL</td>
</tr>
<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>MH/PG/AB</td>
</tr>
<tr>
<td>OBJECTIVE 4: To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements.</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<td>----------------</td>
</tr>
<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>
</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>
</tr>
<tr>
<td>Ensure implementation of innovative plans with our 4 Council partners to secure the integration of primary, secondary and social care to drive performance improvement across health and social care.</td>
<td>March 14</td>
<td>JF, PG, DS and AMcM</td>
</tr>
<tr>
<td>Continue to promote the clinical pathways model to secure management of patients’ journeys across service boundaries through our systems wide managed clinical networks</td>
<td>March 14</td>
<td>AMcM, MH and DF</td>
</tr>
<tr>
<td>Implement revised organisational arrangements which tangibly integrate the management of primary, secondary and social care services and deliver whole-system approaches to the management of unscheduled care.</td>
<td>June 14</td>
<td>ALL</td>
</tr>
<tr>
<td>Review and refresh the maternity strategy and capacity plan</td>
<td>March `14</td>
<td>AMcM</td>
</tr>
</tbody>
</table>
### OBJECTIVE 5: EFFECTIVE INTERNAL AND EXTERNAL COMMUNICATIONS

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement NHS Lothian’s Communications Strategy.</td>
<td>June 2013 SRW and AB</td>
<td></td>
</tr>
<tr>
<td>Develop and Implement Communications Plan for Strategic Clinical Framework.</td>
<td>May 2013 SRW and AB</td>
<td></td>
</tr>
<tr>
<td>Supporting the communication is relation to ‘Our Values Into Action’</td>
<td>On-going SRW and AB</td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>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</td>
<td>March 14 DF/All</td>
<td></td>
</tr>
<tr>
<td>Achieve a 30% reduction in adverse events</td>
<td>March 14 DF/All</td>
<td></td>
</tr>
<tr>
<td>Achieve a 20% reduction in HMSR against 2006/2007 baseline</td>
<td>March 14 DF/All</td>
<td></td>
</tr>
<tr>
<td>Ensure the current Safe Care Patient Safety Programme</td>
<td>March 14 DF/MH/All</td>
<td></td>
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</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 6: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Ensure the new work streams for the patient safety programme are tested and implemented  
  - Venous thromboembolic prevention  
  - Sepsis prevention programme  
  - Mental health  
  - Maternity services  
  - The Warfarin management bundle across general practice | March 14 | DF/MH/All |
| Ensure NHS Lothian’s staphylococcus aureus bacteraemia cares are 0.2% or less per 100,000 acute occupied days, and the rate of clostridium difficile infection in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days. | March 14 | AKM |
| To ensure participation and benefit from involvement in the new Maternity Safety programme. | March 14 | AMcM/MH/DF |
| 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 |
| 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. | March 14 | AB/All |
| Work towards a reduction in the number of staff assaults | March 14 | All |
# NHS Lothian – Corporate Objectives 2013/14

**Objective 7:** Corporate Team Objective  
Implementation of the Patient Centred Collaborative

<table>
<thead>
<tr>
<th>Implementation of the Patient Centred Collaborative</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensue that NHS Lothian participates in and implements the patient centred collaborative methodology</td>
<td>March 14</td>
<td>DF/MH</td>
<td></td>
</tr>
<tr>
<td>Improve patient experience:</td>
<td>March 14</td>
<td>MH/DF/All</td>
<td></td>
</tr>
<tr>
<td>- Ensure the targets for the implementation for the Liverpool care pathway are implemented as are our targets on end of life care replacement of death.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the NHS Lothian Board receives a regular report on the quality of care provided within NHS Lothian services</td>
<td>Monthly</td>
<td>DF/MH</td>
<td></td>
</tr>
<tr>
<td>Ensure that the key learning points are taken from the Francis report and are implemented locally</td>
<td>Ongoing</td>
<td>DF/MH</td>
<td></td>
</tr>
<tr>
<td>Ensure that NHS Lothian and its four council partners fully participate in the Early Years Collaborative and to use this to inform our revised children’s and young people’s strategy</td>
<td>March 14</td>
<td>AMcM</td>
<td></td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

### OBJECTIVE 8: TO LIVE WITHIN AVAILABLE FINANCIAL RESOURCES, DEVELOP A SUSTAINABLE FINANCIAL PLAN AND DELIVER THE CAPITAL INVESTMENT PLAN

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To achieve a break-even position for 2013/14 to live within the Revenue Resource limit.</td>
<td>March 14</td>
<td>SG/All</td>
</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>
</tr>
<tr>
<td>Proceed with the first phase of the new REH re-provision programme</td>
<td>March 14</td>
<td>DS/SG</td>
</tr>
<tr>
<td>Take forward the redesign of the front door and bed model within the RIE to support delivery of improved patient experience and safety</td>
<td>Nov 13</td>
<td>MH/SG/AM cM</td>
</tr>
<tr>
<td>Improve performance management of the Consort RIE contract</td>
<td>Ongoing</td>
<td>SG</td>
</tr>
<tr>
<td>To develop a savings programme for implementation in 2014/15 and beyond.</td>
<td>Ongoing</td>
<td>SG/All</td>
</tr>
<tr>
<td>OBJECTIVE 9: TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
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<tr>
<td>Continue reducing the socio-economic gradient in healthy life expectancy and amenable mortality across Lothian by developing, influencing and delivering evidence-informed policies with partners on smoking, Keep Well health checks and alcohol availability and consumption.</td>
<td>March 14</td>
<td>AKM/All</td>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Continue to strengthen Public Protection arrangements by delivery of the 2013/14 action plan</td>
<td>March 14</td>
<td>MH</td>
</tr>
<tr>
<td>OBJECTIVE 10: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
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<tr>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.</td>
<td>March 14</td>
<td>AKM</td>
</tr>
<tr>
<td>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.</td>
<td>March 14</td>
<td>AMcM</td>
</tr>
<tr>
<td>At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.</td>
<td>March 14</td>
<td>AKM</td>
</tr>
<tr>
<td>To achieve 2268 completed child healthy weight interventions over the three years ending March 2014.</td>
<td>March 14</td>
<td>AKM</td>
</tr>
<tr>
<td>Universal smoking cessation services to achieve at least 11686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.</td>
<td>March 14</td>
<td>JF/AKM</td>
</tr>
</tbody>
</table>
# NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>RELATES TO AIMS 1, 2, 3, 5 AND 6 OF THE STRATEGIC CLINICAL FRAMEWORK</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OBJECTIVE 10:</strong> TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce suicide rate between 2002 and 2013 by 20% and to review further actions in line with this direction of travel.</td>
<td>March 14</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.</td>
<td>March 14</td>
<td>SG</td>
<td></td>
</tr>
<tr>
<td>Reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.</td>
<td>March 14</td>
<td>AB</td>
<td></td>
</tr>
<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.</td>
<td>March 14</td>
<td>AMcM</td>
<td></td>
</tr>
<tr>
<td>No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete by April 2015.</td>
<td>March 14</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>To support 2% shift in the balance of care in the rates of attendance at A&amp;E between 2009/10 and 2013/14.</td>
<td>March 14</td>
<td>MH/PG</td>
<td></td>
</tr>
<tr>
<td>To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.</td>
<td>March 14</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Eligible patients will commence IVF treatment within 12 months by 31 March 2015.</td>
<td>March 14</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td>Further reduce healthcare associated infections so that by March 2016 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate</td>
<td>March 14</td>
<td>AKM</td>
<td></td>
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</table>
### NHS Lothian – Corporate Objectives 2013/14

**Objective 10:** To have a robust system of performance management and reporting aligned to delivery of government targets

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<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
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- **% of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.**
- **95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.**

**Heat Standards**

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<th>Lead CMT Member</th>
<th>Comments</th>
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- **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.**
- **90% of planned / elective patients to commence treatment within 18 weeks of referral.**
- **No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census)**
- **Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team**
- **90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.**
- **To achieve a sickness absence rate of 4% across NHS Lothian.**
- **NHS Lothian and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.**
- **To continue to strive to achieve the target of 90% of stroke patients being admitted to a stroke bed within 24 hours of initial diagnosis**
1 Purpose of the Report

1.1 Following the Board’s endorsement of the Strategic Clinical Framework in February 2013, this paper sets out the next steps required to meet the Board’s corporate objective to develop a cohesive strategic plan for NHS Lothian’s medium and long term ambitions in the context of rapid population growth, a significantly growing older population and constrained public sector resources.

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

2 Recommendations

2.1 Agree the context and background for the recommendations below, which are set out in section 3 of this paper.

2.2 Endorse the agreement that was given in principle at the 1st May seminar to develop a cohesive strategic plan for NHS Lothian’s medium and long term ambitions in the context of rapid population growth, a significantly growing older population and constrained public sector resources, with a view to producing a suite of proposals by March 2014.

2.3 Agree that stakeholder engagement will be built in to the formulation of strategic plans and that subsequent proposals for engagement and consultation on firm proposals will be developed in partnership with colleagues in the Scottish Health Council and Scottish Government.

2.4 Agree that the process for driving this work forward will be led by the Board’s Strategic Planning Group, chaired by the Director of Strategic Planning, Performance Reporting and Information.

2.5 Agree that 6 Non Executive Directors will be members of the Strategic Planning Group including the Chairman, Brian Houston; Professor John Iredale; Alex Joyce; Alison Meiklejohn; Dr Richard Williams and Robert Wilson.

2.6 Agree to establish a sub group of the Strategic Planning Group to develop our communication and engagement plans. This Sub Group would include as a minimum the Director of Communications and Public Affairs; the Director of Strategic Planning, Performance Reporting and Information; the Associate Director, Modernisation and Kay Blair, Non Executive Director, with other members to be recruited as appropriate.
2.7 Agree that one of the first actions will be to develop a Question and Answer Sheet and a standard presentation for engagement with internal and external audiences.

2.8 Note that in developing the communication plan, staff and key stakeholder events will be arranged as part of the engagement and consultation process.

2.9 Note that the Board development session on the 6th June will focus on the 'values' work which is already aligned to the Strategic Clinical Framework and these next steps.

2.10 Note that two further workshops for the Board members have been agreed for the development of this strategic thinking on the 26th August and the 17th December 2013.

2.11 Agree that as part of the process of developing the next steps of this work, the Strategic Planning Group in concert with the chief executive and director of finance will review the resources that are required to ensure that we undertake and deliver the initial stages of this work within the agreed timescale of March 2014.

3 Discussion of Key Issues

3.1 The Strategic Clinical Framework (SCF) approved by the Board in February and the presentation to Board Members on the 1st May respond to the NHS Scotland 2020 Vision for health and healthcare. They set out the actions that NHS Lothian should take in order to respond effectively to the known drivers for service redesign but also for delivering against our corporate objective for 2013/14 to “develop a cohesive strategic plan for NHS Lothian’s medium and long term ambitions”.

3.2 The context for this paper and the decisions that need to be taken are well known. They include the significant changes in our demography, the financial, both revenue and capital, constraints that the public sector will be under in the next number of years and the workforce pressures, particularly in relation to the medical workforce and the numbers of trainees and the feminisation of the workforce.

3.3 The current population of Lothian in 2013 is circa 850,000 people and we know that by 2033 there are expected to be 1.1 million people. This equates to a growth of some 250,000 more people in the next 20 years. The most significant issue is in relation to the growth of the number of people living into old and very old age. With improving life expectancy people also live longer with a number of chronic conditions, and these become more complex and multiple as people get much older i.e. into their 70’s, 80’s and 90’s.

3.4 At the same time the challenge around reducing the level of inequality and providing the best chance in life for children and young people means that both health and social care budgets are going to be significantly stretched unless the way in which care and treatment is delivered changes.

3.5 In addition NHS Lothian has a requirement to ensure that all its residents can register with a General Medical Practice. The predicted growth rate in the population is equal to a new practice every year.
3.6 Overall funding available to the public sector is reducing and we know that 2015/16 is likely to see the lowest point before we expect funding to gradually start to return to 2009/10 levels by 2026/27. Capital spending is also reducing.

3.7 Developing new models of care to deal with these pressures is required. We need to review the way that we deliver both planned (elective) and unscheduled care (emergency) as well as the priority around meeting the demand in primary care and social care through an ageing population with multiple long term conditions. There are three key priority areas which include:

Primary care and long term conditions.

3.8 Based on the projections above in respect of population growth and future demands on healthcare services we need to look at how best to respond to this within the primary care context as well as within the hospital setting. We know that more people will live longer with many multiple co-morbidities such as cancer, dementia, diabetes and neurological conditions. Within the context of primary care we again need to think about supporting general practice to deliver more care at home and in different ways. The demographic profile of our population and the significant projected growth in our absolute population numbers makes it imperative to expand our core capacity in primary care, both in staffing and in premises and technology. This will require the Board to invest in primary care above the levels of funding ring fenced by Scottish Government for primary care contracts. We also need to think differently about how we can work better with the third sector and carers and families.

Unscheduled Care.

3.9 We have commenced a process of investing more money into workforce recruitment within accident and emergency departments and medicine of the elderly as well as other key areas such as stroke care and orthopaedics and in intermediate care in the community. This also builds on the investment made through Change Fund monies.

3.10 But we know that we need to do even more to improve our performance. We, along with many other Boards in Scotland have struggled to meet the 4 hr and the 12 hr targets set for accident and emergency. At the same time our performance on stroke care and also delays is not as we would wish them to be. We are therefore looking at a range of options that we now need to take forward. These include additional beds but also the need to look at improvement in our bed management; improved ‘flow’; 7 day working for staff; more in terms of ambulatory care and much more in relation to community and primary care based responses to need, such as step down beds in partnership with our four Councils, care at home and care home provision as well as how we might work differently with the third sector and carers.

Elective care.

3.11 We know that we need to reduce our dependency on the private sector and we are starting the process of repatriating capacity back to NHS Lothian. We are now looking at the second tranche of investments that will require to be made in 13/14 to further grow our internal elective capacity to support this repatriation. Similarly to unscheduled care, workforce availability and the recruitment of appropriately trained
and skilled staff is an issue. We need to recruit into specialties, which other Boards in Scotland and beyond are also trying to recruit to. At the same time we need to ensure that our work on elective care, unscheduled care and primary care does not ignore the need for ancillary and facilities staff and capacity to deal with the additional demand that will be placed on the whole system.

3.12 In doing this we are looking at using the Demand, Capacity Activity and Queue methodology in building up our capacity plans. We are also looking at extended working days; 7 day working; 3 session days in theatre, endoscopy and the need to transform our outpatient capacity and ways of working as well as one stop clinics and direct to test and treat options. At the same time we need to consider the possibility of expanding capacity for elective treatment across a number of sites within the NHS Lothian estate.

4. **Consideration of Future configuration of services.**

4.1. Safe and sustainable service delivery is a key driver for change and we have highlighted the challenges around workforce supply and demand. We know that there are medical workforce issues and equally we know that many of our current nursing and allied healthcare professionals are reaching retirement age. This means that we will have to look at different ways of delivering services based on some of the workforce planning and assumptions that are being made. Workforce planning, joint training and education with the social care sector and opportunities for developing new ‘breeds’ of workforce need to be explored.

4.2. Reviewing how buildings and other assets and infrastructure support the provision of the right capacity in the right place to meet service needs is another key theme. We therefore need to explore our current service provision by site and also as a set of sites and consider, in light of the priorities and challenges above how best to reconfigure services that will address these challenges.

4.3. We are committed to undertaking this work with our Council Partners to look at solutions which integrate care across both health and social care. Integration is a key enabler of this and we are progressing that agenda with positive support from our four partnerships.

4.4. In addition to looking at a bed based solution, we are, with our council partners looking at developing much better community responses to need. We are now in the third year of the Change Fund and we know that areas where investments have been made and continue to be needed are in emergency and rapid response; crisis management; care at home, as well as care home beds. In addition we are exploring new models of care such as COMPASS in Edinburgh which is a Consultant led service but where GP’s can contact and get telephone advice about supporting a patient to stay at home. In addition to these developments, and particularly within Edinburgh we are now at the point of commissioning 60 step down beds, which will assist patients to move on from being in hospital and in getting back home or indeed where appropriate to a care home bed.

4.5. As part of this work we are considering how best to fully utilise our community hospitals across our system whilst ensuring that the pathways into and back out of hospital and into the community are management well and effectively for patients.
4.6. Ensuring that all parts of Lothian are well served is a priority and we are therefore developing plans for the **East Lothian Community Hospital** and there continue to be opportunities to replace the current **Belhaven and Edington** facilities with modern, improved facilities in partnership with East Lothian Council. There may also be opportunities in West Lothian to replace the facilities at **St Michael’s Hospital**. At the same time we should consider the best way of fully maximising the use of **Midlothian Community Hospital** to provide more post acute care for older people from the Midlothian area (step down) and as an alternative to admission to the Royal Infirmary (step up).

4.7. The Board has already committed itself to the long term strategic development of services at our four major hospital sites: the Royal Infirmary of Edinburgh (RIE) Little France campus; which will include the Royal Hospital for Sick Children and the new Department of Clinical Neuroscience; the Royal Edinburgh Hospital (REH), St John’s Hospital (SJH) as well as the Western General Hospital (WGH) site.

4.8. **The Royal Infirmary of Edinburgh** (RIE) requires additional beds now on the site to be able to cope with current demand. We are currently looking at developing two wards, 109 and 209 which will provide an additional 31 beds by December 2013. In addition a further 20 beds are needed and planned over the next year or so to support immediate future demand.

4.9. In reviewing the bed base and the flow of patients both to and out of the RIE there is the potential to consider other options such as the relocation of outpatients and other forms of ambulatory care from the current RIE footprint to create space for additional inpatient capacity. This could allow space for real additional inpatient capacity for unscheduled and elective care and also for the possible transfer of existing inpatient capacity in poor accommodation on other hospital sites, such as Liberton. If we could move at least some of the inpatient capacity that is currently provided within **Liberton Hospital** on to the RIE site, this would reduce patient transfers from the RIE, improve patient flow within the RIE and allow us to consider short medium and long term options for the future of residual services at the Liberton site. In the short term this potential move of Liberton beds off site would allow us to consider creating better bed spacing between beds at Liberton by reducing current 6-bed bays to 4-bed bays to help combat infection spread. Simply doing this without transferring beds off site is not a viable option when we have a clear need for more beds, not less.

4.10. The development of the **RHSC and the DCN** are, by the nature of their developments on the RIE site bringing changes to the way that laboratory, pharmacy and critical care beds are aligned and this generates another driver for altering the current configuration of services on that site.

4.11. **The Western General Hospital (WGH)** is a very congested site and there is the need to develop a new site master plan to inform future development. One aspect of this is to consider the infrastructure upgrading that is required in order to keep our current services safe in the meantime and also the need to consider what options the move of the DCN to the RIE brings. One key development that should be considered on this site is the redevelopment or complete rebuild of the Edinburgh Cancer Centre. This would be a key ‘first building block’ to inform where any other developments might be developed on this site. At the same time consideration will be given to the other buildings and space that we have on and around the WGH site.
such as the RVH. It has already been agreed that the RVH site should be retained and used as a ‘pressure valve’ for additional inpatient capacity while long term strategic plans are being put into place.

4.12. **St John’s Hospital (SJH)** has seen recent developments including the new scanning machine; the opening of the Hooper Hand unit; the upgrade of the maternity unit and the redesign of the Burns unit.

4.13. At the same time we are looking at the development of the Blood Sciences training School aligned to our Laboratory strategy.

4.14. We need to consider whether any elective capacity in any of our most pressurised specialty services such as orthopaedics, ophthalmology and ambulatory care might be developed at St John’s or the Western General.

4.15. The opportunity to redevelop the **Royal Edinburgh Hospital** Campus and deliver 21st century in-patient mental health services is now very real and we are moving towards an outline business case being prepared for August this year. Within the first phase of the development we are planning 185 beds to reprovide all adult and older people’s assessment, intensive psychiatric care, mental health rehabilitation and brain injury rehabilitation. In the second phase we are planning the balance of older people’s mental health, other specialist mental health, learning disability beds and specialist rehab services currently on the Astley Ainslie site. At the same time we are proposing to keep expansion space for future ‘other’ developments.

4.16. As described above, our estate is extensive and there are other key sites that we need to consider as part of this work plan. **The Lauriston Building** where there is currently a significant outpatient department and also where the Scottish National Blood Transfusion Service (SNBTS) has space needs to feature as part of future capacity. The SNBTS are planning to move out in 2015 so we should consider how best to utilise this city centre space as a result of this move.

4.17. The **Eye Pavilion** accommodation is not fit for purpose and will need to be upgraded or moved and we need to consider the future model for eye care, with the real opportunity for more to be done within the primary care arena with optometrists.

4.18. The other site we have is the **Astley Ainslie Hospital**, which offers a range of specialist rehabilitation services. There are a number of potential options, which include moving to the Royal Edinburgh Hospital as part of the new development on that site or that we redevelop some or all of the rehabilitation services on this site in new build facilities and dispose of the remaining land. We are in discussions with the City of Edinburgh Council about the possible development of a new primary school for Morningside on part of this site, if space allows.

4.19. **Primary care** has already featured as a key priority for us and we are currently developing a range of new premises which will open later this year in Gullane, Wester Hailes and the West End Medical Practice.

4.20. In addition to these developments plans are underway for the Tranent health centre extension; a new surgery at Ratho; the Firrhill Partnership Centre, the North West Edinburgh Partnership Centre and the Blackburn Partnership Centre. But looking forward strategic decisions based on population growth, demography and inequality
will be required to ensure that any future developments will help us to address these demands.

4.21. One of the key aspects of this work is that the model of care that will be developed will be ‘future’ proofed’ and that the overall number of beds in the system may remain roughly as they are but the way in which care is delivered, by whom and where may change as a result of meeting these needs within a hospital, primary and community context.

5. Key Risks

5.1. Failure to progress with this strategic planning agenda, and to engage with stakeholders as we develop and test plans and to communicate clearly the rationale for service change could lead to NHS Lothian being unable to meet the future health care needs of the population within the available resources and in line with the aims of the Strategic Clinical Framework.

6. Risk Register

6.1. The main risk associated with this work is that without a coherent strategic plan in place, NHS Lothian may not be able to develop sufficient health and social care capacity in partnership with its Council partners to cope with the major rise in demand form a rapidly growing and older population.

6.2. A number of issues have already been placed on our risk register such as stroke care and elective care (waiting times) which highlights the need for change. As this work progresses we will ensure that any requirement to place issues on to the risk register is fully considered by the Executive Management Team Risk Management Group.

7. Impact on Inequality, Including Health Inequalities

7.1. Equality and diversity impact assessments will be undertaken on plans as they are developed and the outcomes will be taken into account in formulating the final proposals for consideration by the Board. It would be fair to say that doing nothing would in itself drive and widen the equity and inequalities agenda.

8. Involving People

8.1. For all papers proposing strategies/ policies or service change, evidence must be presented on how legal duties of involvement have been met and how the outputs from informing, engaging and consulting have been used.

9. Resource Implications

9.1. There will be resource implications of progressing the strategic plans and these will be considered at the next meeting of the Strategic Planning Group.

Alex McMahon
Director, Strategic Planning, Performance Reporting and Information
13 May 2013
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UNIVERSALIZED CARE - LINKING THE STRATEGIC CLINICAL FRAMEWORK WITH DELIVERING SUSTAINABLE, QUALITY AND SAFE CARE FOR PATIENTS

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board supports the actions that are being taken, and that require to be taken, to build capacity to deliver improved unscheduled care for patients in NHS Lothian in the medium to longer term and to highlight the relationship between these actions and the Strategic Clinical Framework signed off by the Board in February and discussed again in relation to the strategic plans that need to be developed. The report also highlights actions that are being taken to support improvements in performance in unscheduled care in the short term.

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

2 Recommendations

2.1 Support the actions being taken to develop unscheduled care capacity and improved performance against the 4 hour emergency care target and the importance of the Strategic Clinical Framework in providing a context for developing these actions.

2.2 To agree to the development of detailed option appraisals for each of the potential changes outlined.

2.3 To note the requirement for NHS Lothian to submit a Local Unscheduled Care Action Plan (LUCAP) to the Scottish Government by 30 June 2013 which will be brought to the NHS Lothian Board on 26 June for approval and to support detailed work in developing this plan. This plan will include linkages to the related unscheduled care elements set out in the Strategic Clinical Framework and our strategic planning assumptions.

3 Discussion of Key Issues

3.1 The Strategic Clinical Framework clearly sets out the drivers for change in the delivery of healthcare in terms of a growing and ageing population with increasing co-morbidity, increasing financial constraints and workforce pressures.

3.2 Performance against the 4 hour standard to 12 May 2013 (shown below) requires immediate and long term improvement. It is positive to note however that since mid-April performance against the 4 hour and the number of 12 hour breaches has improved in specific response to a number of local operational actions in particular at the Western General Hospital (WGH) and the Royal Infirmary of Edinburgh (RIE).
While we welcome these gains, the system requires further improvements and the gains achieved must be sustained. The performance of the system remains vulnerable to the drivers described above.

**NHS Lothian ED Weekly attendances, 4hr emergency care standard compliance, 12hr breaches**

Weekly compliance with 4hr emergency access standard (%); average daily attendances; ED LoS >12hrs

Source: TRAK data via BOXI; excludes planned returns

Notes: ED refers to RIE, SJH, RHSC emergency departments & ARAUT/MIC at WGH. Process limits are unadjusted XmR-based control limits

**Definition**

Weekly compliance with 4hr emergency access standard (%); average daily attendances; and ED Length of stay patients >12h.

ED refers to RIE, SJH, RHSC emergency departments and ARAUT/MIC at WGH.

Process limits are unadjusted XmR-based control limits.

**Data Source**

TRAK data via BOXI; excludes planned returns.

**Constraints**

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

**Expected Trend**

It is expected that the 4hr compliance (%) will increase to the national standard of 98%.

12h breaches should reduce to the target of 0.

Attendances are likely to rise due to population growth; but growth will be dependent on T10 workstreams.

3.3 There are a number of key strategic areas set out in the framework which will impact significantly upon NHS Lothian’s ability to provide sustainable unscheduled care performance. These actions relate to:

- The need to review and refresh models of care and develop new pathways in some specialties which will support improved patient flow in unscheduled care. This would include particular emphasis upon putting place better alternatives to A&E attendance from the point of view of the patient experience and, where possible, encouraging community based alternatives which are safe and appropriate for patients.
- Site developments at the three main acute sites (Royal Infirmary of Edinburgh (RIE), Western General Hospital (WGH) and St John’s Hospital (SJH)) to better match demand
• Developing different uses of rehabilitation and community hospital locations (Roodlands Hospital, Astley Ainslie Hospital, Royal Victoria Hospital, Midlothian Community Hospital, Liberton Hospital) in order to deliver safe and sustainable care
• Workforce developments to ensure safe and sustainable services
• Providing increased Health and Social Care capacity to match demand
• Delivering improvements and changes to the model of unscheduled care

3.4 These key areas are outlined in more detail below.

3.5 Site developments at acute sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIE</td>
<td>Increasing ward in-patient bed capacity by 31 beds by December 2013</td>
</tr>
<tr>
<td></td>
<td>Continue to develop plans to increase the assessment bed capacity by 18 and the GP referred assessment area / ambulatory care area to better match known demand and reduce pressure for boarding and other access targets e.g. Stroke and Orthopaedics</td>
</tr>
<tr>
<td></td>
<td>Continue to explore the potential for the transfer of suitable services offsite to release further clinical space to accommodate the potential transfer of some older people rehabilitation capacity and additional inpatient ward capacity (for either unscheduled or elective demand)</td>
</tr>
<tr>
<td></td>
<td>Explore potential redesign of outpatient model to reduce demand and to relocate freeing up additional physical space for bed capacity (for either unscheduled or elective demand)</td>
</tr>
<tr>
<td></td>
<td>Explore potential relocation of laboratory and pharmacy space to free up additional physical space for bed capacity (for either unscheduled or elective demand)</td>
</tr>
<tr>
<td></td>
<td>Manage the disruption and operational losses in capacity while the RHSC and DCN works progress across the site from 2013 to 2017</td>
</tr>
<tr>
<td>WGH</td>
<td>Develop plans to increase in-patient ward and assessment/ambulatory care in recognition that elective activity in colorectal, urology and general surgery will now utilise previously underutilised ward capacity to sustain elective targets</td>
</tr>
<tr>
<td></td>
<td>Develop plans to replace out-dated physical ward capacity for the Clocktower building and the Regional Infectious Diseases Unit (RIDU).</td>
</tr>
<tr>
<td></td>
<td>Progress the WGH site masterplan to allow plans for site reconfiguration once Department of Clinical Neurosciences (DCN) has relocated to RIE in 2017 with the redevelopment of the Edinburgh Cancer Centre as the key building block in the site plan</td>
</tr>
<tr>
<td></td>
<td>Include RVH in WGH site masterplanning process</td>
</tr>
</tbody>
</table>
SJH
- Progress installation of an MRI scanner
- Develop the Hooper Hand Unit
- Progress the upgrade of the maternity unit and Burns unit
- Develop plans to transfer additional clinical activity to SJH to support balancing capacity and demand elsewhere across Lothian
- Continued development of ambulatory care and Outpatient Paterenteral Antimicrobial Treatment (OPAT) satellite service to reduce in-patient bed day demand through treatment of IV antibiotics as an outpatient not inpatient.
- Develop plans to transfer additional elective activity from RIE with extended theatre working day

3.6 Developing different uses of rehabilitation and community hospital locations to deliver safe and sustainable care

<table>
<thead>
<tr>
<th>Site</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costorphine Hospital</td>
<td>Explore development of an option appraisal for the transfer older peoples beds to other sites to provide fit for purpose clinical accommodation</td>
</tr>
<tr>
<td>Roodlands Hospital</td>
<td>Increase capability to accommodate East Lothian patients from Liberton Hospital to allow greater local rehabilitation access</td>
</tr>
<tr>
<td>Astley Ainslie Hospital</td>
<td>Explore development of an option appraisal for transfer of older peoples beds to RVH to provide fit for purpose clinical accommodation</td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>Explore development of an option appraisal for a further five wards to be refurbished to meet HEI quality standards and provide consolidated older people’s service under WGH management</td>
</tr>
<tr>
<td>Midlothian Community Hospital</td>
<td>Explore development of an option appraisal for increased capability/capacity to accommodate Mid Lothian patients from Liberton to allow greater local rehabilitation access</td>
</tr>
<tr>
<td>Liberton Hospital</td>
<td>Explore development of an option appraisal for future model to reduce risks to patients and unscheduled care flows at RIE arising from Norovirus outbreaks through changing bed numbers in line with Health Protection Scotland advice and rep providing capacity on other sites or with alternative community rehabilitation models.</td>
</tr>
</tbody>
</table>

3.7 Workforce developments to ensure safe and sustainable services

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>The 3 year workforce plan (2011-14) for Emergency Medicine (EM) is largely completed and has achieved in FY13-14 6 consultants, 2 specialty doctors, 3 ENPs and 25 Band 5 nurses for RIE (complete June 2013)</td>
</tr>
</tbody>
</table>
Further recruitment is agreed and planned for 2013 including 1 consultant and GP/LUCS ED posts for SJH. This recruitment provides a marked increase in consultant presence on both RIE and SJH sites, additional support of Minors patient flow on RIE and SJH. It also provides a demonstrable improvement in time to triage, clinical decision time and total time in ED for patients on RIE.

Following a very disappointing response to the advertisement via LUCS for GP’s to undertake work within SJH ED the executive team are urgently considering alternatives. Dr Farquharson will provide an update on this matter at the Board meeting.

A proposed 2nd phase of the EM workforce plan is now being developed to respond to in recruitment risks which would include additional grades of staff at RIE and SJH in 2013/14 and 14/15 to be considered by the Unscheduled Care Group.

Advanced Nurse Practitioners

[Further recruitment and training to increase the ANP contribution to the unscheduled care workforce is required and currently being scoped.]

Specialty doctors

As this cohort of medical staff increases further work is required to ensure appropriate recruitment, retention and development.

Senior decision-making at the “front door”

Additional resource has been provided to support extending consultant rota’s at the RIE and WGH and SJH to increase presence at weekends and later in the evening. This better matches staffing capacity with demand, helps prevent unnecessary admissions, reduces length of stay, offers better governance around the identification of potential boarding patients and also supports junior medical staff from a quality and safety perspective. This has been implemented at the RIE and recruitment is underway at WGH. SJH has still to finalise working rota arrangements.

3.8 Providing increased Health and Social Care capacity to match demand

3.8.1 Health and Social Care plays a vital role in supporting people in the community by helping prevent admissions to hospital and facilitating discharges from hospital. Through investment of Change Fund resources and additional demographic funding, services for older people have been able to support more discharges from hospital as well as preventing unnecessary admissions.

3.8.2 Progress has been made in shifting the balance of care of people with high level needs being supported at home. At March 2013, the figure stood at 31.9%. By 2018 the target is for 40% of older people with high needs being supported at home.

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Care Home capacity</td>
<td>Additional respite beds for people with dementia – 12 beds phased to come into use between October 2013 and December 2013.</td>
</tr>
</tbody>
</table>
Three new independent sector care homes with 184 opened in April and May 2013.

### Alternative models for older people
- Reablement will start an in-reach model in hospitals to take part in multi-disciplinary team meetings to ensure that those most appropriate for the service can be identified.
- Intermediate Care works with individuals to prevent admission to hospital and facilitate discharge. This service will build upon the in-reach currently provided within hospitals to support timely discharge.
- Maximise contribution of District Nursing and IMPACT teams to develop alternative models of care.
- Continued development of the Compass model in Edinburgh and equivalent “frailty” models in West, East and Midlothian supporting admission avoidance, use of other services such as day hospitals, falls prevention and early discharge linking with Change Fund supported intermediate care and reablement services. Compass will be rolled out across Edinburgh.
- Step down care home beds – 60 beds phased to come onstream between October 2013 and March 2014. Step down in care homes will provide rehabilitation. It will mean shorter hospital stays and will give people and their carers time to think, assess and recover. This initiative should reduce the need for boarding beds. Step-down is not intended to provide specialist rehabilitation that requires hospital-based care and treatment but should be seen as a stepping stone for people who no longer require this support but would likely benefit from continuing their recovery in a more homelike setting.

### Surge capacity
- Health and Social Care will build upon the additional winter capacity put in place last year to ensure enough capacity is in place in the coming winter.

### Capacity planning
- Finalise the Capacity Planning work, to assess the capacity requirements for social care provision alongside community and acute flows. A key element of this work will be the development of a standardised referral pathway at the point where health and social care services meet.

### Delivering improvements to the models of unscheduled care

#### 3.9

The Unscheduled Care Group has been overseeing a number of investments and actions in Unscheduled Care over the last two years. Some of these are described above. A large number of other actions are undertaken locally at a site level and are led by site based Emergency Access teams. These will focus on process improvements at patient level. Many of these will be captured in the paper being
brought to the Board in June which relates to requirement to produce a Local Unscheduled Care Action Plan (LUCAP).

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
</tr>
</thead>
</table>
| Reduce demand - community response: Health and social care, LUCS/ NHS 24 | ➢ Development of increased numbers of Anticipatory care plans for patients  
➢ Development of professional to professional line between LUCS and SAS  
➢ Piloting increased access for two GP practices to support reduced attendance at A&E’s  
➢ Development of frailty models in West, East & Midlothian and Edinburgh which reduce admissions |
| Improved bed management                   | ➢ The introduction of a single system bed management system incorporating both hospital and community hospital capacity will support improved whole system working, information sharing and patient flow |
| Revised site management arrangements      | ➢ New arrangements for site hospital management to provide increased focus on managing flow and laying foundations for the integration of health and social care partnership working |
| Improved flow                             | ➢ Development of proposals to support increased 7 day working capacity following a workshop in April being considered by the Unscheduled Care Group including Hospital At Weekend and increased AHP staffing  
➢ Ongoing work to increase clarity about the medical models of engagement following a Short Life Working Group of senior clinicians  
➢ Development of a mobile Medicine of the Elderly team at the WGH  
➢ Development of Respiratory redesign at WGH with greater integration with acute medicine to sustain WGH as an acute site in response to reduction in numbers of respiratory trainees  
➢ Development of supervisory charge nurse roles to facilitate improved focus on effective and timely discharge  
➢ Development of revised rehabilitation model in response to Day of Care Audit at RIE in January which indicated a need for improved effectiveness of the rehabilitation pathways including improved acute sector understanding of thresholds for transfers  
➢ Regular focus on patients within acute sites with over 28 day length of stays as a performance indicator of complex patient pathways which require redesign |
| Reducing demand                           | ➢ Development of increased Ambulatory care pathways to reduce admissions |
3.11 Development of a Local Unscheduled Care Action Plan (LUCAP)

3.12 The national Unscheduled Care Expert Group (UMEC) was established in October 2012 to make sure there was a single, coordinated approach nationally to unscheduled care. This group has approved an Action Plan for unscheduled care aimed at bringing all national work directly and indirectly concerned at improving unscheduled care within a common framework.

3.13 The UMEC agreed two programme planning streams (Care in Acute Hospitals / Care outside the Acute Hospital in the Community) and five strategic themes. Boards are expected to reflect these components in their LUCAP. The work undertaken by the Unscheduled Care Group in the last twelve months addresses many of these themes – many of which are described above. The existing NHS Lothian Unscheduled Care plan is currently being adapted to reflect these prescribed themes. The priority areas identified within NHS Lothian’s Strategic Clinical Framework can effectively be aligned to these nationally identified themes.

The five strategic themes are:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Focus</th>
</tr>
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<tbody>
<tr>
<td>Flow and the Acute Hospital <em>(Right Time)</em></td>
<td>This theme will concentrate upon management of flow through A&amp;E Departments, matching capacity to activity/demand by day of week/hour of day; management of flow between A&amp;E Departments and acute receiving beds; and inpatient capacity (including the impact of flows on available beds).</td>
</tr>
<tr>
<td>Promoting Senior Decision Making <em>(Right Care, Right Time)</em></td>
<td>This theme is centred on the evidence that patient flow and outcomes is improved if senior clinicians take decisions about the critical decision points in the management of patients’ care. This theme will also cover the outreach of senior decision makers to support the assessment and treatment of patients in the community and consider issues of out of hours cover.</td>
</tr>
<tr>
<td>Assuring Effective and Safe Care 24/7 at the Hospital Front Door <em>(Right Care)</em></td>
<td>This stream aims to develop a national model of the future organisation of emergency care to guide local service planning. This will include workforce elements recognising future planned work to reduce the number of emergency presentations at hospital for those with complex ongoing needs.</td>
</tr>
<tr>
<td>Making the Community the Right Place <em>(Right Place / Right Care)</em></td>
<td>This theme is centred upon people with ongoing conditions who present at A&amp;E and/or admitted as an emergency inpatient on what is – from a quality perspective seen in many cases as “unnecessary” or “avoidable” because better community based</td>
</tr>
</tbody>
</table>

- Development of OPAT service for intravenous treatments given as an outpatient instead of inpatient
- Proposed development of Alcohol Related Brain Disease step-down capacity outwith acute hospital sites
- Development of chronic disease pathways (outlined in the Strategic Clinical Framework e.g. COPD to support reduced unscheduled care attendances)
alternatives such as extending rehabilitation/re-ablement could or should be available.

3.18 **Developing the Primary Care Response (Right Place / Right Time).** This stream is concerned with the system for patients with urgent, but non-emergency needs who have a self-limiting illness. Further national work will include considering models to incentivise use of alternatives/discourage the use of A&E for this group of patients as well as the ability of primary care to offer same day urgent care as well as alternatives for patients with mental health and substance misuse problems who currently attend A&E.

3.19 The LUCAp is to be a three year plan to encourage a longer term strategic approach. It will also be expected to show specific actions with expected measurable outcomes. The LUCAp will be required to specifically set out plans for Winter 2013/14 to show what is required to maintain sufficient capacity to manage emergency admissions effectively during periods of high demand including taking account of elective scheduling and social care capacity.

3.20 NHS Lothian is required to show within the LUCAp that the necessary actions, supported by quarterly and annual trajectories to reach a minimum of 95% performance by September 2014 and to move to 98% as rapidly beyond this milestone in as short a time period as possible. The LUCAp will also be expected to incorporate any relevant actions relating to the HEAT T10 target (reducing unscheduled attendances).

3.21 The LUCAp will be formally signed off by the Director General of Health & Social Care in the same way as the Local Delivery Plan and is therefore important that the Board is fully aware of the plan and the organisational commitment required to deliver it.

3.22 National funding is available to support NHS Boards with their plans. The Board is asked to note that SGHD has directed territorial Boards that they should work closely with NHS24 and SAS in the development of their plans including them in any funding proposals. In Boards have been any proposals involving Council services demonstrate partnership agreement is in place.

3.23 The implementation and performance management of the LUCAp and the associated trajectory will be managed by the Unscheduled Care Group. The co-chairs of these groups are the joint Executive lead for the LUCAp. A review of the management arrangements within NHS Lothian has resulted in the appointment of Hospital Site Directors. These individuals will work closely with the wider health and social care teams to ensure that we effectively manage patient’s pathways of care. This will be particularly important in relation to working with primary and community care colleagues, particularly those in social care for helping us to achieve our desired performance on delayed discharges a well as reducing the number of patients who are boarded within our hospitals.
4  **Key Risks**

4.1 The investment in the actions supporting unscheduled care may not yield the required improvement in performance against the 4 hour standard.

4.2 Risks to the EM workforce plan include a reduction in doctors in training from August 2013 by approx. 50% over subsequent nine months, and the challenges to recruit speciality doctors and GPs to EM posts on three sites in NHS Lothian.

4.3 Option appraisal for potential redesign of older people services and the strategic clinical framework fails to support increased capacity required to sustain older people pathways at the required level.

4.4 The number of patients being discharge and requiring packages of care has increased significantly and there is a risk that social work teams across Lothian will be unable to meet this demand.

5  **Risk Register**

5.1 The primary implication for the risk register relate to the ability to deliver safe high quality unscheduled care provision and achieve the national standard required for NHS Boards.

5.2 In addition the specific risk associated with recruitment of staff for overnight Emergency Care has been included within the risk register.

6  **Impact on Inequality, Including Health Inequalities**

6.1 An impact assessment has not been undertaken but would be as part of any options appraisal work.

7  **Involving People**

7.1 The Director of Communications and Public Affairs met with the Scottish Health Council to gather their views in regards to the requirement for consultation and/or engagement around any proposals specifically around Corstorphine, Astley Ainslie and Liberton Hospitals. The SHC has recommended that a small group be set up to include PPF members, Older Peoples’ Forum members, representatives from Voice of Carers Across Lothian, a partnership representative and NHS Lothian representatives. This group should consider the proposals as a whole and make comments and recommendations about who needs to be engaged at this stage. The SHC was keen that patients, relatives and carers in the first instance are engaged before consideration is given to a wider public discussion about the proposals. It was the view of the SHC that this would be enough at this stage before there are any concrete proposals which may need further engagement.

8  **Resource Implications**

8.1 The resource implications for current actions supporting Unscheduled Care improvements are addressed through existing funding allocations made through the
Unscheduled Care Group or the Change Fund. This includes allocations made from Scottish Government for support towards the HEAT T10 target.

8.2 Scottish Government have indicated that funding will be made available for some aspects of support for winter capacity, additional Emergency Medicine workforce, improvement capacity and additional assessment capacity.

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WAITING TIMES PROGRESS AND PERFORMANCE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board accepts the attached local access policy to set out the management of waiting lists for acute elective care in Lothian.

1.2 Due to the date of the Board meeting this month, the position at the end of April will not be available in time to distribute before the meeting. A verbal update will be provided on the day.

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

2 Recommendations

2.1 Approve the attached policy governing the management of waiting times for acute elective care in Lothian and that this policy be introduced from August 2013; and

2.2 Receive a verbal update on the waiting time position at the end of April.

3 Waiting Time Performance

3.1 Due to the date of the Board meeting this month, final figures for the end of April are not available to be distributed before the meeting. Provisional information suggests both inpatient and outpatient waiting times are broadly progressing as outlined at the last meeting, with further reductions anticipated in coming months.

3.2 It is recommended that the board receives a verbal update at the meeting.

4 Local Access Policy

4.1 The Scottish Government expects that Boards articulate their approach regarding the management of waiting list in a local access policy. This document is attached as Appendix 1 for approval.

4.2 The policy outlines the Board’s approach to waiting list management and is based upon guidance from Government. Particular regard is paid Patient Rights Act, which expects NHS bodies to uphold the health care principles with due account taken of patient needs, dignity and confidentiality, in providing the optimum benefit to the patient’s health and well-being.

4.3 Consistent with the Board’s Internal Audit report, as well as the recommendations of the Scottish Parliament’s Public Audit Committee earlier this month, where the
Board has gone beyond the government guidance is detailed in Appendix 2 of the policy.

4.4 There is merit in highlighting certain aspects of the policy.

- The 97 minute catchment for reasonable offer location agreed by the Board last June is proposed to remain for adult patients. Locations in the UK are considered reasonable for paediatric care given the lesser number of hospitals able to undertake the options;
- If a patient identifies him or herself as possessing a specified additional need and that patient feels this need prevents him or her from accepting a location outside Lothian, only offers within Lothian would be considered reasonable;
- That a reasonable offer should be made place 14 days before the appointment for non-urgent care;
- That where a patient wishes to be seen by a particular consultant or location, for an operation which can be performed by different clinician or at another location deemed reasonable, then
  o patient advised unavailability for reasons of choice would be applied to the patient’s wait if the patient would otherwise exceed the treatment time guarantee;
  o That unavailability for choice could only be applied for a maximum of six months;
  o If such a choice is not able to be accommodated with Treatment Time Guarantee, and the patient is unwilling to accept an offer with a different consultant or setting, then the patient would be referred back to their GP.

4.5 A workshop is being arranged to work through the implementation of the access policy. It is anticipated that the Policy would come into force once these arrangements are finalised with a target date of 1 August 2013.

4.6 It is proposed that this policy be reviewed no later than August 2014.

5 Impact on Inequality, Including Health Inequalities

5.1 An impact assessment was carried out on the draft access policy in October 2012.

5.2 The main findings were see what further support could be put in place with regards to those patients with additional needs and also to improve communication through clear identification between letters to patients for information and those requiring action.

5.3 Functionality to support identification and communication to patients with additional needs is able to be implemented in TrakCare, the predominant Patient Management System used in Lothian and covering almost all elective acute areas. The timescale for this implementation is currently being explored and an update on this will be provided to the Board’s Audit and Risk Committee in June, when actions relating to reports from Internal Audit and from the Auditor General for Scotland.

5.4 As Board members will know from waiting time updates, TrakCare is yet to be updated for the new guidance and operational solutions have been put in place to
address all but one instance\(^1\). The updating of Trak will include automatic letter production and it is intended to differentiate the letters at this point. The timescale for the upgrade is being confirmed.

5.5 Currently required letters not available through TrakCare are produced through the mailmerge facility using word processor software.

6 Involving People

6.1 The draft version of the policy was also discussed at the Patients’ Forum.

7 Resource Implications

7.1 There are no implications from this document.

Andrew Jackson
Associate Director, Strategic Planning
15 May 2013
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List of Appendices

Appendix 1: Local Access Policy

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\(^1\) The instance not covered is the change in the 2012 guidance that clock changes occurring after the waiting time standard do not apply (ie the clock will not be paused for unavailability nor reset in any circumstance once the patient has exceeded the standard). This is not possible within Trak currently. A local software solution has been commissioned to be available in advance of the nationally commissioned Trak upgrade.
1 Introduction
The Patient Rights Act summarises the duties of NHS bodes to uphold the health care principles. Due account must be taken of patient needs, dignity and confidentiality, in providing the optimum benefit to the patient’s health and well-being.

NHS Lothian is committed to delivering high quality, effective, patient-centred care in a timely manner for all its patients in line with Act and clinical guidance.

This Local Access Policy has been developed in conjunction with the National Access Policy released in August 2012¹ which aims to ensure consistency of approach in providing access to services. It details the responsibilities of patients, referring clinicians and receiving hospitals/clinicians in ensuring management of patient access to services is transparent, fair, equitable and managed according to clinical priority.

This policy is supported by a set of standard operating procedures² that have been developed to ensure there is a consistent approach to the management of referrals and waiting lists.

NHS Lothian strives to ensure that there is equitable and sustainable delivery of waiting time standards and that systems are in place to ensure there is sufficient capacity available and that the use of this capacity is optimised. This involves delivering a programme of continual service redesign and working collaboratively with other healthcare providers to ensure that patients receive the most appropriate treatment with the shortest possible wait.

¹ NHS Scotland National Access Policy
² NHS Lothian Standard Operating Procedures for Waiting List Management
2 Waiting Times Standards
The current waiting time standards in elective acute care are:
- 18 weeks Referral to Treatment for 90% of patients;
- 12 weeks for new outpatient appointment;
- 6 weeks for the eight key diagnostic tests and investigations; and,
- the 12 week Treatment Time Guarantee

To deliver the 18 weeks Referral to Treatment Standard, all stages of the patient’s pathway need to be as short as possible.

There are also additional waiting times standards for patient with cancer.
- 62 day target from referral to treatment for all cancers
- 31 day target from decision to treat until first treatment for all cancers no matter how patients are referred.

2.1 Treatment Time Guarantee
This guarantee is part of the Patient Rights Act (Scotland) 2011 and came into effect on 1 October 2012. It outlines an expectation that patients will wait no longer than a maximum of 12 weeks from the decision to treat until the treatment, as either an inpatient or daycase, occurs and specifies the actions a Health Board should take to prevent a patient from having to wait longer than this.

Certain treatments, specified at a national level, are excluded from the Treatment Time Guarantee.

These exclusions, as at October 2012, are outlined in the CEL (2012) 33. They are:
- Assisted reproduction;
- Obstetrics Services;
- Organ, tissue or cell transplantation whether from living or deceased donor;
- Designated national specialist services for surgical intervention of spinal scoliosis; and
- Treatment of injuries, deformities or disease of the spine by injection or surgical intervention.

2.2 Armed Forces & Veterans
When a member of the UK armed forces or a member of their family moves to a new location in the UK, their previous waiting time should be taken into account and treatment in their new location should meet waiting times standards and be according to their clinical need. NHS Lothian has processes in place to identify

3 Patient Rights (Scotland) Act 2011 – Treatment Time Guarantee Guidance (CEL 32 2012)
Delivery Waiting Times (CEL 33 2012)
4 The Patient Rights (Scotland) Act 2011
5 Access to Health Services for Armed Forces Veterans (CEL 8 2008) and Access to NHS Care for Armed Forces Personnel (CEL 3 2009)
6 Priority Treatment for War Pensioners (NHS HDL 2006 16)
how long these patients have already waited to ensure that their waiting time can continue and their clocks are not reset.

All veterans (including those who have served as reservists) should receive priority access to NHS Primary, secondary and tertiary care for any conditions which are likely to be related to their armed forces service, even when they are not in receipt of a war pension, subject to the clinical needs for all patients.

GPs and referring clinicians should ensure all relevant information is included in the `referral.
3 Effective Waiting Lists Management

Like other Health Boards, NHS Lothian seeks to manage waiting lists as effectively as possible to meet the needs of patients, which, as indicated earlier, are supported through a set of operating procedures.

3.1 Management of Referrals

All referrals received from GPs should be made via SCI Gateway and will be managed electronically. These referrals should be directed to the appropriate department and should contain all relevant contact and clinical information, using the relevant protocol documentation when appropriate.

All referrals should be directed to a service team and not to an individual consultant. Referrals will be triaged by an appropriate member of staff to ensure that they are appropriate and direct them, where necessary, to the relevant subspecialty service within the waiting list.

On some occasions on triaging referrals, it will be felt appropriate that the patient’s care can best be managed by advising the GP on the best way to support a patient without the need for an unnecessary journey to hospital.

GPs are responsible for ensuring that patients are prepared for their hospital appointment. They should make patients aware of where and when their appointment is likely to take place.

3.2 Managing Waiting Lists

To maximise the use of all available capacity, referrals will, where suitable, be added to “pooled” or “common” waiting lists. This means that patients will be seen by a suitable professional rather than a specific individual on each occasion.

This means that patients will not always be seen by the same clinician for treatment as saw them at the initial outpatient consultation.

All patients will be seen in order of clinical priority. It is imperative that all relevant information is included in referrals particularly if there is any suspicion of cancer or need to be seen urgently.

Patients will only be added to a waiting list when they are available to be seen.

3.3 Managing Unavailability

A patient can only be offered an appointment or treatment when they are available to attend and undergo any procedure.

There are two types of unavailability outlined in national guidance – Medical and Patient Advised.

Whenever unavailability is applied for someone waiting for inpatient or daycase, a letter is automatically produced outlining the reason for the change made.
3.3.1 Medical Unavailability
Medical unavailability can be applied only when a registered medical practitioner advises that the patient has another medical condition that prevents them from continuing with agreed treatment for a known period of time. In these cases it is expected that this period of unavailability will be for a known length of time.

If a patient becomes indefinitely unavailable while on the waiting list then their waiting time clock will stop and they will be reviewed after a maximum of 12 weeks.

Any patient for whom it is unclear at referral when they will be able to be seen (ie “indefinitely unavailable”) will not be added to the waiting list.

National guidance indicates that when, after 24 weeks, it is not clear when this unavailability will come to an end, the patient should be passed back to the care of their referring clinician or GP for monitoring.

NHS Lothian will confirm this in writing with the patient and their GP.

3.3.2 Patient Unavailability
Patients often have arrangements which prevent them from attending for an appointment, for example a holiday. In common with medical unavailability, it is expected that the duration of such periods will be known and where it is not, it will be kept under review.

3.4 Making a Reasonable Offers
Patients will be offered at up to 2 appointment dates.

For an offer to be considered reasonable, the notice period for routine patients is a minimum of 14 days from production of the letter sent to patients. In line with national guidance no notice period is required for urgent patients.

If a patient refuses a reasonable offer of appointment then their waiting time clock may be reset to zero if it is reasonably and clinically appropriate to do so. If a patient refuses subsequent reasonable offers then they could be referred back to their referring clinician or GP in order to allow other options to be considered.

This “reasonable offer package” can be made through a variety of booking processes.

Appointments in Lothian will be offered to patients by any of the processes mentioned in the Scottish Government’s outline of Effective Patient Booking - Patient Focussed Booking, Implied Acceptance or Telephone Booking.

Under implied acceptance process patients will be sent an appointment letter with a confirmed appointment date and time. If this appointment is not suitable then the patient can contact the booking office to arrange a more suitable date and time. In a patient focussed booking process the patient will be asked, usually by letter, to contact the booking office and arrange a suitable appointment over the phone.
In other instances the arrangements for appointment or admission will be made over the telephone to the patient.

3.5 Changes by the Hospital to Agreed Arrangements
On occasion it may be necessary for the hospital to cancel an arranged appointment.

If this is the case then the patient will be contacted by phone or in writing as soon as possible.

Situations when a patient cancels an agreed appointment are covered in 6.2.

3.6 Communication with Patients
NHS Lothian will ensure that all patients are kept appropriately informed at all stages of the patient journey.

Patients will be provided with clear, accurate and timely information about when, where and how they are to receive care and their responsibilities in helping ensure this happens.

This communication will usually be in writing. Other forms of communication including by email are being investigated.

The new Treatment Time Guarantee legislation requires that a letter is sent to patients wherever a change is made affecting the waiting time clock. This includes when a patient cancels an appointment, requests a period of unavailability or is removed from the waiting list.

With the upgrade of Trak to incorporate new waiting list functionality, there may be the potential to clearly differentiate between letters sent to the patient for information as opposed to those for action. This possibility, identified as part of the Equality and Diversity Assessment, will be pursued at that time.

3.7 Measuring and Reporting Waiting Times
The process for the measurement of waiting times is specified by the Scottish Government and performance against national standards are set out at Board Meeting and reported as part of the national position by ISD Scotland.

NHS Lothian also has established monitoring processes to highlight unexpected changes in the recording of patients’ journeys to ensure that the waits reported as accurate and reflect the experiences of the patients. Adverse results from this monitoring and also levels of unavailability, as outlined in the report from the Scottish Parliament’s Public Audit Committee, are to be included in papers provided to the Board.

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7 Public Audit Committee, 3rd Report, 2013 (Session 4), Report on the management of patients on NHS waiting lists
http://www.scottish.parliament.uk/S4_PublicAuditCommittee/Reports/paur-13-03w.pdf
Appendix 1 outlines the calculation of the waiting time in more detail and Appendix 2 highlights areas where local decisions have additionally informed the management of waiting lists.
4 Recognising Additional Needs of Patients

Table 1 outlines a range of additional needs of patients, based on those identified by the Scottish Government in CEL (2012) 33.

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<thead>
<tr>
<th>Table 1 - Additional Needs</th>
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<tbody>
<tr>
<td><strong>Literacy Issues</strong></td>
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<tr>
<td><strong>Learning Disability</strong></td>
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<td><strong>English as a second language</strong></td>
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<td><strong>Speech impairment</strong></td>
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<td><strong>Using lip-reading</strong></td>
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<td><strong>Mobility Issues</strong></td>
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<td><strong>Other</strong></td>
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</tbody>
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The potential to automatically collect these details on referral from information systems in general practice is being explored, so that it is electronically flagged in patient’s records in secondary care. This would allow appropriate arrangements to be in place to meet a patient’s needs.

The information sent to patients from hospitals as they start the elective journey also highlight how support can be accessed, such as translation and interpretation services.

Additional needs are also felt to have a bearing on which locations can be deemed reasonable. This is covered in 5.1.1.
5 Accommodating Patient Choice

Patients will sometimes request that their care is undertaken at a particular location, with a specific clinician or at a certain time.

NHS Boards do not have to comply with such requests. However if such a request is accepted and the patient cannot be accommodated within the waiting time standard, a period of patient advised unavailability is to be applied.

Although there is no limit on such periods of unavailability in the guidance, the Board has determined that this unavailability cannot be applied for longer than 6 months.

If it is not anticipated to be possible to see a patient within the standard once a 6 month period of unavailability has been applied, a preference for a particular consultant or location will not be accepted. Where a patient is unwilling to accept the alternative arrangement offered in such a situation, having taken account of the patients' additional needs, they will be removed from the waiting list and referred back to their GP.

5.1 Choice of Location or Local Treatment

NHS Lothian will endeavour to treat all patients locally wherever possible. For some services and in times of waiting times pressures it may be necessary for a patient to attend a non-NHS Lothian site for their appointment or treatment.

Patient will be advised as early as possible if this is the case.

In line with the expectations of the Patients' Right Act, the Board will seek to treat at any appropriate provider outlined in the Act. This means that where options are not available locally, efforts will be made to identify an alternative location, potentially outside Scotland and the United Kingdom.

Any location within 97 minutes travel time of its headquarters, Waverley Gate in central Edinburgh, should be considered reasonable for non-paediatric care as long as a patient’s additional needs were taken into account. This travel boundary is shown in the following figure.

Different parameters apply for children in light of the limited number of other locations offering paediatric care. In these situations, offers outside of the UK are considered reasonable.
Map showing NHS and Private Hospitals Within a 97 Minute* Drive Time of Waverley Gate

*Average drive time from Waverley Gate to Golden Jubilee Hospital

By Mette Traill, HLU, NHS Lothian, 14th June 2012
Reproduced by permission of Ordnance Survey on behalf of HMSO. © Crown copyright and database right 2012. All rights reserved, Ordnance Survey Licence number: 0100022972.
Where a patient is being seen outside of the NHS Lothian area then any necessary and reasonably incurred transport and accommodation expenses will be covered. These will be agreed on an individual basis with each patient.

In situations where a patient prefers to be seen at certain locations and it is not possible to accommodate this preference within the waiting time standard, a period of patient advised unavailability will be applied up to a maximum of six months as described above.

5.1.1 Additional Needs and Reasonable Location
It is appropriate that a patient’s additional needs are taken into account and a location only to be deemed reasonable if those needs can be accommodated at the identified sites.

For those patients who are identified, either by themselves, carer or staff members, as possessing an additional need, and if the patient or carer believes that that the need deems an offer outside board area unreasonable, then only offers to sites in Lothian will be made.

5.2 Choice of Clinician
Although requests to see the same Consultant or other professional will be considered, it will not be possible to accommodate these at a matter of course. Where it is not possible for such a request to be accommodated within the standard, if the patient does not wish to be seen by a different clinician, they can be offered a date with their preferred clinician but beyond the waiting time standard.

In such situations a period of patient unavailability is to be applied for a maximum of six months as outlined above.

5.3 Choice of Time or Date
Patients can advise NHS Lothian if they will be unavailable for a period of time and therefore unable to accept an appointment. In these situations patients should contact the hospital department where they are due to be seen to inform them of this.

This period of unavailability will be entered onto the booking system to ensure that an appointment is not sent during this time. Any offer of dates which subsequently occurs would be expected to take account of the patient’s periods of unavailability.
6 Patients’ Responsibilities

NHS Lothian will seek to see patients as equitably, efficiently and as quickly as possible. To support this, patients are asked to undertake certain responsibilities.

- To ensure that their personal details are kept up to date at their GP practice and hospital service;
- To provide services with details of when they will not be available to be seen or treated to enable the most appropriate offer to be made;
- To highlight any additional needs which the patient requires to be met in order to fulfil the appointment;
- To respond timeously to offers of appointment and, when appropriate, highlighting where these are not suitable in the appropriate timeframe;
- That following a change in circumstances, give notice to services as soon as possible that any arrangements made may need to be altered; and
- To attend for appointments or treatments at the agreed time and date.

6.1 Did Not Attend (DNA)

If a patient does not attend (DNA) for an agreed appointment without giving adequate notice then a clinician will be asked to decide if a further appointment should be offered. If another appointment is required then another reasonable offer will be made to this patient. If another appointment is not required then the patient will be removed from the waiting list and a letter sent to them and their referrer informing them of this.

Prior to removal the booking staff will ensure that they have the correct contact details for the patient and confirm these with the GP or referring clinician.

In situations where the offer was written rather than verbal, the patient will be put back on the waiting list if they request this within seven days of their removal.

NHS Lothian is working to reduce the number of patients that do not attend for appointments. This includes ensuring patients are given adequate notice of appointments, they have the ability to change an unsuitable appointment and introducing an appointment reminder service.

6.2 Patient Cancellations

If a patient wishes to cancel an appointment then they should contact the appropriate department as soon as possible when they will be offered another appointment.

If any patient cancels an appointment for a third time then a clinician will be asked to agree if it is still appropriate to offer them another appointment. If another appointment is not to be made then the patient will be removed from the waiting list and sent back to their referrer. A letter will be sent to the patient and the GP informing them of this.
Appendix 1 - Calculation of Waiting Time

The waiting time measured for patients, both those covered under the Treatment Time Guarantee and others, such as those seen in the outpatient setting, are set out in by the Scottish Government in CEL (2012) 32 and 33.

These measurements also incorporate aspects of local guidance covered in Appendix 2.

Waiting Time Starts:
- For those covered by the Treatment Time Guarantee at the time of agreement between the patient and the medical professional;
- For others when added to the waiting list for admission or when the referral is received in the outpatient setting.

Waiting Time Stops:
- Admitted to hospital for the treatment, seen at clinic or diagnostic test reported;
- The patient is removed from the waiting list as no longer requiring treatment

It will additionally stop, for those who have not exceeded the relevant waiting time standard, when the patient becomes indefinitely unavailable.

Waiting Time Pauses:
- When the patient has an adjusted wait of less than 12 weeks; and
  - has indicated that they are unavailable between specific dates;
  - the patient wishes to be seen at specific location or with a specific consultant and NHS Lothian is able to accommodate this request, the clock will pause from the time of that conversation until the anticipated date when the patient is to be seen;
  - under guidance from medical staff, it is advised that the patient is not able to progress for treatment for a specific period;
  - for those not covered by the treatment time guarantee, under “patient focussed booking”, a patient does not respond to an invitation to contact the Board to agree an admission or appointment within seven days. The waiting time clock will be paused for seven days and if the patient does not respond to the follow up letter within this timescale, they will be removed from the waiting list;

Waiting Time will be reset:
- When the patient has an adjusted wait of less than 12 weeks; and
  - does not accept either of the two dates put forward as part of a reasonable offer.

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8 An adjusted wait is the time on patient has waited having taken set aside any time identified when the patient was unavailable and taking account of any clock resets.
o does not attend or seek to rearrange an appointment previously accepted. This includes offers made through the “Implied Acceptance” where patients are informed of a single date but are offered the opportunity to seek an alternative within 14 days of the offer letter being produced.

o When a patient who has been previously made indefinitely unavailable, becomes available again;

\[9\] This element may be reviewed following the implementation of the rules within ISD National Data Warehouse and their incorporation into Trak. The warehouse does not allow for any resets for urgent patients in this circumstance.
Appendix 2 – Local Guidance

Standard Operational Procedures have been produced to support a uniform approach to waiting list management across Lothian. These are based upon the national guidance referred to earlier and on discussions with clinical and service staff.

The Internal Audit into waiting list management in 2012 indicated that those aspects of practice that have additionally been informed by local decisions should be detailed in the Local Access Policy. This is also consistent with the recommendations of Scottish Parliament’s Public Audit Committee.

The Standard Operating Procedures can be found on NHS Lothian’s internet site.

Resetting of the Clock
Many instances in the national guidance ask for clinical assessment on whether a waiting time clock should be reset in certain situations. Discussion with the Medical Director and Divisional Medical Director did not identify a reason why resets would not apply to patients regardless of their situation. However it was felt strongly that urgent patients in this situation should be booked as quickly as possible, irrespective of the time shown on their waiting time clock. This has been incorporated into the procedures.

Hence if a patient does not attend an appointment or cancels an agreed appointment, the waiting time clock will automatically reset in every instance.

Reinstatement on Waiting List following Removal
Under the national guidance, patients who do not attend an appointment can be removed from the waiting list if clinically appropriate.

Following discussion with Primary Care representatives, it was asked that an arrangement be put in place for patients to be put back on the waiting list following removal if patient requests it. This is to avoid unnecessary involvement of GPs in re-referral and subsequent delay in instances where patients may not have received details of their appointment.

This has been incorporated into local guidance for patients where the offer was by written means.

Patient Focussed Booking
Historically where patients do not respond to an invitation to get in contact with clinical services after 7 days, patients have been made unavailable. This use of unavailability is not included within the Treatment Time Guarantee legislation.

However it is felt to be appropriate for patients in other settings, such as outpatients, and the potential use of this unavailability is included in the specification for ISD National Data Warehouse, which is used to report waiting time performance nationally.
Notice Period for a Reasonable Offer
National Guidance indicates that a minimum of seven days’ notice should be given to non-urgent patients for an offer to be deemed reasonable if refused. 14 days is seen as best practice.

In a move towards best practice, and also to overcome the difficulty in identifying when a letter is received as opposed to produced, a letter outlining an offer 14 days or more from the point at which it is printed will be considered reasonable.

The same timeframe applies for offers made to patients verbally.

While no notice period is required for urgent patients, the waiting time clocks of these patients will not be reset if any offer is refused (see Resetting of the Clock above).

Implied Acceptance
Implied Acceptance is when a patient is offered a single date and asked to contact the hospital if it is not suitable. If not response is received within a set period, it is assumed that the patient has accepted the offer.

The timeframe for this acceptance to be assumed is set at 14 days in line with the notice period for reasonable offer stated above. If a patient does not attend the appointment or subsequently seeks to rearrange it, it will be treated as a “did not attend” or “could not attend” event and thus eligible for a clock reset.

Although the use of implied acceptance is acknowledged nationally, it is not wholeheartedly in line with the national guidance. Discussions are occurring nationally in this regard and alternative booking arrangements being considered.

Unavailability for Patient Choice
Following discussion on the operational practicalities of applying unavailability for patient choice, rather than it being applied from the date at which the patient reaches the waiting time standard until the date they are seen, it is being applied from the day of the conversation with the patient when their preference is indicated until the day before their appointment.

This practice is consistent with that outlined under New Ways by ISD (see http://isd.scot.nhs.uk/isd/4574.html)

A maximum of six months unavailability is proposed.

Additional Unavailability linked to Travel Plans
In situations such as when a patient is taking a flight on holiday, their ability to have an operation may be impacted by the need for a period of recuperation.

In such instances the period of patient advised unavailability relating to the journey itself, should be extended to cover the period of recuperation required and the patient informed of this.
This practice is consistent with that outlined under New Ways by ISD (see http://isd.scot.nhs.uk/isd/4580.html).

**Maximum Period of Known Unavailability**

There is no maximum length for known unavailability in the guidance. However the intent that patients should only be included on the waiting list when they are available or likely to be available is clear.

To prevent patients remaining on the waiting list for too long when their care going be better managed in a different setting, discussion with medical staff concluded that a six month maximum was appropriate.
PERFORMANCE MANAGEMENT

1 Purpose of the Report

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

2 Recommendations

2.1 Receive this update on the current performance against all of the current 2013/14 HEAT targets, and relevant standards as set out in appendix 1.

2.2 To note that work is continuing on the development of this Performance paper as part of a wider programme of Data Quality and Governance.

2.3 Note that it is proposed that we adopt a red (off trajectory and/or target) and green (on trajectory/and or target) reporting mechanism against targets to simplify the way that information is reported.

3 Discussion of Key Issues

3.1 Of the 23 items monitored within Appendix 1, the most recent data indicates NHS Lothian is off trajectory / does not meet the overall target on 11 occasions.

4 Key Risks

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

4.1 Heat Targets

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

To note that as discussed and agreed at the last Board meeting in April information on the wider aspects of managing the delivery of the 18 weeks referral to treatment target have been set out in the waiting times paper presented by the Medical Director.

4.1.2 Faster Access to Psychological Therapies (PT’s) (Responsible Director: Director Health & Social Care West Lothian)
To note that as discussed and agreed at the last Board meeting in April information on the wider aspects of managing the delivery of the 18 weeks referral to treatment target have been set out in the waiting times paper presented by the Medical Director.

4.1.3 **Detect Cancer Early** (Responsible Director: Director of Public Health & Health Policy)

After further development work with the service in recent months, the Detect Cancer Early programme baseline data is now being finalised by ISD Scotland with a view to the first national publication of these data on the 28th May 2013. NHS Lothian is submitting data to ISD Scotland on a quarterly basis per the Detect Cancer Early reporting schedule.

4.1.4 **4-hour Emergency Access** (Responsible Director: Nurse Director)

At this month’s Board the Nurse Director and the Joint Director, Edinburgh will provide a comprehensive report and presentation on the wider unscheduled care agenda and the key performance metrics, which include this target.

4.1.5 **IVF Treatment** (Responsible Director: Medical Director)

As reported last month work is still to progress in developing the wider capacity required with other Boards as well as within NHS Lothian and this is in part due to the delay in the publication of the national review of IVF as commissioned by Board Chief Executives.

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

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

4.2 **HEAT Standards**

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

Monthly management information on cancer waiting times shows that performance in NHS Lothian was:

- 62 days – 97.8% (All Scotland 95.6%)
- 31 days – 99.7% (All Scotland 98.2%)

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

The table gives a summary of headline figures from the April 2013 census
Total ISD Delays (incl. x-codes) | Total Delays (Excel. x-codes) | Complex Codes | >4Weeks National standard from April 13 Zero | >2Weeks National standard due in April 15 Zero | Acute Short Stay Beds > 3 days | Average length of stay as a delayed discharge Days (non- x)
---|---|---|---|---|---|---
March | 160 ↓ | 107 ↓ | 53 ↓ | 17 ↓ | 40 | 9↑ | 16↓

- 107 delays after X codes removed (120 Mar, 112 Feb, 135 Jan)
- 160 overall including X codes (180 Mar, 191 Feb, 177 Jan)
- 17 Patients delayed >4wks (24 Mar, 26 Feb, 24 Jan)
- 16 days is the average length of stay (18 Mar, 22 Feb, 18 Jan)
- 1 Non-Lothian delays (0 Mar, 0 Feb, 1 Jan)
- 53 X codes (60 Mar, 79 Feb, 42 Jan)
- 390 Overall number of patients held on the delayed discharge data base in April (Mar 367, 398 Feb, 365 Jan)
- Edinburgh had 62 delays which is down 80 in March, of which 12 were over four weeks
- East had 30 delays one more than the 29 in March, with 4 being over the 4 week standard
- Midlothian had 12 delays also one more than the 11 in March, and one was over the 4 week standard.
- West Lothian had 2 delays both under 1 week, in March they and Zero

The table below sets out, by Local Authority area the length of delay broken down by Hospital, for April

<table>
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<tr>
<th>Local Authority</th>
<th>Hospital Name</th>
<th>ISD Delays</th>
<th>&lt;2 wks</th>
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The volume of patients, whose discharge from hospital is delayed, continues to grow. The white range in the graph below tracks this from Oct-2007. From having around 250 we are now at just under 400 as at April this year. The grey range is the reportable delays that fall into the monthly census snapshot reported to the
Information Services Division (ISD). Rule changes in early 2012 increased the number of patients who fall within the ISD reportable rules.

4.2.3 Stroke (Responsible Director: Nurse Director)

The RIE stroke unit (Ward 101) generally receives over 50% of the total stroke admissions in Lothian, but was closed for two weeks in March (7th – 21st) because of a Norovirus outbreak. This meant ‘new’ stroke patients could not be admitted during this time. The outreach nurse was advised by Infection Control that he should not visit other wards or the Acute Medical Unit, so could only review patients remotely. Ward 55 (Stroke Unit at the WGH) was also closed 7th – 18th March because of Norovirus, so capacity was insufficient for the increasing numbers of admissions.

Ward 101 at the RIE have arranged for eight of their Registered Nurses to undergo education and development to undertake stroke outreach on a daily basis. As well as the daily reviews on each site to progress patient flow, a weekly teleconference with RIE, Liberton and AAH will review their expected discharges and expedite any decisions required if capacity is an issue.

Weekly exception reports are being produced and actions planned on the outcomes.

5 Risk Register

5.1 Responsible Directors have been asked to ensure that any risks associated with their targets have been clearly identified within the risk register. Risks are escalated to the corporate risk register as appropriate i.e. delayed discharges.
6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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Business Manager

Alex McMahon  
Director of Strategic Planning

10 May 2013
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List of Appendices

Appendix 1: Performance Management Scorecard
### Health Improvement

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Dir.</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr-11 - Mar-12 682</td>
<td>Apr-12 - Dec-12 467</td>
<td>↓</td>
<td>AVM</td>
<td></td>
<td></td>
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</table>

#### Suicide Reduction
- Target: % of suicides per year 100,000 population
- Period: 2013
- Comparison: 2008-10 20%
- Status: ↑
- Status: AVN

#### Smoking Cessation
- Target: 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
- Period: Mar-14
- Comparison: Oct-11 682
- Status: ↑
- Status: AVM

#### Child Fluoride Varnishing
- Target: Aged 3 in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year
- Period: Mar-14
- Comparison: Oct-11 30.72% Quintile 1 | 32.93% Quintile 2 | 21.25% Quintile 3 | 12.36% Quintile 4 | 60% Quintile 5
- Status: ↑
- Status: AVM

#### Reducing Cancer Early
- Target: - of all those diagnosed with breast, colorectal and lung cancer, 20% aim to be diagnosed while in the first stage of the disease
- Period: Mar-15
- Comparison: Feb-13 8.06% Quintile 1 | 12.06% Quintile 2 | 8.06% Quintile 3 | 12.06% Quintile 4 | 8.06% Quintile 5
- Status: ↑
- Status: AVM

#### Efficiency

### Access to Services

#### Reducing Energy Consumption
- Target: % reduction year-on-year (Energy GJ)
- Period: Mar-15
- Comparison: Mar-13 2.97%
- Status: ↑
- Status: AVM

#### A&E Attendances
- Target: rate of A&E attendances per 100,000 population
- Period: Mar-14
- Comparison: Mar-13 2,014
- Status: ↑
- Status: AVM

#### MRSA / MSSA Reductions
- Target: achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MRSA) cases to 0.24 or less per 1,000 acute occupied bed days
- Period: Mar-15
- Comparison: 0.33
- Status: ↑
- Status: AVM

#### C. diff Infections
- Target: achieve a reduction of the rate of Clostridium difficile infections in patients aged 15 and over to 0.25 cases or less per 1,000 total occupied bed days
- Period: Mar-15
- Comparison: 0.33
- Status: ↑
- Status: AVM

#### A&E Attendances - rate of A&E attendances per 100,000 population
- Target: 1,911
- Period: Mar-14
- Comparison: Mar-13 2,014
- Status: ↑
- Status: AVM

#### MRSA / MSSA Reductions
- Target: achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MRSA) cases to 0.24 or less per 1,000 acute occupied bed days
- Period: Mar-15
- Comparison: Mar-14 0.23
- Status: ↑
- Status: AVM

#### C. diff Infections
- Target: achieve a reduction of the rate of Clostridium difficile infections in patients aged 15 and over to 0.25 cases or less per 1,000 total occupied bed days
- Period: Mar-15
- Comparison: Mar-14 0.25
- Status: ↑
- Status: AVM

#### Reduction in emergency bed day rates for patients aged 75+
- Target: 5,143
- Period: Mar-14
- Comparison: Mar-13 5,335
- Status: ↓
- Status: AVM
Delayed Discharges - no people to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015

- April 2015: 0
- February 2013: 62
- April 2013: 40

Dementia Diagnosis - all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of person-centred support plan

- April 2015: 0

IVF - Eligible patients will commence IVF treatment within 12 months by 31 March 2015

- April 2015: 0

Dementia Diagnosis - all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of person-centred support plan

- April 2015: 0

Dementia Diagnosis - all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of person-centred support plan

- April 2015: 0

4-hour A&E - 95% of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&E treatment as a minimum and NHS Boards should pursue further sustainable improvement towards the 98% 4 hour A&E standard

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<th>Target</th>
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<th>Trend</th>
<th>Status</th>
<th>Lead Drtr</th>
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<td>Drug and Alcohol waiting times</td>
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<td>Cancer Waiting Times - 62 day referral to treatment</td>
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<td>Mar-13</td>
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This will be discussed at Nurse Director’s update on Unscheduled Care.
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for April 2013, 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 measures and exception reporting to inform assurance requirements.

2.2 Support the proposal to report complaints numbers and responses on a monthly basis through the Quality Report, accompanied by a detailed complaints assurance paper to the Board on a quarterly basis.

3 Discussion of Key Issues

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

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

3.3 The Quality Report is intended to link with NHS Lothian’s Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

3.4 The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-
based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

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

3.6 The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report 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).

3.7 Following discussions at the March/April Board concerning complaints reporting, it is proposed that complaints numbers and responses will be reported monthly through the Quality Report with a detailed assurance report to the Board on a quarterly basis; the next detailed complaints report will be in June 2013.

3.8 As stated in the April report, the Quality Report is being reviewed within the context of the Francis Report and will be a central component of the Board Workshop on Francis on 26 June 2013, with respect to data required to inform assurance needs concerning quality and safety of care provided by NHS Lothian.

3.9 Exception Reporting – Quality Dashboard

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

3.9.2 Compliance with Incident Management Key Performance Indicators (KPI) (see graph 7) of completing Significant Adverse Events investigation within 60 working days of being reported continues to reduce. This is reflective of a new Lothian-wide process being put into place to strengthen accountability for management and approval of these events through line management structures from service to Executive Management. This will take a few months to reliably embed. A monthly monitoring of compliance with this KPI for all services has been developed to support system-wide monitoring of this process. A number of the outstanding incidents relate to the completing of suicide investigations. As reported in the April Quality Report, a number of the incidents that are not meeting the KPI are suicides and an improvement plan is in place to address this.

3.9.3 Meeting the HEAT target for Staph. Aureus Bacteraemia and Clostridium Difficile infection remains a challenge (see graphs 13 & 14) and is described in more detail in the Healthcare Associated Infections paper.

3.9.4 Compliance with the stroke standard for admission to Stroke Unit within one day of admission and Swallow Screen on day of admission also remains a challenge (see graphs 22 & 23).
3.10 **Effectiveness Measures**

3.11 Four system-level measures are presented for mental health care covering registers in general practice for dementia and mental health and re-admissions to psychiatric inpatient care. These link to Lothian’s Joint Mental Health and Wellbeing Strategy’s measurement framework which includes some system level measures and a wider range of more local measures. Some of the system level measures, for example those reflecting the physical health of people with mental health problems, are relatively new. Trend data for these cannot therefore be included; it is planned to do this in subsequent years.

3.11.1 **Number of patients being identified with dementia and placed on a register in primary care**

A register is seen as a pre-requisite for the organisation of good primary care. There has been a steady increase in numbers since 2006/7 when the register was introduced (Figure 1).

Evidence-based care for patients with dementia requires a range of investigations (blood tests) to be carried out at the time of diagnosis. Provisional data for 2012/13 show that 85.6% of patients in Lothian had these tests done; no Scotland data are yet available.

3.11.2 **Proportion of patients with dementia receiving care review in primary care**

Once a diagnosis of dementia has been made there is an important role for primary care in relation to ongoing medical management, including prescription of relevant medication and management of physical co-morbidities, and management of psychosocial issues including carer support. Depression should be considered since it is more common in people with dementia than those without.

The proportion of patients on the register who have had their care reviewed has increased slightly for the latest reporting period and is slightly higher than the level across Scotland as a whole (Figure 1). Over the next year, there will be an increased focus on GP care for dementia patients including post diagnostic support.

3.11.3 **Number of patients being identified with a diagnosis of schizophrenia, bipolar disorder and other psychoses and placed on a register in primary care**

There are relatively few indicators of the quality of mental health care in relation to the importance of these conditions. This reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues involved. The indicators included in the QOF only provide a partial view on the quality of mental health care. Once patients are identified and placed on the register, there is a call-recall system which helps to ensure that they receive a range of evidence based interventions to improve their mental and physical health and quality of life. These include having a comprehensive care plan.

In 2011/12, there was a further increase in the numbers of patients with schizophrenia, bipolar disorder and other psychoses on registers in primary care practices across Lothian (Figure 2).
For 2011/12 92.8% of these patients received a BP check, compared to 94.4% for Scotland as a whole. Provisional data for 2012/13 indicate that this position has improved slightly (to 93.9%).

**Figure 1**

Number of patients in Lothian on the Dementia QoF Register (DEM 01) and percentage of those who have had their care reviewed in previous 15 months (DEM 02) - 2006/7 to 2011/12

![Bar chart showing number of patients in Lothian on the Dementia QoF Register (DEM 01) and percentage of those who have had their care reviewed in previous 15 months (DEM 02) from 2006/7 to 2011/12. The chart indicates a trend with slight improvement over the years.](image)

Note that right hand scale does not start at zero

**Figure 2**

Number of patients in Lothian on the Mental Health QoF Register 2006/7 to 2011/12

![Bar chart showing number of patients in Lothian on the Mental Health QoF Register from 2006/7 to 2011/12.](image)
3.11.4 **28-Day Readmission Rate of Patients Discharged**

The data presented in Table 1 below is taken from the National Mental Health Benchmarking Project set up to support improvements in mental health. Lothian has reduced the readmission rate over the last four years and remains below the Scotland level.

**Table 1: Percentage readmissions with 28 days for 2007/8 to 2010/11 for Lothian and Scotland**

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<th>Percentage readmissions with 28 days</th>
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<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
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<tr>
<td>Scotland</td>
<td>10.3</td>
<td>8.8</td>
<td>8.6</td>
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The reduction in psychiatric admissions has been achieved by enhancing the provision of community based mental health services provided by multi-disciplinary professional teams to support more people at home.
## Quality Dashboard - April 2013 (dates for each data item stated in background charts)

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

### Quality Ambition: Person-centred

#### Process Measures

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### Quality Ambition: Safe

#### Process Measures

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

### Quality Ambition: Effective

#### Process Measures

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

### Additional Quality Measures

**Hospital Scorecard: July 2011-June 2012 (Next release due April/May 2013)**

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

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

---

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

<table>
<thead>
<tr>
<th>Title: 20-day Complaints Response Rate</th>
<th>Graph 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of complaints responses within 20 days</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of all complaints responses</td>
</tr>
<tr>
<td>Goal:</td>
<td>85% of complaints responded to within 20 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title: Number of Complaints</th>
<th>Graph 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Total number of complaints</td>
</tr>
<tr>
<td>Goal:</td>
<td>Reduction in number of complaints</td>
</tr>
</tbody>
</table>

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

**Data Source: Datix**

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

**Data Source: Datix**

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

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

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

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

### Safe: Reduction in mortality

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

### Outcome Measure

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

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

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

Data Source: ISD (Quarterly)

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Incident Management Key Performance Indicators (KPIs) (Graph 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Incidents with harm  (Graph 8)</td>
</tr>
</tbody>
</table>

8
| Numerator: | Number of incidents associated with serious harm reported per month in NHS Lothian (Mar 2011- Jan 2013) |
| Denominator: | Number of incidents with major harm or death and/or graded as very high/high. |
| Goal: | Compliance target – 100% |

**Process Measure**

| Title: | Adverse Event Rate (NHS Lothian Acute Hospitals) (Graph 9) |
| Numerator: | The number of adverse events (AE) in a monthly random sample of closed case notes (deaths and live discharges) |
| Denominator: | The total number of patient days (PD) in the month for the randomly drawn patients in the sample. |
| Goal: | 30% reduction in Adverse Events from a 2007 baseline by 2012 |

**Outcome Measure**

| Data Source: Datix |

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

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

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

<table>
<thead>
<tr>
<th>Graph 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Total number of patients over 65 with C.Difficile toxin positive stool sample (CDI)</td>
</tr>
<tr>
<td>Goal: Further reduce healthcare associated infections so that by March 2013 NHS Boards’ rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less. <strong>Rate at Mar 2013 – 0.33</strong></td>
</tr>
</tbody>
</table>

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

**Title:** Percent compliance with PVC Bundle (NHS Lothian Acute Hospitals)  **(Graph 12)**

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

**Denominator:** Total number of patients reviewed per month. **n=1000**

**Goal:** 95% Compliance

---

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

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

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less. **Rate at Mar 2013 – 0.32**

**Process Measure**

Data Source: Local Audits (QIDS)

**Outcome Measure**

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

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

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

**Numerator:** The total number of SEWS observations completed correctly

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

**Goal:** 95% Compliance

### Cardiac/Respiratory Arrests

**Title:** Number of Cardiac & Respiratory Arrest Calls *(Graph 15)*

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

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

---

**Process Measure**

**Outcome Measure**

Source Data: Local Audits (QIDS)

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

Title: Percent of patients with medication reconciliation performed (NHS Lothian Acute Hospitals) (Pilot Site=One Ward) (Graph 16)

Numerator: Total number of patients with medication reconciliation performed
Denominator: Total number of patients reviewed. n=15 per month
Goal: 95% Compliance

Process Measure

Source Data: Local Audits (QIDS)

Outcome Measure

OUTCOME MEASURE TO BE DETERMINED
Quality Ambition: Effective

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

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

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

**Patient Falls with Harm (Graph 18)**

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

**Process Measure**

Compliance with Clinical Quality Indicator: Falls

Data Source: QiDS

**Outcome Measure**

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

Count of reported patient falls with harm

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

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

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

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

Numerator: Number of Grade 2 or above pressure ulcers
Goal: To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2014 (from one a day to none a day)
Effective: Delivering Better Care - Reduction in Nursing Medication Administration Incidents

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

Numerator: Number of all medication incidents

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

Outcome Measure

Number of Nursing Administration of Medication Incidents:
All Incidents

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

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

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

**Denominator:** Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board

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

**Process Measure**

**Data Source:** ISD

---

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

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

**Denominator:** Number of patients admitted with initial diagnosis of stroke

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

**Process Measure**

**Data Source:** ISD

---

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

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

**Process Measure**

**Data Source:** ISD
Key Risks

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

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

Risk Register

5.1 Maintaining the national complaints targets is captured on the Risk Register under Litigation Exposures (1082) and is identified as a high risk. Achieving HAI targets is also on the Corporate Risk Register (Risk 1076). Access to Acute Stroke Unit is on the University Hospital Division Risk Register – Medicine and Associated Services (Risk 2444).

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).

Involving People

7.1 Not applicable.

Resource Implications

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

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10 May 2013  
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Elizabeth.bream@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Supporting Technical Appendix
Technical Appendix

Exception Reporting
The Quality & Outcomes Framework (QOF) represents one of the main sources of potential income for general practices (GP surgeries) across the UK. It is a major part of the new General Medical Services (GMS) contract, introduced on 1st April 2004. Participation by general practices in the QOF is voluntary. For those that do participate, the QOF measures achievement against a range of evidence-based indicators, with points and payments awarded according to the level of achievement.

The QOF includes the concept of ‘exception reporting’ to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. Exceptions are removed from the denominator to calculate payment coverage, which is therefore higher than the population coverage.

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

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

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

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

Incidents associated with harm
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.
Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty.
The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

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

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

Medical Re-admissions Within 28 Days
As for 7 day readmissions.

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

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

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

1 Purpose of the Report

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

2 Recommendations

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

- Maintain enhanced weekly surveillance of Meticillin Resistant *Staphylococcus aureus* and Meticillin Sensitive *Staphylococcus aureus* Bacteraemia to target resources for a sustained reduction.
- Support the reduction of healthcare associated *Clostridium difficile* Infection by promoting compliance with the antimicrobial stewardship recommendations.
- Support the ongoing work with Meticillin Resistant *Staphylococcus aureus* screening programme by promoting compliance with Clinical Risk Assessment and swabbing.
- Recognise the need for ongoing work to maintain standards in anticipation of announced and unannounced Healthcare Environment Inspectorate visits.
- Increased compliance with best practice, as recommended by the Antimicrobial Management Team.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 19 episodes of *Staphylococcus aureus* Bacteraemia in April 2013 (4 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*), compared to 23 in March 2013 (5 Meticillin Resistant *Staphylococcus aureus*, 18 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian’s new Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days by March 2015, with a current rate of 0.28 (updated to April 2013). In order to achieve the target, NHS Lothian has to average no more than 15 episodes per month for the twenty-four month period, with a current average of 19 episodes per month.

3.2 *Clostridium difficile* Infection: there were 42 episodes of *Clostridium difficile* Infection in patients aged 15 or over in April 2013, compared to 27 in March 2013. NHS Lothian’s new Health Efficiency Access Treatment Target is to achieve a rate of 0.25 cases or fewer per 1000 total occupied bed days by March 2015 in patients aged 15 and over, with a current rate of 0.51 (updated to April 2013). In order to achieve the target, NHS Lothian has to average no more than 21 episodes per month for the twenty-four month period. The denominator data changed from
patients aged 65 and over to patients aged 15 and over from 1st April. The previous year with extended denominator averaged 30 episodes per month.

3.3 Norovirus outbreaks: Since 1/1/2013 there have been 455 patients identified as norovirus positive in acute sites, with 66 patients identified as norovirus positive within community hospitals. Currently an Incident Management Team is managing a prolonged outbreak at the Royal Infirmary Edinburgh.

3.4 The Meticillin Resistant *Staphylococcus aureus* Screening Programme: Key Performance Indicators have been agreed and the compliance levels have been set at a minimum of 90% for both Clinical Risk Assessment and Swabbing. Data is to be submitted to Health Protection Scotland on a quarterly basis with a published annual aggregated report for NHS Scotland compliance rates.

3.5 Mandatory Surgical Site Infection Surveillance: NHS Lothian continues to undertake mandatory Surgical Site Infection Surveillance: Monthly and quarterly reports are compiled and distributed to the clinical areas and any actions required are discussed. In conjunction with clinical teams, a cluster of surgical site infections for obstetrics and cardio thoracic are currently being investigated.

3.6 Healthcare Environmental Inspectorate: The Healthcare Environmental Inspectorate carried out an unannounced inspection at the Royal Infirmary of Edinburgh on Tuesday 30th April-Wednesday 1st May 2013. The draft report for the inspection is expect on 29th May 2013 with deadline to return accuracy statement and completed action plan to the Inspectorate of 6th June 2013. The final report is anticipated to be published on 24 June 2013.

3.7 Antimicrobial Management Team:
3.7.1 Antibiotic Prescribing Indicators: the target level for compliance within the Acute Services Antimicrobial Prescribing Guidelines and documentation of antibiotic indication is 95%. In-scope clinical areas within the Western General Hospital, the Royal Infirmary of Edinburgh and St Johns Hospital are at or above the target level compliance for both Prescribing Indicators and documentation compliance. For surgical prophylaxis, the data collection focuses on colorectal surgery. Compliance for both Surgical Prophylaxis Policy and administration of single dose antibiotic prophylaxis remained above target at 100% for areas being measured.

3.7.2 Antimicrobial ward-rounds: Review of patients receiving intravenous antibiotics and alert antibiotics for greater than 48 hours is being undertaken as part of an Invest to Save initiative at the Royal Infirmary of Edinburgh for the next 12 months. Twice weekly ward rounds involving an Infectious Diseases Consultant and Antimicrobial Pharmacist are visiting a selected range of wards with the aim of reducing unnecessary use of intravenous and alert antibiotics and optimising antibiotic therapy.

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
Funding for Meticillin Resistant *Staphylococcus aureus* screening and monitoring of Key Performance Indicators set by Health Protection Scotland is non-recurring.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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13 May 2013  
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List of Appendices

Appendix 1: Scottish Government Health Directorates Record Cards for NHS Lothian
SAB There were 19 SAB recorded during April 2013 (4 MRSA & 15 MSSA). The lowest number recorded in the last 12 month period is 15 (Aug 2012).

CDI There were 42 CDI recorded in April 2013, in patients aged 15 years and over. May 2012 recorded the lowest number in the last 12 month period with 22 cases.

SAB HEAT Target NHS Lothians HEAT target is to achieve a rate of 0.24 or less cases per 1000 AOBDS by March 2015.

CDI HEAT Target for Patients aged 15 and over NHS Lothians HEAT target is to achieve a rate of 0.25 or less cases per 1000 OBDS by March 2015.

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

Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th></th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
<th>N-12</th>
<th>D-12</th>
<th>J-13</th>
<th>F-13</th>
<th>M-13</th>
<th>A-13</th>
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<tr>
<td></td>
<td>97%</td>
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Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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

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**Staphylococcus aureus Bacteraemia (SAB)**
There were 3 SAB recorded during April 2013.

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

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**Hand Hygiene Monitoring Compliance**

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**Royal Infirmary of Edinburgh**

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**Western General Hospital**

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

**Clostridium difficile Infection (CDI)**
There were 16 CDI recorded during April 2013.

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

**Hand Hygiene Monitoring Compliance**

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

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

**MRSA Bacteraemia Cases**

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

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

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

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**Hand Hygiene Monitoring Compliance**

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

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

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**MSSA Bacteraemia Cases**

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

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

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

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

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**Hand Hygiene Monitoring Compliance**

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

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**MRSA Bacteraemia Cases**

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

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**MSSA Bacteraemia Cases**

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Royal Hospital for Sick Children

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

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

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

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

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

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Royal Victoria Hospital

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

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

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

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

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**Community Hospitals**

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

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

This is the new Report Card Format introduced by Scottish Government July 2011
Staphylococcus aureus Bacteraemia (SAB)
Patients who are identified with a SAB within 48 hours of admission to Hospital are included in this report card. There were 14 SAB recorded during April 2013.

Clostridium difficile Infection (CDI)
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice's. There were 10 CDI recorded during April 2013.

This is the new Report Card Format introduced by Scottish Government July 2011.
PROPOSED REVISION TO THE TERMS OF REFERENCE OF THE AUDIT & RISK COMMITTEE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approves the revised terms of reference as described below.

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

2 Recommendations

The Board is recommended to:

2.1 Approve the revised terms of reference for the Audit & Risk Committee.

3 Discussion of Key Issues

3.1 The Board approved the current terms of reference of the Committee on 24 October 2012. These terms of reference have subsequently been reviewed as part of the organisation’s action plan to address organisational culture and the issues raised by the Review of Information Received report (April 2012). This further review was performed by the Committee Chair, the Associate Director of Finance, the Corporate Governance Manager and the Associate Director of Analytical Services.

3.2 This process of review is being applied to all governance committees, and has 4 key stages:

- A review of the Board’s overall assurance map, to ensure that the right things are in the scope of the Committee’s remit (Step 1).
- A review of the terms of reference, informed by Step 1 and further consideration of the Board’s legal responsibilities. (Step 2)
- Once the Committee and the Board has approved the revised terms of reference, the Committee will then develop a statement of assurance needs (Step 3).
- The Committee will then identify what information it requires to service its assurance needs and its wider remit, so as to be satisfied that it has reliable information sources and an adequate system of reporting (Step 4).
3.3 The application of Steps 1 & 2 to the Audit & Risk Committee has led to a few minor proposed changes to its terms of reference (Appendix 1). The key outcomes from Steps 1 & 2 were:

- Assurance on Freedom of Information (Scotland) Act 2002 to be added to the terms of reference. This had previously been allocated to the former Healthcare Governance & Risk Management Committee.
- Oversight of primary care contracting expenditure to be transferred to the Finance & Resources Committee.
- The description of the Committee’s core functions for corporate governance was edited, to give a more explicit cross-reference to the relevant legislation.

3.4 The proposed terms of reference are attached at Appendix 1, with the changes tracked on pages 5 & 6. The Audit & Risk Committee considered the changes on 2 April and agreed that the changes were reasonable clarifications and suitably minor that they could be accepted and submitted to the Board for adoption at its next meeting.

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 fundamental risk is managed on a subject by subject basis and there are many risks on the register relating to it. The systems of corporate governance are subject to audit by both external and internal audit, and the process for the Governance Statement requires an annual report from Board committees on their effectiveness. The Board does have an action plan on organisation culture.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment is not required for this paper, as it relates to an improvement to the Committee’s governance processes which has no bearing on any particular group or service.

7 Involving People

7.1 This is not applicable to this paper.

8 Resource Implications

8.1 A Committee with clear terms of reference which 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. These changes to the terms of reference will not
require further expenditure, and should assist in improving the efficiency and effectiveness of the Board’s system of governance.

Alan Payne  
Corporate Governance Manager  
30 April 2013  
alan.payne@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Terms of Reference of Audit & Risk Committee (30 April 2013)
AUDIT & RISK COMMITTEE

Introduction
These terms of reference have been prepared to ensure that the Committee complies with the Scottish Government Audit Committee Handbook (July 2008). Where applicable, the provisions of the UK Code of Corporate Governance (Financial Reporting Council, June 2010) and the associated “Guidance on Audit Committees” of December 2010, has also been considered.

Remit and Delegated Authority:

- The main objective of the Audit & Risk Committee (the Committee) is to support the Accountable Officer and Lothian NHS Board in meeting their assurance needs. This includes:

  1. Helping the Accountable Officer and Lothian NHS Board formulate their assurance needs with regard to risk management, governance and internal control.
  2. Reviewing and constructively challenging the assurances that have been provided, as to whether their scope meets the needs of the Accountable Officer and Lothian NHS Board.
  3. Reviewing the reliability and integrity of those assurances, i.e. considering whether they are they founded on reliable evidence, and that the conclusions are reasonable in the context of that evidence.
  4. Drawing attention to weaknesses in systems of risk management, governance, and internal control, and making suggestions as to how those weaknesses can be addressed.
  5. Commissioning further assurance work for areas that are not being subjected to sufficient review.
  6. Seeking assurance that previously identified areas of weakness are being remedied.

- The Committee has no executive authority, and is not charged to make or endorse any decisions. The only exception to this principle is the approval of the Board’s accounting policies and audit plans. The Committee exists to advise the Board or Accountable Officer who in turn make the decisions.

- The Board authorises the Committee to investigate any activity within its terms of reference, to request any Board member or employee to attend a Committee meeting, and request a written report or seek any information it requires. The Board directs all employees to co-operate with any Committee request.

Continued/
Remit and Delegated Authority (continued):

- The Board authorises the Committee to obtain outside legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

- The Board authorise the Committee to co-opt members for a period up to 1 year, with the approval of the Board and Accountable Officer, to provide specialist skills, knowledge and experience which the Committee needs at a particular time. N.B. A co-opted member is an individual who is not a member of Lothian NHS Board, and is not to be counted as part of the Committee's quorum.
Membership:

Lothian NHS Board shall appoint all members of the Committee. All members shall be non-executive members of the Lothian NHS Board, with the exception of any co-opted members. The Board shall appoint at least three, and up to six non-executive board members to the Committee.

The Committee members must also be independent and objective. The Board shall give due regard to whether a proposed non-executive member for appointment to the Committee is sufficiently independent from other Board Committees.

The Board shall give all members a fixed term of appointment that does not exceed 3 years. Members can only be re-appointed by the Board on two further occasions, so long as they continue to be independent.

The Board shall ensure that the Committee’s membership has an adequate range of skills and experience that will allow it to effectively discharge its responsibilities. With regard to the Committee’s responsibilities for financial reporting, the Board shall ensure that at least one member can engage competently with financial management and reporting in the organisation, and associated assurances.

The Chairman of Lothian NHS Board cannot be a member of the Committee. All Board members, through the Chair of the Committee may request to attend any meeting. All Board members shall receive the minutes of the Committee (at the Board meeting), and shall have the right to have access to the Committee papers.

At the Committee the role of executive Board members and officers is to provide information, and to participate in discussions, either for the whole duration of the meeting or for particular agenda items. The following people will normally be routinely invited to attend Committee meetings:

- Chief Executive
- Director of Finance
- Chief Internal Auditor or representative
- Clinical Governance & Risk Manager or representative
- Statutory External Auditor or representative

However, only the Committee members are entitled to be present at meetings, and it is for those members to decide if non-members should attend for a particular meeting or agenda items. The Committee members will usually meet in a closed session at the commencement and conclusion of each meeting.

Continued/
Membership (continued):

The Committee can request any member of the Board or employee to attend a meeting with respect to specific items being considered. Committee members are entitled to discuss matters directly with the Chair of the Audit & Risk Committee and Chair of Lothian NHS Board. Furthermore members also have a right of access to the Accountable Officer where they feel that this is necessary.

The Chair of the Committee may
- Call a meeting at any time, or when required to do so by the Board
- May exclude all parties other than Members of the Committee from the deliberations of the Audit Committee

Quorum:
No business shall be transacted at a meeting of the Committee, unless at least three non-executive Board members are present.

There may be occasions when due to the unavailability of the above non-executive members, the Board Chairman will ask other non-executive members of Lothian NHS Board to act as members of the Committee so that quorum is achieved. Such occasions will be drawn to the attention of Lothian NHS Board, when subsequently adopting the Committee minutes, and the Board will be asked to approve the membership of the Committee meeting as having been appropriate and in quorum.

Core Functions of the Audit & Risk Committee:

Overall Assurance on Corporate Governance, Internal Control and Risk Management

➢ To support the Board and the Accountable Officer in comprehensively defining their assurance needs.
➢ To assess whether there are sources of assurance in place that provide coverage for all of the identified assurance needs.
➢ To test and determine the reliability of the sources of assurance which are available.
➢ To form an opinion on the exposure to risk relevant to the Board’s Risk Appetite, and the adequacy and effectiveness of the systems of internal control for individual areas/ subjects.
➢ Drawing from the consideration of individual assurances, to form an overall view on the state of risk management, corporate governance and internal control. This will inform the content of the Accountable Officer’s Governance Statement.

Continued/
Core Functions of the Audit & Risk Committee:

Corporate Governance

- Assess the Board’s overall arrangements to be systematically assured on its compliance with all relevant laws, regulations and Government directions that are pertinent to the Board’s functions and responsibilities.

- Review the Board’s arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members’ compliance with the Lothian NHS Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees, and the Board’s procedures to prevent bribery (Bribery Act 2010).

- Seek assurance that the Board has in place arrangements whereby employees may, in confidence, raise concerns about possible improprieties in matters of administration, financial reporting, fraud, breaches of standards of conduct, any other concerns of an ethical nature, and any other matters that are regarded as “qualifying disclosures” in the Employment Rights Act (1996). The Committee will require assurance that there are arrangements for proportionate and independent investigation of such matters, and for appropriate follow-up action.

- Seek assurance that the Board has adequate systems of control to ensure that it complies with the taxation laws that are relevant to the conduct of its activities.

- Seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002.

- Ensure that the Standing Orders package is periodically reviewed, including the Standing Financial Instructions and the Scheme of Delegation, and to advise the Board when any changes are required.

- Ensure that the circumstances associated with each occasion when Standing Orders are waived and suspended, are appropriately examined.

- Periodically review the Board’s Risk Management Policy, and advise the Board of the Committee’s views as to its adequacy.

- Review the Board’s arrangements for the prevention and detection of fraud and other irregularities.

- Receive and review schedules of losses and compensations where the amounts exceed the delegated authority of the Board, before they are referred to the Scottish Government for approval.
 Evaluate the assurances that are provided to support the Accountable Officer’s Governance Statement.

 Advise the Scottish Government Health & Wellbeing Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

 To present to the Board an Audit & Risk Committee Annual Statement of Assurance.

 The Committee will annually review these terms of reference and its own effectiveness, and recommend any necessary changes to the Board.

Core Functions of the Audit & Risk Committee:

Internal Control

 Receive and review all reports from internal and external audit.

 Review audit reports from auditors of national, regional or shared systems upon which NHS Lothian relies, e.g. audit reports from NSS.

 Review of other material pertinent to improving systems of corporate governance and internal control, e.g. Best Value material, studies from other organisations, national performance audit reports from Audit Scotland.

 Receive and review stewardship reports from senior staff in areas that are key to corporate governance, e.g. finance, HR, ICT.

 Receive and review a summary of issues raised by line managers in the annual managerial statements of internal control, which inform the drafting of the Governance Statement.

 Receive and review assurance reports from other Board Committees, so as to inform the review of the Governance Statement.

 Receive assurance that the Board has adequate and effective systems for internal financial control (identify, assess, manage and monitor financial risks) and to produce the annual accounts.

 Review of fraud and theft reports as reported to it from the NHS Lothian Fraud Liaison Officer.

Deleted: Reviewing quarterly payment verification reports in relation to primary care contracting and reports relating to the Quality Outcomes Framework.
Core Functions of the Audit & Risk Committee:

Systems of Risk Management

The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk.

However the Committee shall seek assurance that:

- There is a comprehensive risk management system in place to identify, assess, manage and monitor risk at all levels of the organisation.

- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management.

- The Board has clearly defined its risk appetite (i.e. the amount of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the executive’s approach to risk management is consistent with that appetite.

In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- At each meeting, receive and review a report summarising any significant changes to the Board’s corporate risk register, and what plans are in place to manage them. The Committee may also elect to occasionally receive information on significant risks held on other risk registers held in the organisation.

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board.

- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required.

- Reflect on the assurances that have been received to date, and identify whether entries on the Board’s risk management system requires to be updated.

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk.

Continued/
Core Functions of the Audit & Risk Committee:

Systems of Risk Management (continued)

Whilst the Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions, the Board’s Healthcare Governance Committee shall provide particular oversight to clinical risks and all matters relating to the Board’s legal duty to monitor and improve the quality of health care which it provides (Reference: S12H of National Health Service (Scotland) Act 1978).

The Healthcare Governance Committee shall also provide oversight to the Board’s responsibilities for information governance, through the Information Governance Assurance Board.

The Staff Governance Committee shall have particular oversight of risks relating to the Board’s legal duty in relation to the governance of staff. (Reference: S12I of National Health Service (Scotland) Act 1978)

Financial Reporting
The Committee shall consider the following:

- The accounting policies, any changes to them, and any significant estimates and judgements. The Committee is authorised to approve accounting policies of the Board.

- The significant financial reporting issues and judgements made in connection with the preparation of the annual accounts.

- Any significant or unusual transactions that have been flagged by management, where the accounting treatment is open to different approaches.

- The appropriateness of all the above in light of any comments from the Board’s external auditors.

- The clarity and completeness of disclosures in the financial statements, and whether the disclosures made are set properly in context.

- Any related information presented in the financial statements, e.g. Governance Statement, Operating and Financial Review.

The Committee shall perform the above for the Board’s annual accounts, and the Board’s patients’ private funds annual accounts.

If the Committee is not satisfied with any aspect of financial reporting, it will report its views to the Board.

Continued/
Core Functions of the Audit & Risk Committee:

Internal Audit

- Review the Internal Audit Strategy and plan for the forthcoming year, which are prepared by the Chief Internal Auditor, and assess its appropriateness to give reasonable assurance on the whole of risk, control and governance. The Committee is authorised to approve the Internal Audit Strategy and plans.

- Receive internal audit reports and review the progress of the delivery of the internal audit plan.

- Review the adequacy of internal audit staffing and other resources.

- Review the adequacy of the formal remit that has been granted to the internal audit function to discharge its function.

- Monitor and assess the role and effectiveness of the internal audit service in the context of the Board’s system of risk management.

- Review and monitor management’s responsiveness to internal audit’s findings and recommendations.

- Meet the Chief Internal Auditor once a year without the presence of management.

- Ensure that the Chief Internal Auditor has direct access to the Board Chairman and the Chair of the Audit & Risk Committee.

- The Chief Internal Auditor will be selected and appointed by a panel chaired by a non-executive Board member, preferably the Chair of the Audit & Risk Committee. The Chair of the Audit & Risk Committee shall approve the composition of the panel.

Continued/
Core Functions of the Audit & Risk Committee:

External Audit

- Approve the remuneration of the External Auditors within the range set by Audit Scotland.
- Examine any reason for the resignation or dismissal of the External Auditors.
- Review and confirm the External Auditor’s strategy and plans.
- Receive and review the outputs from the work of the Board’s external auditor.
- Ensure that the External Auditor has direct access to the Board Chairman and the Chair of the Audit Committee. Meet the External Auditor once a year without the presence of management.
- Annually appraise the performance of the External Auditors and report results to Audit Scotland.
- Receive assurance that the external auditor has arrangements in place to maintain their independence and objectivity. This should include consideration as to whether any of the audit staff have any business interest with Lothian Health Board, or personal relationships with any of the Board employees, which could compromise independence and objectivity.
- To develop and recommend to the Board a policy on the provision of non-audit services by the external auditor. The Committee should also set out in its annual report whether such services have been provided during the year.
Communication with the Board and Accountable Officer

The Board secretariat shall prepare minutes of every Committee meeting, and these will be presented at the next Board meeting.

The Secretary and Chair of the Committee will ensure that matters arising from the Committee are communicated appropriately to relevant parties for action and information as appropriate, and in particular ensure that this is circulated to other Board members.

If required, the Chair of the Audit & Risk Committee may meet individually with the Chief Internal Auditor, the External Auditor, and the Accountable Officer.

Administrative Arrangements

Support to the Committee

The Director of Finance is responsible for providing the necessary support to facilitate the effective functioning of the Committee.

The Corporate Governance Manager shall be the Secretary to the Committee, supported by the Board’s secretariat function. The Secretary shall ensure that all necessary administration shall be undertaken to ensure the effective conduct of Committee business, as set out in the Scottish Government Audit Committee Handbook.

Frequency of Meetings:

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. A meeting is normally scheduled to occur in February, April, June, October and December each calendar year. In any event meetings shall be held no less than four times per year.
1 Purpose of the Report

1.1 The purpose of the report is to recommend the Board accept the South East Scotland Research Ethics Committees annual reports for 2012-2013. It is a requirement for NHS Research Ethics Committees to submit standardised annual reports to their appointing authorities to demonstrate that research ethics committees comply with the principles, requirements and standards set out in Governance Arrangements for Research Ethics Committees (A Harmonised Edition). Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Accept the South East Scotland Research Ethics Committees reports for 2012-2013.

3 Discussion of Key Issues

3.1 The National Research Ethics Service requires NHS Research Ethics Committees to produce annual reports. These are generated by the National Research Ethics Service database as a standard report. The report incorporates the data that must be submitted to appointing authorities as set out in Governance Arrangements for Research Ethics Committees (A Harmonised Edition). The reports for South East Scotland Research Ethics Committee 01 and South East Scotland Research Ethics Committee 02 are attached as Appendix 1. These annual reports will also be sent to the National Research Ethics Service and the Chief Scientist Office.

3.2 At the Board meeting 27/7/2011 it was proposed a single report should replace the reports in Appendix 1. This is not possible as NHS Research Ethics Committees must submit standardised annual reports to their appointing authorities, as set out in Governance Arrangements for Research Ethics Committees (A Harmonised Edition). However, a supplementary report summarising the activity of the South East Scotland Research Committees has been provided in Appendix 2.

4 Key Risks

4.1 There are minimal risks attached to the recommendations. There is a risk NHS Research Ethics Committees become non-compliant, for example fail to act as prescribed by the National Research Ethics Service Standard Operating Procedures. This would expose the Board, as the appointing authority, to the risk of approving research whilst not adhering to the National Research Ethics Service...
standards, of involving NHS patients in research that has not received adequate NHS ethical review and reputational risk.

4.2 This risk is actively mitigated by several processes. The South East Scotland Research Ethics Committees undergo Quality Control Checks twice a year. This involves following a nationally-prescribed Quality Control checklist that reviews a selection of research ethics applications, meetings, membership and membership training, ensuring they all comply with current National Research Ethics Service standards. Quality Control checks are then assessed by the audit department of the National Research Ethics Service. Any findings are incorporated into an Action Plan that the Research Ethics Committee implement, reviewed at the next Quality Control Check. The National Research Ethics Service conducts regular independent audits of both the Research Ethics Committees and the Research Ethics Centre; passing the audit results in full accreditation. Since the introduction of the audit scheme, all the South East Scotland Research Ethics Committees have been, and remain, fully accredited. Similarly, the Research Ethics Centre was last audited 17/12/12 and retained its full accreditation.

5 Risk Register

5.1 There is no requirement for risks to be added or removed from NHS Lothian’s Risk Register.

6 Impact on Health Inequalities, Including Health Inequalities

6.1 Researchers must satisfy a research ethics committee the research they propose will be ethical and worthwhile, including considering the effects social inequalities may have on the research. For example, Research Ethics Committees ensure non-English speakers are not excluded from research studies by requiring researchers to incorporate the appropriate paperwork and/or translators into the research protocol. Where studies propose to use solely internet-based research materials, the Research Ethics Committee will require researchers to provide study materials suitable for those who do not have access to the internet.

7 Involving People

7.1 The composition of NHS Research Ethics Committees is defined by the National Research Ethics Service Standard Operating Procedures. These Standard Operating Procedures state that to ensure that Research Ethics Committees reflect the currency of public opinion, at least a third of Research Ethics Committees members must be lay members. Both of the South East Scotland Research Ethics Committees comply with this requirement. Members are recruited by open advertisement (as per the Nolan principles) and serve a maximum of eight years.

7.2 All research ethics applications contain detailed questions about the aspects of the research process in which patients, carers and members of the public have played a role. Research Ethics Committees members consider the answers to these questions as part of their review. Additionally, both of the South East Scotland Research Ethics Committees insist that a lay summary of the overall research results are made available to all research participants.
8 Resource Implications

8.1 There are no resource implications arising from this report or recommendations.

Dr Alex Bailey
Scientific Officer
7 May 2013
alex.bailey@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Annual reports for the South East Scotland Research Ethics Committees for 2012-2013

Appendix 2: Summary for the South East Scotland Research Ethics Committees 2012-2013
Appendix 1: Annual reports for the South East Scotland Research Ethics Committees for 2012 – 2013

South East Scotland Research Ethics Committee 01

Annual Report

01 April 2012 – 31 March 2013
This has been a busy and successful year for SESREC01. We welcomed some new members to the committee at the beginning of the session after the dissolution of SESREC03 and subsequently there has been one resignation.

We have reviewed 58 full applications and 33 substantial amendments. The average time taken to reach a final decision for full applications was 17 days which is an excellent achievement. This year saw the introduction of proportionate review and three of our members (Mr Lindsay Murray, Dr Sara Smith and Dr Kevin Smith) volunteered to join the proportionate review sub-committee. I would like to thank them for taking on this additional commitment which will reduce the work load of the full committee.

On behalf of the whole committee I would like to thank our co-ordinator Mrs Sandra Wyllie who has again worked tirelessly for us. Finally I would also like to take this opportunity to thank all of the committee members for their hard work and support throughout the year.
## South East Scotland Research Ethics Committee 01 Membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation</th>
<th>Expert or Lay</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Janet Andrews</td>
<td>Associate Specialist</td>
<td>Expert</td>
<td>31/03/2010</td>
</tr>
<tr>
<td>Mrs Fiona Barry</td>
<td>Psychologist</td>
<td>Expert</td>
<td>01/04/2004</td>
</tr>
<tr>
<td>Dr Jan Gill</td>
<td>Senior Lecturer in Physiology and Pharmacology</td>
<td>Lay</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>Retired</td>
<td>Lay Plus</td>
<td>17/11/2009</td>
</tr>
<tr>
<td>Dr Calum MacKellar</td>
<td>Director of Research</td>
<td>Lay Plus</td>
<td>31/03/2010</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>Health &amp; Safety Manager</td>
<td>Lay Plus</td>
<td>01/04/2004</td>
</tr>
<tr>
<td>Mr Andy Neustein</td>
<td>Retired</td>
<td>Lay Plus</td>
<td>31/03/2011</td>
</tr>
<tr>
<td>Mrs Patricia Perry</td>
<td>Lecturer</td>
<td>Expert</td>
<td>01/10/2006</td>
</tr>
<tr>
<td>Dr Derek Santos</td>
<td>Lecturer</td>
<td>Expert</td>
<td>31/05/2012</td>
</tr>
<tr>
<td>Dr Lillian Schweizer</td>
<td>BSc PhD</td>
<td>Expert</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Mrs Judy Scopes</td>
<td>Physiotherapist</td>
<td>Expert</td>
<td>01/04/2011</td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>Biochemist</td>
<td>Expert</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Dr Sara Smith</td>
<td>Senior Lecturer- Dietetics</td>
<td>Expert</td>
<td>01/04/2011</td>
</tr>
<tr>
<td>Dr Jill Stavert</td>
<td>Reader</td>
<td>Lay Plus</td>
<td>01/04/2011</td>
</tr>
<tr>
<td>Dr Chee-Wee Tan</td>
<td>Lecturer in Physiotherapy</td>
<td>Expert</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Mr Warwick Taylor</td>
<td>Retired</td>
<td>Lay Plus</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Name</td>
<td>Declaration of Interest</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>Member of Branch Council, Scottish Branch, Society of Biology</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Janet Andrews</td>
<td>None</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Mrs Judy Scopes</td>
<td>None</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Mr Andy Neustein</td>
<td>None</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Mrs Fiona Barry</td>
<td>Involved in research projects of Psychology trainees and potentially projects in which the Psychology department in which I work may be involved.</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>None</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>University lecturer and researcher</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Lillian Schweizer</td>
<td>None</td>
<td>23/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Derek Santos</td>
<td>Currently carrying out some exploratory research (consultancy) for Denfotex Research Ltd on the effects of PAD technology to treat fungal nails. As a university lecturer I am currently involved and potentially will be further involved in future studies at undergraduate and postgraduate level and funded research.</td>
<td>24/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Jan Gill</td>
<td>Member Editorial Board journal Alcohol and Alcoholism</td>
<td>24/04/2012</td>
<td></td>
</tr>
<tr>
<td>Mrs Patricia Perry</td>
<td>Lecturer in a School of Nursing, Midwifery and Social Care</td>
<td>24/04/2012</td>
<td></td>
</tr>
<tr>
<td>Mr Warwick Taylor</td>
<td>None</td>
<td>24/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Sara Smith</td>
<td>None</td>
<td>25/04/2012</td>
<td></td>
</tr>
<tr>
<td>Dr Calum MacKellar</td>
<td>None</td>
<td>02/05/2012</td>
<td></td>
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</table>
Meetings for Full Ethical Review 01 April 2012 - 31 March 2013:

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Number of Members Present at Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>09/05/2012</td>
<td>10</td>
</tr>
<tr>
<td>June</td>
<td>06/06/2012</td>
<td>8</td>
</tr>
<tr>
<td>July</td>
<td>04/07/2012</td>
<td>9</td>
</tr>
<tr>
<td>August</td>
<td>08/08/2012</td>
<td>12</td>
</tr>
<tr>
<td>September</td>
<td>05/09/2012</td>
<td>12</td>
</tr>
<tr>
<td>October</td>
<td>10/10/2012</td>
<td>9</td>
</tr>
<tr>
<td>November</td>
<td>07/11/2012</td>
<td>11</td>
</tr>
<tr>
<td>December</td>
<td>05/12/2012</td>
<td>11</td>
</tr>
<tr>
<td>January</td>
<td>16/01/2013</td>
<td>10</td>
</tr>
<tr>
<td>February</td>
<td>06/02/2013</td>
<td>8</td>
</tr>
<tr>
<td>March</td>
<td>06/03/2013</td>
<td>10</td>
</tr>
</tbody>
</table>

11 full committee meetings were held during the reporting period.

Proportionate Review Sub Committee Meetings held during 01 April 2012 - 31 March 2013:

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Number of Members Present at Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>23/01/2013</td>
<td>3</td>
</tr>
<tr>
<td>March</td>
<td>26/03/2013</td>
<td>3</td>
</tr>
</tbody>
</table>

2 proportionate review sub-committee meetings were held during the reporting period.
Attendance of Members: 01 April 2012 – 31 March 2013:

<table>
<thead>
<tr>
<th>Name</th>
<th>Number of Meetings Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Andy Neustein</td>
<td>11</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>11</td>
</tr>
<tr>
<td>Mr Warwick Taylor</td>
<td>9</td>
</tr>
<tr>
<td>Dr Janet Andrews</td>
<td>9</td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>8</td>
</tr>
<tr>
<td>Dr Lillian Schweizer</td>
<td>8</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>8</td>
</tr>
<tr>
<td>Mrs Patricia Perry</td>
<td>7</td>
</tr>
<tr>
<td>Dr Sara Smith</td>
<td>7</td>
</tr>
<tr>
<td>Dr Jan Gill</td>
<td>7</td>
</tr>
<tr>
<td>Dr Chee-Wee Tan</td>
<td>6</td>
</tr>
<tr>
<td>Dr Derek Santos</td>
<td>6</td>
</tr>
<tr>
<td>Dr Jill Stavert</td>
<td>6</td>
</tr>
<tr>
<td>Dr Calum MacKellar</td>
<td>4</td>
</tr>
<tr>
<td>Mrs Judy Scopes</td>
<td>3</td>
</tr>
</tbody>
</table>

Number of inquorate meetings held: 0

Attendance of Members at proportionate review sub-committee meetings: 01 April 2012 – 31 March 2013:

<table>
<thead>
<tr>
<th>Name</th>
<th>Number of Meetings Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanne Mair</td>
<td>2</td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>1</td>
</tr>
<tr>
<td>Dr Sara Smith</td>
<td>1</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>1</td>
</tr>
<tr>
<td>Mrs Louisa Wilson</td>
<td>1</td>
</tr>
<tr>
<td>Name of Member</td>
<td>Date</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Dr Janet Andrews</td>
<td>06/12/2012 - 06/12/2012</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>06/12/2012 - 06/12/2012</td>
</tr>
<tr>
<td>Dr Calum MacKellar</td>
<td>06/12/2012 - 06/12/2012</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>06/12/2012 - 06/12/2012</td>
</tr>
<tr>
<td>Dr Derek Santos</td>
<td>17/01/2013 - 17/01/2013</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>03/05/2012 - 03/05/2012</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>28/05/2012 - 28/05/2012</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>14/09/2012 - 14/09/2012</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>10/11/2012 - 11/11/2012</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>23/01/2013 - 23/01/2013</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>30/01/2013 - 30/01/2013</td>
</tr>
<tr>
<td>Dr Janet Andrews</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Dr Jan Gill</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Mr Andy Neustein</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Mrs Patricia Perry</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Dr Derek Santos</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Dr Lillian Schweizer</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>10/10/2012 - 10/10/2012</td>
</tr>
<tr>
<td>Dr Janet Andrews</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr Jan Gill</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr Calum MacKellar</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Name</td>
<td>Dates</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Mr Andy Neustein</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Mrs Patricia Perry</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr Sara Smith</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
<tr>
<td>Dr Janet Andrews</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr Jan Gill</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr George Howat</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Mr Lindsay Murray</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Mr Andy Neustein</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Mrs Patricia Perry</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr Lillian Schweizer</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr Kevin Smith</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr Sara Smith</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr Chee-Wee Tan</td>
<td>06/03/2013 - 06/03/2013</td>
</tr>
<tr>
<td>Dr Jill Stavert</td>
<td>06/12/2012 - 06/12/2012</td>
</tr>
<tr>
<td>Dr Jill Stavert</td>
<td>05/12/2012 - 05/12/2012</td>
</tr>
</tbody>
</table>
Part 2: REC workload and activity during the reporting period.

Table 1: Applications assigned to a full committee meeting held within the reporting period:

<table>
<thead>
<tr>
<th>Applications for full ethical review – Study Type</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Trial of Investigational Medicinal Product</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Phase 1</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Gene Therapy</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Research Tissue Bank</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Research Database</td>
<td>1</td>
<td>1.72</td>
</tr>
<tr>
<td>Others</td>
<td>57</td>
<td>98.28</td>
</tr>
<tr>
<td><strong>Total Applications Reviewed</strong></td>
<td><strong>58</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 2: Other REC activity during the reporting period:

<table>
<thead>
<tr>
<th>Number of applications made invalid by co-ordinator</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of studies withdrawn prior to the meeting</td>
<td>15</td>
</tr>
<tr>
<td>Number of student applications reviewed</td>
<td>33</td>
</tr>
<tr>
<td>Number of paediatric applications reviewed</td>
<td>11</td>
</tr>
<tr>
<td>Number of device applications reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of prisoner applications reviewed</td>
<td>1</td>
</tr>
<tr>
<td>Number of applications involving adults unable consent reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications reviewed funded by the US DHHS</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3: Decisions given at meetings held within the reporting period:

<table>
<thead>
<tr>
<th>Decisions taken at meetings following review of applications</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favourable Opinion with Standard Conditions</td>
<td>1</td>
<td>1.72</td>
</tr>
<tr>
<td>Favourable Opinion with Additional Conditions</td>
<td>9</td>
<td>15.52</td>
</tr>
<tr>
<td>Unfavourable Opinion</td>
<td>4</td>
<td>6.90</td>
</tr>
<tr>
<td>Provisional Opinion</td>
<td>44</td>
<td>75.86</td>
</tr>
<tr>
<td>Invalid</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>No Opinion Pending Consultation with Referee</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Provisional Opinion Pending Consultation with Referee</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Not Requiring Review by NHS REC</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>58</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>Number of studies sent back to full committee meeting for final opinion</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
### Table 4: Summary of current status of applications reviewed during the reporting period:

<table>
<thead>
<tr>
<th>Status of applications at date of generation of report</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further Information Favourable Opinion with Standard Conditions</td>
<td>26</td>
<td>44.83</td>
</tr>
<tr>
<td>Further Information Favourable Opinion with Additional Conditions</td>
<td>18</td>
<td>31.03</td>
</tr>
<tr>
<td>Further Information Unfavourable Opinion</td>
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<tr>
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<tr>
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<tr>
<td>Further Information response not complete</td>
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<tr>
<td>Not Requiring Review by NHS REC</td>
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<tr>
<td>No decision entered on RED</td>
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<tr>
<td>Number of studies withdrawn after the meeting</td>
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</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
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</tbody>
</table>

### Table 5: Applications assigned to a proportionate review sub-committee within the reporting period:

| Total Applications Reviewed | 4 |

### Table 6: Decisions given at proportionate review sub-committee meetings held within the reporting period:

<table>
<thead>
<tr>
<th>Decisions taken at proportionate review sub-committee meetings</th>
<th>Number</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Favourable Opinion with Standard Conditions</td>
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<td>Favourable Opinion with Additional Conditions</td>
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<td>No Opinion transfer to full committee for review</td>
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<td>Unfavourable Opinion</td>
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<tr>
<td>Total</td>
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### Table 7: Other Management Information for the reporting period:

<table>
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<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Average number of applications reviewed per full meeting</td>
<td>5.27</td>
</tr>
<tr>
<td>Number of applications for full ethical review over 60 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications over 60 days as a % of total</td>
<td>0.00%</td>
</tr>
<tr>
<td>Number of days taken to final decision - average</td>
<td>17</td>
</tr>
<tr>
<td>Number of days taken to final decision - mode</td>
<td>16</td>
</tr>
<tr>
<td>Number of SSAs (non-Phase 1) reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 25 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 25 days as % of all non-Phase 1 (SSAs)</td>
<td>0%</td>
</tr>
<tr>
<td>Number of SSAs (Phase 1) reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 14 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 14 days as % of all Phase 1 (SSAs)</td>
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</tr>
<tr>
<td>Number of substantial amendments reviewed</td>
<td>33</td>
</tr>
<tr>
<td>Number of substantial amendments over 35 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of substantial amendments over 35 days as a % of total substantial amendments</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of proportionate review applications for ethical review over 14 days*</td>
<td>0</td>
</tr>
<tr>
<td>Number of proportionate review applications over 14 days as a % of total</td>
<td>0.00%</td>
</tr>
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</table>
Table 8: Breakdown of current status of all applications reviewed within the reporting period:

<table>
<thead>
<tr>
<th>REC Reference</th>
<th>Application Short Title</th>
<th>Number of Days on Clock</th>
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<tbody>
<tr>
<td>12/SS/0067</td>
<td>Long Term Mortality in Patients with Aortic Stenosis</td>
<td>20</td>
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<tr>
<td>12/SS/0070</td>
<td>Investigating the prevalence of synaesthesia in Multiple Sclerosis</td>
<td>20</td>
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<tr>
<td>12/SS/0087</td>
<td>Bones and Brains – Vitamin D in Childhood Epilepsy</td>
<td>20</td>
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<tr>
<td>12/SS/0089</td>
<td>Increasing walking in stroke survivors</td>
<td>16</td>
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<tr>
<td>12/SS/0090</td>
<td>Refining lab techniques to detect newborn infection using cord blood</td>
<td>20</td>
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<tr>
<td>12/SS/0107</td>
<td>Mindfulness Lifeworld Study V.1</td>
<td>20</td>
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<tr>
<td>12/SS/0112</td>
<td>Evaluating the use of EPG in schools for children with DS</td>
<td>20</td>
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<tr>
<td>12/SS/0114</td>
<td>Version 3.4 Sleep Self management trial for chronic pain patients</td>
<td>21</td>
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<tr>
<td>12/SS/0126</td>
<td>Chronic pain internet intervention 3.4v</td>
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<tr>
<td>12/SS/0130</td>
<td>Basic Emotions in Psychosis</td>
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<td>12/SS/0132</td>
<td>Salt appetite in heart disease (Version 1)</td>
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<tr>
<td>12/SS/0134</td>
<td>A pilot study of CACR in mentally disordered offenders</td>
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<tr>
<td>12/SS/0142</td>
<td>Identification and support of carers of people approaching end of life</td>
<td>19</td>
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<tr>
<td>12/SS/0172</td>
<td>Tongue colour as a good surrogate of oxygen saturation range</td>
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<td>12/SS/0175</td>
<td>Epilepsy Database Project</td>
<td>24</td>
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<tr>
<td>12/SS/0195</td>
<td>The Role of Psychological Factors in Self-harm</td>
<td>21</td>
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<tr>
<td>12/SS/0203</td>
<td>Reducing Radial Artery Occlusion following Coronary Angiography</td>
<td>15</td>
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<tr>
<td>12/SS/0206</td>
<td>Association between trauma and psychosis</td>
<td>16</td>
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<tr>
<td>12/SS/0218</td>
<td>THE THERAPEUTIC CHOIR (Version 1)</td>
<td>15</td>
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<tr>
<td>12/SS/0226</td>
<td>Oxygen levels in babies during a physiological 3rd stage of labour</td>
<td>16</td>
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<tr>
<td>12/SS/0234</td>
<td>Memory complaints in epilepsy: the role of mood and illness perceptions</td>
<td>18</td>
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<tr>
<td>13/SS/0004</td>
<td>Body weight and school experiences: A qualitative study. Version 1.0</td>
<td>16</td>
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<tr>
<td>13/SS/0015</td>
<td>WARM v1</td>
<td>21</td>
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<tr>
<td>13/SS/0017</td>
<td>TST version 1</td>
<td>19</td>
</tr>
<tr>
<td>13/SS/0019</td>
<td>EAGLE</td>
<td>18</td>
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<tr>
<td>13/SS/0037</td>
<td>Intensive Communication Groups for people with Aphasia (ICGA)-a pilot</td>
<td>20</td>
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<tr>
<td>13/SS/0060</td>
<td>Women's motivation for intervention for pelvic organ prolapse</td>
<td>4</td>
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### Further Information

<table>
<thead>
<tr>
<th>REC Reference</th>
<th>Application Short Title</th>
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<tbody>
<tr>
<td>12/SS/0071</td>
<td>Caring for a child with type 1 diabetes: qualitative study</td>
<td>20</td>
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<tr>
<td>12/SS/0108</td>
<td>Testing HPV activity in LBC samples using a novel biomarker set</td>
<td>19</td>
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<tr>
<td>12/SS/0131</td>
<td>Women’s experiences of weight management &amp; health following childbirth</td>
<td>16</td>
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<tr>
<td>12/SS/0135</td>
<td>Effect of thiamine formulation and dose on CSF penetration. Vers 1.0</td>
<td>16</td>
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<tr>
<td>12/SS/0145</td>
<td>Arts therapies for depression</td>
<td>17</td>
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<tr>
<td>12/SS/0158</td>
<td>Multimodal brain imaging study in autism spectrum disorder - Version1</td>
<td>20</td>
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<tr>
<td>12/SS/0190</td>
<td>Visualising Articulation V 1.0</td>
<td>16</td>
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<tr>
<td>12/SS/0194</td>
<td>Early detection of mood disorder: a case series analysis</td>
<td>16</td>
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<td>12/SS/0216</td>
<td>BAmBiNo</td>
<td>17</td>
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<tr>
<td>12/SS/0222</td>
<td>PETALS</td>
<td>20</td>
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<td>12/SS/0235</td>
<td>A feasibility study, developing of a body map for neuropathic pain</td>
<td>17</td>
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<tr>
<td>13/SS/0002</td>
<td>Achilles Tendon Rupture: Standard Non-Operative vs Accelerated Rehab</td>
<td>16</td>
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<tr>
<td>13/SS/0005</td>
<td>Siblings’ experience of having a brother/sister with an eating disorder</td>
<td>16</td>
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<tr>
<td>13/SS/0012</td>
<td>Ultrasound for prostate cell release</td>
<td>22</td>
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<tr>
<td>13/SS/0013</td>
<td>Selective attention in children with asthma</td>
<td>21</td>
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<tr>
<td>13/SS/0014</td>
<td>Radiostereometric Analysis (RSA) of Ankle Replacement</td>
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<tr>
<td>13/SS/0016</td>
<td>How do identity-release gamete donors understand donation in the UK?</td>
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<tr>
<td>13/SS/0031</td>
<td>Neurodevelopment in &lt;5s with epilepsy</td>
<td>19</td>
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<tr>
<td>13/SS/0038</td>
<td>A feasibility study to communicate weight-related risk in pregnancy 1</td>
<td>19</td>
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<tr>
<td>13/SS/0058</td>
<td>Pre-hospital Care for Adults admitted with Pneumonia</td>
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### Favourable Opinion with Standard Conditions

<table>
<thead>
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<tbody>
<tr>
<td>12/SS/0091</td>
<td>A qualitative study of psychological change following psychotherapy.</td>
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### Favourable Opinion with Additional Conditions

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<tr>
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<tbody>
<tr>
<td>12/SS/0088</td>
<td>Arterial stiffness in CKD</td>
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<td>12/SS/0137</td>
<td>The CA-125 Decision Aid Development Study for Ovarian Cancer.</td>
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<td>12/SS/0146</td>
<td>Transition from active to palliative care for children with cancer V1</td>
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### Table 9: Items exceeding timelines:

<table>
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<td>Factors influencing satisfaction following hallux valgus surgery</td>
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<td>12/SS/0153</td>
<td>Sub clinical changes in nerve function following total hip replacement</td>
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<td>12/SS/0179</td>
<td>Chondrocyte Viability in Tibial Plateau Fractures</td>
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<td>12/SS/0186</td>
<td>Pro-inflammatory lung dendritic cells in severe RSV bronchiolitis</td>
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<tr>
<td>12/SS/0219</td>
<td>Exploring values and goals in mentally disordered offenders. Version 1</td>
<td>15</td>
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<tr>
<td>13/SS/0034</td>
<td>An exploration of the factors that influence desistance from self harm</td>
<td>16</td>
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<tr>
<td>13/SS/0059</td>
<td>Expert versus local review of cases of near-miss maternal morbidity</td>
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<table>
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<th>REC Reference</th>
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<th>Number of Days on Clock</th>
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</thead>
<tbody>
<tr>
<td>12/SS/0069</td>
<td>A qualitative study of psychological change following psychotherapy.</td>
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<tr>
<td>12/SS/0084</td>
<td>The impact of institutionally abusive practices on older people.</td>
<td>16</td>
</tr>
<tr>
<td>12/SS/0102</td>
<td>Arts therapies for depression</td>
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<td>12/SS/0174</td>
<td>Reducing Radial Artery Occlusion following Coronary Angiography</td>
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#### Unfavourable Opinion

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<tr>
<td>12/SS/0069</td>
<td>A qualitative study of psychological change following psychotherapy.</td>
<td>10</td>
</tr>
<tr>
<td>12/SS/0084</td>
<td>The impact of institutionally abusive practices on older people.</td>
<td>16</td>
</tr>
<tr>
<td>12/SS/0102</td>
<td>Arts therapies for depression</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0174</td>
<td>Reducing Radial Artery Occlusion following Coronary Angiography</td>
<td>16</td>
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#### Full applications for ethical review over 60 day timeline

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#### Substantial Amendments over 35 day timeline

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#### Modified Amendments over 14 day timeline

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South East Scotland Research Ethics Committee 02

Annual Report

01 April 2012 – 31 March 2013
Part 1 – Committee Membership and Training

Name of REC: South East Scotland Research Ethics Committee 02
Type of REC: Authorised
Type of Flag: Medical Devices
Chair: Mr Thomas Russell
Vice-Chair: Professor Lindsay Sawyer
Alternate Vice-Char: Dr Jo Mair
Co-ordinator: Joyce Clearie
Committee Address: Waverley Gate
2 - 4 Waterloo Place
Edinburgh
EH1 3EG
Telephone: 0131 650 5674
Email: joyce.clearie@nhslothian.scot.nhs.uk

Chair’s overview of the past year:

Over the past 12 months the work of the Committee has continued at a high standard. I would like to thank all the members of SESREC02 for their hard work throughout the year reviewing applications. There were only three outright unfavourable opinions, one of which has been subsequently approved. Review of medical device submissions continues to be challenging.

In total the Committee reviewed 58 applications, 49 amendments and 5 modified amendments. The average review time for full applications was 16 days, with 24% of applications getting a final opinion at the meeting. The Chief Scientist Office target at present stands at 30 days and SESREC02 currently has one of the fastest average review times in the whole of the UK.

I have been ably assisted by Professor Lindsay Sawyer who is Vice-Chair. I would like to offer a special thanks to him for his very valuable and prompt assistance. I would also like to thank Joyce Clearie our Committee Coordinator for all her efforts which were essential to the smooth running of the Committee. Alex Bailey, as usual, provides a consistently high standard of input to the Committee.

There have been no significant changes in our membership during the past year. I would like to thank all our members for devoting so much time and effort to the process of ethical review.
# South East Scotland Research Ethics Committee 02: Membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation</th>
<th>Expert or Lay</th>
<th>Dates</th>
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</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td><strong>Occupation</strong></td>
<td><strong>Expert or Lay</strong></td>
<td><strong>Dates</strong></td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>General Practitioner</td>
<td>Expert</td>
<td>01/04/2010</td>
</tr>
<tr>
<td>Mrs Ann Chiswick</td>
<td>Nurse</td>
<td>Expert</td>
<td>01/04/2008</td>
</tr>
<tr>
<td>Mr William Farquhar</td>
<td>Retired</td>
<td>Lay Plus</td>
<td>01/04/2010</td>
</tr>
<tr>
<td>Reverend Denise Herbert</td>
<td>Rector</td>
<td>Lay Plus</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Mrs Alanah Kirby</td>
<td>Senior Lecturer</td>
<td>Expert</td>
<td>01/04/2011</td>
</tr>
<tr>
<td>Dr Yann Maidment</td>
<td>General Dental Practitioner</td>
<td>Expert</td>
<td>01/04/2011</td>
</tr>
<tr>
<td>Ms Joanne Mair</td>
<td>University manager</td>
<td>Lay Plus</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Mr Hugh Olson</td>
<td>Lawyer</td>
<td>Lay Plus</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Dr Lynne Phillip</td>
<td>General Practitioner</td>
<td>Expert</td>
<td>01/04/2011</td>
</tr>
<tr>
<td>Mr Alec Richard</td>
<td>Researcher</td>
<td>Lay Plus</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Mr Thomas Russell</td>
<td>Retired Consultant Neurosurgeon</td>
<td>Expert</td>
<td>01/04/2008</td>
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<tr>
<td>Professor Lindsay Sawyer</td>
<td>University Lecturer</td>
<td>Lay</td>
<td>01/04/2010</td>
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<tr>
<td>Mrs Anne Tod</td>
<td>Retired</td>
<td>Lay Plus</td>
<td>01/04/2012</td>
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<tr>
<td>Dr Hester Ward</td>
<td>Public Health Consultant</td>
<td>Expert</td>
<td>01/04/2011</td>
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<tr>
<td>Mrs Louisa Wilson</td>
<td>Senior Research Monitor</td>
<td>Lay</td>
<td>01/04/2012</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>Pharmacy Assessor</td>
<td>Expert</td>
<td>01/04/2012</td>
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</table>
South East Scotland Research Ethics Committee 02: Members’ Declarations of Interest:

<table>
<thead>
<tr>
<th>Name</th>
<th>Declaration of Interest</th>
<th>Date</th>
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<tbody>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>None</td>
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</tr>
<tr>
<td>Mr Thomas Russell</td>
<td>None</td>
<td>22/05/2012</td>
</tr>
<tr>
<td>Dr Hester Ward</td>
<td>None</td>
<td>22/05/2012</td>
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<tr>
<td>Mrs Ann Chiswick</td>
<td>None</td>
<td>22/05/2012</td>
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<tr>
<td>Mr Alec Richard</td>
<td>None</td>
<td>22/05/2012</td>
</tr>
<tr>
<td>Dr Lynne Phillip</td>
<td>GP, Occupation Health Physician Astley Ainslie Hosp</td>
<td>22/05/2012</td>
</tr>
<tr>
<td>Professor Lindsay Sawyer</td>
<td>None</td>
<td>22/05/2012</td>
</tr>
<tr>
<td>Mr William Farquhar</td>
<td>Director of Crossroads Care</td>
<td>18/04/2012</td>
</tr>
<tr>
<td>Ms Joanne Mair</td>
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<td>27/07/2012</td>
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<td>Mrs Alanah Kirby</td>
<td>None</td>
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<tr>
<td>Reverend Denise Herbert</td>
<td>None</td>
<td>27/07/2012</td>
</tr>
<tr>
<td>Mrs Louisa Wilson</td>
<td>None</td>
<td>20/03/2013</td>
</tr>
<tr>
<td>Mrs Anne Tod</td>
<td>None</td>
<td>17/10/2012</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>None</td>
<td>18/04/2012</td>
</tr>
</tbody>
</table>

Meetings for Full Ethical Review 01 April 2012 - 31 March 2013:

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Number of Members Present at Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>18/04/2012</td>
<td>9</td>
</tr>
<tr>
<td>May</td>
<td>16/05/2012</td>
<td>12</td>
</tr>
<tr>
<td>June</td>
<td>20/06/2012</td>
<td>8</td>
</tr>
<tr>
<td>July</td>
<td>18/07/2012</td>
<td>11</td>
</tr>
<tr>
<td>August</td>
<td>22/08/2012</td>
<td>12</td>
</tr>
<tr>
<td>September</td>
<td>19/09/2012</td>
<td>11</td>
</tr>
<tr>
<td>October</td>
<td>17/10/2012</td>
<td>9</td>
</tr>
<tr>
<td>November</td>
<td>14/11/2012</td>
<td>11</td>
</tr>
<tr>
<td>December</td>
<td>19/12/2012</td>
<td>11</td>
</tr>
<tr>
<td>February</td>
<td>20/02/2013</td>
<td>14</td>
</tr>
<tr>
<td>March</td>
<td>20/03/2013</td>
<td>12</td>
</tr>
</tbody>
</table>

11 full committee meetings were held during the reporting period.

0 proportionate review sub-committee meetings were held during the reporting period.
<table>
<thead>
<tr>
<th>Name</th>
<th>Number of Meetings Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr William Farquhar</td>
<td>11</td>
</tr>
<tr>
<td>Dr Lynne Phillip</td>
<td>10</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>10</td>
</tr>
<tr>
<td>Mr Thomas Russell</td>
<td>9</td>
</tr>
<tr>
<td>Reverend Denise Herbert</td>
<td>9</td>
</tr>
<tr>
<td>Dr Yann Maidment</td>
<td>9</td>
</tr>
<tr>
<td>Mr Alec Richard</td>
<td>9</td>
</tr>
<tr>
<td>Mrs Alanah Kirby</td>
<td>9</td>
</tr>
<tr>
<td>Professor Lindsay Sawyer</td>
<td>8</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>8</td>
</tr>
<tr>
<td>Dr Hester Ward</td>
<td>6</td>
</tr>
<tr>
<td>Mrs Ann Chiswick</td>
<td>6</td>
</tr>
<tr>
<td>Mrs Anne Tod</td>
<td>5</td>
</tr>
<tr>
<td>Ms Joanne Mair</td>
<td>5</td>
</tr>
<tr>
<td>Mr Hugh Olson</td>
<td>4</td>
</tr>
<tr>
<td>Mrs Louisa Wilson</td>
<td>2</td>
</tr>
</tbody>
</table>

Number of inquorate meetings held: 0
<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Date</th>
<th>Event(s) attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Ann Chiswick</td>
<td>28/05/2012 - 28/05/2012</td>
<td>Conversations about Consent and Health Research, Mason Institute for Medicine</td>
</tr>
<tr>
<td>Reverend Denise Herbert</td>
<td>06/06/2012 - 06/06/2012</td>
<td>'The Future of Medical Law &amp; Ethics', Mason Institute for Medicine</td>
</tr>
<tr>
<td>Mr Thomas Russell</td>
<td>06/12/2012 - 06/12/2012</td>
<td>Scottish Human Tissue Consensus Day, WTCRF Edinburgh</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>06/12/2012 - 06/12/2012</td>
<td>Scottish Human Training Consensus Day, WTCRF Edinburgh</td>
</tr>
<tr>
<td>Dr Yann Maidment</td>
<td>08/11/2012 - 08/11/2012</td>
<td>Lecture / address inc Ethical Aspects , Royal Odonto-Chirological Society</td>
</tr>
<tr>
<td>Dr Yann Maidment</td>
<td>18/01/2013 - 20/01/2013</td>
<td>Primespeak - an ethical sales seminar for dentists</td>
</tr>
<tr>
<td>Professor Lindsay Sawyer</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate , NRES</td>
</tr>
<tr>
<td>Mrs Ann Chiswick</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Reverend Denise Herbert</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Mrs Alanah Kirby</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Dr Yann Maidment</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Dr Lynne Phillip</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Mr Alec Richard</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate, NRES</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>21/11/2012 - 21/11/2012</td>
<td>Equality &amp; Diversity, NHS Borders</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>21/11/2012 - 21/11/2012</td>
<td>Adult Supervision and protection, NHS Borders</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>16/01/2013 - 16/01/2013</td>
<td>Information Governance - Data Protection, NHS Borders</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>01/06/2012 - 01/06/2012</td>
<td>Information Governance - IT security, NHS Borders</td>
</tr>
<tr>
<td>Mrs Helen Wright</td>
<td>01/09/2012 - 01/06/2013</td>
<td>Ethics module in practical epidemiology course, London School of Hygiene and Tropical Medicine</td>
</tr>
<tr>
<td>Mrs Ann Chiswick</td>
<td>19/11/2012 - 19/11/2012</td>
<td>Howard League lecture entitled 'Vulnerable mothers, Vulnerable children', Howard League &amp; Law Society Scotland</td>
</tr>
<tr>
<td>Mrs Ann Chiswick</td>
<td>04/12/2012 - 04/12/2012</td>
<td>SASO lecture, Perspectives , SASO</td>
</tr>
<tr>
<td>Mrs Ann Chiswick</td>
<td>22/01/2013 - 22/01/2013</td>
<td>Lecture entitled 'Troubling Young People focus on vulnerable, SASO</td>
</tr>
<tr>
<td>Dr Hester Ward</td>
<td>31/01/2013 - 31/01/2013</td>
<td>Equality &amp; Diversity, National Services Scotland</td>
</tr>
<tr>
<td>Professor Lindsay Sawyer</td>
<td>10/12/2012 - 10/01/2013</td>
<td>Stem Cell Revolutions Vision of the Future Discussion</td>
</tr>
<tr>
<td>Professor Lindsay Sawyer</td>
<td>01/09/2012 - 01/09/2012</td>
<td>Science and Ethics Course Lecturer Tutor</td>
</tr>
<tr>
<td>Name</td>
<td>Sessions Dates</td>
<td>Events</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>01/02/2013 - 01/02/2013</td>
<td>Equality &amp; Diversity, HRA NRES</td>
</tr>
<tr>
<td></td>
<td>06/06/2012 - 06/06/2012</td>
<td>Future of Law and Medical Ethics, University of Edinburgh</td>
</tr>
<tr>
<td></td>
<td>03/12/2012 - 03/12/2012</td>
<td>Health Equalities - What does this mean for people in older age</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>01/06/2012 - 01/06/2012</td>
<td>Understanding Medical Research, Medline Plus</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>01/06/2012 - 01/06/2012</td>
<td>Understanding Risk in Research Studies, Medscape</td>
</tr>
<tr>
<td>Reverend Denise Herbert</td>
<td>01/04/2012 - 01/04/2013</td>
<td>Member of Protection of Vulnerable Groups Committee, Scottish Episcopal Church</td>
</tr>
<tr>
<td>Reverend Denise Herbert</td>
<td>01/10/2012 - 01/10/2012</td>
<td>Health and Belief in Dialogue Forum, NHS Fife Department of Pastoral Care</td>
</tr>
<tr>
<td>Mr Thomas Russell</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Professor Lindsay Sawyer</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Dr Balkishan Agrawal</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Mr William Farquhar</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Mr William Farquhar</td>
<td>19/12/2012 - 19/12/2012</td>
<td>Shared Ethical Debate No 12 stroke study, NRES</td>
</tr>
<tr>
<td>Mrs Alanah Kirby</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Dr Lynne Phillip</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Dr Hester Ward</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Dr Yann Maidment</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Mrs Louisa Wilson</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, NRES</td>
</tr>
<tr>
<td>Mr Alec Richard</td>
<td>20/03/2013 - 20/03/2013</td>
<td>Shared Ethical Debate Publication and Dissemination of research, SESRES</td>
</tr>
</tbody>
</table>
### Part 2: REC workload and activity during the reporting period.

#### Table 1: Applications assigned to a full committee meeting held within the reporting period:

<table>
<thead>
<tr>
<th>Applications for full ethical review – Study Type</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Trial of Investigational Medicinal Product</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Phase 1</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Gene Therapy</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Research Tissue Bank</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Research Database</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Others</td>
<td>58</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Total Applications Reviewed</strong></td>
<td>58</td>
<td>100</td>
</tr>
</tbody>
</table>

#### Table 2: Other REC activity during the reporting period:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of applications made invalid by co-ordinator</td>
<td>0</td>
</tr>
<tr>
<td>Number of studies withdrawn prior to the meeting</td>
<td>14</td>
</tr>
<tr>
<td>Number of student applications reviewed</td>
<td>24</td>
</tr>
<tr>
<td>Number of paediatric applications reviewed</td>
<td>6</td>
</tr>
<tr>
<td>Number of device applications reviewed</td>
<td>5</td>
</tr>
<tr>
<td>Number of prisoner applications reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications involving adults unable consent reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications reviewed funded by the US DHHS</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Table 3: Decisions given at meetings held within the reporting period:

<table>
<thead>
<tr>
<th>Decisions taken at meetings following review of applications</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favourable Opinion with Standard Conditions</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Favourable Opinion with Additional Conditions</td>
<td>14</td>
<td>24.14</td>
</tr>
<tr>
<td>Unfavourable Opinion</td>
<td>3</td>
<td>5.17</td>
</tr>
<tr>
<td>Provisional Opinion</td>
<td>41</td>
<td>70.69</td>
</tr>
<tr>
<td>Invalid</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>No Opinion Pending Consultation with Referee</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Provisional Opinion Pending Consultation with Referee</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Not Requiring Review by NHS REC</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>58</td>
<td>100</td>
</tr>
</tbody>
</table>

| Number of studies sent back to full committee meeting for final opinion | 0 |
### Table 4: Summary of current status of applications reviewed during the reporting period:

<table>
<thead>
<tr>
<th>Status of applications at date of generation of report</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further Information Favourable Opinion with Standard Conditions</td>
<td>34</td>
<td>58.62</td>
</tr>
<tr>
<td>Further Information Favourable Opinion with Additional Conditions</td>
<td>2</td>
<td>3.45</td>
</tr>
<tr>
<td>Further Information Unfavourable Opinion</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Favourable Opinion with Standard Conditions</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Favourable Opinion with Additional Conditions</td>
<td>14</td>
<td>24.14</td>
</tr>
<tr>
<td>Unfavourable Opinion</td>
<td>3</td>
<td>5.17</td>
</tr>
<tr>
<td>Provisional Opinion</td>
<td>3</td>
<td>5.17</td>
</tr>
<tr>
<td>Provisional Opinion Pending Consultation with Referee</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Invalid</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>No Opinion Pending Consultation with Referee</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Further Information response not complete</td>
<td>1</td>
<td>1.72</td>
</tr>
<tr>
<td>Not Requiring Review by NHS REC</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>No decision entered on RED</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Number of studies withdrawn after the meeting</td>
<td>1</td>
<td>1.72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>58</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Table 5: Applications assigned to a proportionate review sub-committee within the reporting period:

| Total Applications Reviewed | 0 |

### Table 6: Decisions given at proportionate review sub-committee meetings held within the reporting period:

<table>
<thead>
<tr>
<th>Decisions taken at proportionate review sub-committee meetings</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favourable Opinion with Standard Conditions</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Favourable Opinion with Additional Conditions</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>No Opinion transfer to full committee for review</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Provisional Opinion</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Unfavourable Opinion</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 7: Other Management Information for the reporting period:

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of applications reviewed per full meeting</td>
<td>5.27</td>
</tr>
<tr>
<td>Number of applications for full ethical review over 60 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications over 60 days as a % of total</td>
<td>0.00%</td>
</tr>
<tr>
<td>Number of days taken to final decision - average</td>
<td>16</td>
</tr>
<tr>
<td>Number of days taken to final decision - mode</td>
<td>16</td>
</tr>
<tr>
<td>Number of SSAs (non-Phase 1) reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 25 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 25 days as % of all non-Phase 1 (SSAs)</td>
<td>0%</td>
</tr>
<tr>
<td>Number of SSAs (Phase 1) reviewed</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 14 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of applications for SSA review over 14 days as % of all Phase 1 (SSAs)</td>
<td>0%</td>
</tr>
<tr>
<td>Number of substantial amendments reviewed</td>
<td>49</td>
</tr>
<tr>
<td>Number of substantial amendments over 35 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of substantial amendments over 35 days as a % of total substantial amendments</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of modified amendments reviewed</td>
<td>5</td>
</tr>
<tr>
<td>Number of modified amendments over 14 days</td>
<td>0</td>
</tr>
<tr>
<td>Number of modified amendments over 14 days as a % of total modified amendments</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
### Table 8: Breakdown of current status of all applications reviewed within the reporting period:

<table>
<thead>
<tr>
<th>REC Reference</th>
<th>Application Short Title</th>
<th>Number of Days on Clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/SS/0055</td>
<td>Imagin’. Version 1</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0060</td>
<td>Assessment of nutritional profile in children on HETF</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0061</td>
<td>The origin of endothelial progenitor cells</td>
<td>19</td>
</tr>
<tr>
<td>12/SS/0064</td>
<td>Qualitative Study of the Effects of information on SUDEP</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0073</td>
<td>Using an Aluminium Step Wedge to Estimate Bone Mineral Density</td>
<td>18</td>
</tr>
<tr>
<td>12/SS/0074</td>
<td>Nasopharyngeal Sample Collection for Detection of Respiratory Viruses</td>
<td>16</td>
</tr>
<tr>
<td>12/SS/0077</td>
<td>quality of life effects from attendance at paediatric allergy clinic</td>
<td>20</td>
</tr>
<tr>
<td>12/SS/0078</td>
<td>Quantification of myocardial blood flow by 15O-water PET</td>
<td>16</td>
</tr>
<tr>
<td>12/SS/0092</td>
<td>Survivors of adverse childhood experiences and emotions V2 01-06-12</td>
<td>18</td>
</tr>
<tr>
<td>12/SS/0094</td>
<td>Study of a screening tool to identify people without allergy</td>
<td>18</td>
</tr>
<tr>
<td>12/SS/0095</td>
<td>Examining the influence of childhood trauma in forensic mental health</td>
<td>20</td>
</tr>
<tr>
<td>12/SS/0097</td>
<td>ASTRID: Aarhus Statement Tool for Researching Intervals in Diagnosis</td>
<td>14</td>
</tr>
<tr>
<td>12/SS/0101</td>
<td>CHIRON 20</td>
<td>24</td>
</tr>
<tr>
<td>12/SS/0122</td>
<td>Qualitative examination of the patient experience of ARBD</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0123</td>
<td>MRI Study of Effect of Dignitana Device on Brain Temperature</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0144</td>
<td>HIFU for primary malignant osseous tumours of the sacrum and coccyx</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0148</td>
<td>The assessment of prostate mechanical characteristics in vivo</td>
<td>17</td>
</tr>
<tr>
<td>12/SS/0150</td>
<td>Traumatic imagery after life-threatening cardiac trauma</td>
<td>16</td>
</tr>
<tr>
<td>12/SS/0151</td>
<td>Viking Health Study - Shetland</td>
<td>18</td>
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<tr>
<td>12/SS/0160</td>
<td>LIVER 2 TRIAL</td>
<td>19</td>
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<td>12/SS/0163</td>
<td>Can a questionnaire capture premorbid functioning in dementia?</td>
<td>16</td>
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<tr>
<td>12/SS/0167</td>
<td>A study using an electronic capsule to deliver quinine (v1)</td>
<td>17</td>
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<tr>
<td>12/SS/0170</td>
<td>Help4Mood Integrated System Usability Evaluation</td>
<td>16</td>
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<tr>
<td>12/SS/0183</td>
<td>Macrophages for Regenerative Medicine in Cirrhotics</td>
<td>16</td>
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<tr>
<td>12/SS/0184</td>
<td>Side effects of Opioids Study (SOS)</td>
<td>18</td>
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<tr>
<td>12/SS/0185</td>
<td>The experience of ‘watch and wait’ for people with follicular lymphoma</td>
<td>15</td>
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<tr>
<td>12/SS/0202</td>
<td>Double Loop Ureteral Stent Study - DUDLUIV1201EC</td>
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<td>12/SS/0204</td>
<td>Angiogenesis and Fibrosis in Aortic Stenosis</td>
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<td>12/SS/0205</td>
<td>Angiogenesis and Fibrosis following Myocardial Infarction</td>
<td>11</td>
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<tr>
<td>13/SS/0018</td>
<td>Social Cognition in mentally disordered offenders with schizophrenia.</td>
<td>17</td>
</tr>
<tr>
<td>13/SS/0021</td>
<td>Social cognition deficits and violence in people with schizophrenia.</td>
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South East Scotland Research Ethics Committee 02 Annual Report
## South East Scotland Research Ethics Committee 02 Annual Report

### Further Information Favourable Opinion with Additional Conditions

<table>
<thead>
<tr>
<th>REC Reference</th>
<th>Application Short Title</th>
<th>Number of Days on Clock</th>
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<tbody>
<tr>
<td>12/SS/0128</td>
<td>Emotion recognition and people with an intellectual disability (V1)</td>
<td>20</td>
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<tr>
<td>12/SS/0154</td>
<td>Sidus Stem-Free Shoulder post market clinical follow-up study Rev.0</td>
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### Favourable Opinion with Additional Conditions

<table>
<thead>
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<tbody>
<tr>
<td>12/SS/0062</td>
<td>The Prevalence of Skin Disease in the Elderly Inpatient Population.</td>
<td>17</td>
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<tr>
<td>12/SS/0065</td>
<td>Master study of the Evia/Entovis HF-T pacemaker</td>
<td>18</td>
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<tr>
<td>12/SS/0083</td>
<td>Role of ERCC1 induction in ovarian cancer resistance (version 3.0)</td>
<td>16</td>
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<tr>
<td>12/SS/0103</td>
<td>Percuflex Vs Polaris loop Vs Percuflex Helical, stent symptom study</td>
<td>15</td>
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<td>12/SS/0124</td>
<td>Utility of Contrast Enhanced Harmonic Endoscopic Ultrasound</td>
<td>15</td>
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<tr>
<td>12/SS/0127</td>
<td>Pilot testing of methods for RESpeck respiratory monitor trial v1.0</td>
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<td>12/SS/0133</td>
<td>Low intensity Psychological Intervention for Irritable Bowel Syndrome</td>
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<td>12/SS/0149</td>
<td>Neuropathic pain in women with chronic pelvic pain</td>
<td>15</td>
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<tr>
<td>12/SS/0182</td>
<td>Clinical evaluation of the NANO lead system in chronic situation- LENA</td>
<td>15</td>
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<tr>
<td>12/SS/0189</td>
<td>INGEVITY Active and Passive Fixation Pace/Sense Lead study</td>
<td>16</td>
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<td>12/SS/0199</td>
<td>USPIO Assessment of Inflammation Post Acute Myocardial Infarct</td>
<td>14</td>
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<td>12/SS/0201</td>
<td>Early estimation of pandemic influenza vaccine effectiveness (EAVE)</td>
<td>15</td>
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<tr>
<td>12/SS/0217</td>
<td>Mapping recovery capital throughout treatment for addiction v1</td>
<td>13</td>
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<tr>
<td>12/SS/0225</td>
<td>Supportive pathway in colorectal liver metastases resection v1</td>
<td>13</td>
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<tr>
<td>13/SS/0052</td>
<td>Prevalence of aero-allergy and/or food allergy in children with eczema</td>
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### Unfavourable Opinion

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<th>Application Short Title</th>
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<tbody>
<tr>
<td>12/SS/0200</td>
<td>Listening to psychosis</td>
<td>15</td>
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<tr>
<td>13/SS/0020</td>
<td>AGP as a Breast Cancer Biomarker in at Risk Individuals</td>
<td>16</td>
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<tr>
<td>13/SS/0027</td>
<td>Listening to psychosis</td>
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### Provisional Opinion

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<tr>
<td>13/SS/0042</td>
<td>BENEFIT-11</td>
<td>N/A</td>
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<tr>
<td>13/SS/0046</td>
<td>Comparison of NPH insulin and insulin glargine in type 2 diabetes</td>
<td>N/A</td>
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### Further information response not complete

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<tbody>
<tr>
<td>12/SS/0236</td>
<td>&quot;JUST BECAUSE I'M OLD DOESN'T MEAN I'M VULNERABLE &quot;</td>
<td>N/A</td>
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### Withdrawn after the meeting

<table>
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<tr>
<td>12/SS/0161</td>
<td>Acute effects of Weight Training on Glycaemia (full study)</td>
<td>14</td>
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</table>

### Table 9: Items exceeding timelines:

### Full applications for ethical review over 60 day timeline

<table>
<thead>
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<th>REC Reference</th>
<th>Application Short Title</th>
<th>Number of Days on Clock</th>
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</thead>
<tbody>
<tr>
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### Substantial Amendments over 35 day timeline

<table>
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<tbody>
<tr>
<td>None</td>
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</table>

### Modified Amendments over 14 day timeline

<table>
<thead>
<tr>
<th>Amendment Reference</th>
<th>Application Short Title</th>
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<th>Number of Days on Clock</th>
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</thead>
<tbody>
<tr>
<td>None</td>
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</table>
Appendix 2: Summary for the South East Scotland Research Ethics Committees 2012-2013

In 2012 - 2013 there were two South East Scotland Research Ethics Committees appointed by the Board: South East Scotland Research Ethics Committee 01 and South East Scotland Research Ethics Committees 02.

Despite the closure of South East Scotland Research Ethics Committee 03 in 2012, the total number of research ethics applications reviewed by the South East Scotland Research Ethics Committees in 2012 - 2013 decreased by only 5% compared to the previous year. This relatively small reduction is largely due to South East Scotland Research Ethics Committee 01 and South East Scotland Research Ethics Committee 02 reviewing more applications at each meeting, the addition of two extra meetings each year, and the establishment of a proportionate review system.

The main change to the South East Scotland Research Ethics Committees in 2012 - 2013 was a switch of management from Secretariat to Research and Development from August 2012. This has allowed a reduction in the meeting deadline duration and reorganisation of staff, both of which had a marked positive effect on the research ethics service. For example, the mean ethics application review times have been reduced as follows:

South East Scotland REC 01: 31 days to 17 days
South East Scotland REC 02: 29 days to 16 days

The Chief Scientist Office ethics application review target is 30 days.

This provides researchers with a speedier research ethics service and allows NHS patients to enter research studies up to two weeks earlier than was previously possible.

A proportionate ethics review service was introduced in 2013 that allows applications with ‘no material ethics issues’ to enter an expedited review process. The mean review time for proportionate review applications in South East Scotland is currently 5.5 days. This compares favourably with the U.K. target review time of 14 days.

A comparison with other Scottish Research Ethics Committees for 2012 (data supplied by the National Research Ethics Service) shows that the South East Scotland Research Ethics Service received more full research ethics applications than any other Scottish Research Ethics Service but maintained the fastest mean review time.
COMMUNICATIONS RECEIVED

1 Purpose of the Report

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Government:

<table>
<thead>
<tr>
<th></th>
<th>Communication</th>
<th>Description</th>
<th>Date</th>
<th>Author(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PCA(P)(2013)7</td>
<td>Pharmaceutical services: Amendment to annex A: Discount Clawback scale for Proprietary Drugs</td>
<td>26/03/2013</td>
<td>PCCO</td>
</tr>
<tr>
<td>2</td>
<td>CEL(2013)7</td>
<td>Hospital Eye Services</td>
<td>26/03/2013</td>
<td>MD</td>
</tr>
<tr>
<td>3</td>
<td>NMC(2013)1</td>
<td>Guidance for local supervising authorities annual report submission to the Nursing and Midwifery Council practice year 1 April – 31 March 2013</td>
<td>26/03/2013</td>
<td>DN</td>
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<tr>
<td>4</td>
<td>PCS(AFC)(2013)1</td>
<td>New injury allowance provisions</td>
<td>28/03/2013</td>
<td>DHR&amp;OD</td>
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<tr>
<td>5</td>
<td>PCA(P)(2013)8</td>
<td>Pharmaceutical services: Discount Clawback scale for Proprietary Drugs</td>
<td>02/04/2013</td>
<td>PCCO</td>
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<tr>
<td>6</td>
<td>CEL(2013)5</td>
<td>Addendum to Cel 5 2013: Protection of Vulnerable Groups (PVG) Scheme Membership</td>
<td>16/04/2012</td>
<td>DHR&amp;OD</td>
</tr>
<tr>
<td>7</td>
<td>PCA(P)(2013)9</td>
<td>Independent Prescribing Clinics: Funding for 2013-14</td>
<td>16/04/2013</td>
<td>MD, PCCO</td>
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<tr>
<td>8</td>
<td>PCA(P)(2013)10</td>
<td>Pharmaceutical services: community pharmacist practitioner champions.</td>
<td>22/4/2013</td>
<td>PCCO</td>
</tr>
<tr>
<td>9</td>
<td>CNO(2013)1</td>
<td>MRSA Key Performance Indicators – April 2013</td>
<td>24/04/2013</td>
<td>DN</td>
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<tr>
<td>10</td>
<td>CMO(2013)6</td>
<td>Important Changes to the Scottish Immunisation Programme in 2013 - 14 – Changes to the Schedule for Meningococcal Serogroup C Conjugate Vaccination.</td>
<td>09/05/2013</td>
<td>DPH</td>
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<tr>
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<td>PCS(AFC)(2013)2</td>
<td>Pay and Conditions For Staff Covered by the Agenda for Change Agreement.</td>
<td>10/05/2013</td>
<td>DF DHR</td>
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<tr>
<td>12</td>
<td>CMO (2013)4</td>
<td>Important Changes to the Scottish Immunization Program in 2013/14 – Rotavirus immunization program</td>
<td>13/05/2013</td>
<td>DPH PCCO</td>
</tr>
</tbody>
</table>

Douglas Weir  
Corporate Services Manager  
14 May 2013

AFC  Agenda for Change  
CEL  Chief Executive Letter  
(The designation for general circulars)  
CMO  Chief Medical Officer  
SAN  Safety Action Notice  
(A standard priority notice where action can be planned rather than immediate)  
HAZ  Hazard Notice  
(A high priority notice where immediate action is required)  
MDA  Medical Devices Agency  
PCA  Primary Care Administration  
(Circulars relating to Primary Care staff i.e. P - Pharmacy, D - Dentistry)  
PCS  Pay & Conditions of Service  
(Circulars relating to the pay and conditions of service of staff)  
SHS  Scottish Health Service  
SPPA  Scottish Public Pensions Agency  
SSI  Scottish Statutory Instrument
Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Tuesday, 2 April 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; Councillor D Grant; Councillor R Henderson and Councillor C Johnstone.

In Attendance: Ms L Bream (Shadowing Director of Finance); Mr T Davison (Chief Executive); Mrs S Goldsmith (Director of Finance); Mr A Jackson (Assistant Director of Healthcare Planning) (for item 8.1); Ms L Martin (Chief Nurse, REAS) (for item 1); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D McConnell (Audit Scotland); Ms D Milne (Deputising for Dr McCallum); Mr T Montgomery (Director of Operations) (for item 1); Mr A Perston (Audit Scotland); Mr D Woods (Chief Internal Auditor); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Ms Bennett, Dr Bryce, Dr Farquharson, Dr McCallum and Mr Payne. N.B. Dr Bryce and Ms Bennett were unable to attend due to the Healthcare Governance Committee meeting at the same time.

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. Mr Ash declared links between his employer the Accounts Commission and the external auditors Audit Scotland.

1 Royal Edinburgh Hospital & Associated Services Risk Register

1.1 Mr Montgomery and Ms Martin gave a detailed overview of the individual risk register for the Royal Edinburgh Hospital Services and Associated Services excluding learning disabilities and substance misuse. Ms Martin assured the Committee that the report only provided a snapshot of the high and medium level risks within the Royal Edinburgh Hospital and Associated Services. Meanwhile, matters such as self harm including suicide had been deemed low risk to reflect mitigating factors that have been put in place, but were incorporated within the full risk register.

1.2 The Committee were assured that there was consistency across the Board in relation to the complaint process. It was noted that following the centralisation of the complaints team and the realignment of line management further work to develop working relationships that would inform the proposed restructure and rapid response team approach was required. Mr Payne would liaise with Mr Boyter and Mr Wilson to bring forward a brief report on risks associated with the Complaints department for the June meeting.

1.3 It was noted that child and adult protection would remain high on the risk register given the volume and the complexity of the patients it referred to.
Ms Martin assured the Committee that the service would remain vigilant as it moves forward with the reduction of incidents within vulnerable patient groups.

1.4 There was some discussion in respect of the positive steps taken to mitigate risk within the Royal Edinburgh Hospital and the Associated Services. Mr Montgomery advised the Committee on proposals to create an intensive psychiatric care unit at the Royal Edinburgh Site. Mr Davison welcomed the proposal. He encouraged Mr Montgomery and Ms Martin to take advantage of the period of planning to factor in the intensive psychiatric care unit into the Royal Edinburgh Hospital Acute Inpatient Services. Ms Martin advised that discussions to take this matter forward in under phase 2 were ongoing.

1.5 Mr Brettell asked Mr Montgomery and Ms Martin if the Risk Log/Management process was generally helpful, and they confirmed it was really useful to their day to day activities. Mr Brettell thanked them for volunteering to present their Risk log and for their informative and educational report and they left the meeting.

2 Risk Management

2.1 NHS Lothian Corporate Risk Register

2.1.1 Mr Davison advised the Committee of the following matters raised and agreed during discussions at the March Board meeting:
• The Board would now receive quarterly reports on the corporate risk register for the next year. Any critical risk would be reported by exception as and when they arose.
• Members were concerned that the complexities of the top 16 risks were being masked by the language that defined them. The Risk Management Steering Group had been tasked with identifying an appropriate balance.
• Further work to provide context in relation to the likelihood and subsequent impact of the high and medium risks the Board faces. The Risk Management Steering Group had been tasked with developing detail and narrative for each risk.

Mr Brettell welcomed Mr Davison’s update on the actions following discussion at the March Board meeting. He noted that the Audit and Risk Committee would require sight of the top 16 risk with detailed mitigation marked against each risk, in addition following an enquiring from Mr Ash he proposed that those risks that had a gross minus net score higher than 9 be brought forward to the Committee for oversight and review.

2.1.2 Members noted that a Board Risk session had been proposed for May 2013. Mr Davison agreed to clarify what was happening and feedback to the Committee.

2.1.3 The non-executive members of the Committee expressed concerns in respect of the increasing volume and quality of the reports received at Board Committees making it more difficult to assess underlying risk. Mr Brettell
requested that Risk Management Steering Group look into this matter on behalf of the Audit and Risk Committee. 

2.1.4 Following the assurance review the Committee raised concerns that the volume risk attributed to the Healthcare Governance was not sustainable noting the potential for overload and failure that may arise if action was not taken to resolve this matter. Mr Davison assured the Committee that this had been recognised at Board level and action to resolve this matter had commenced. He went on to advise the Committee of recent discussions in respect of the Community Health Partnerships and delegation of responsibility under their proposed governance role with the overarching responsibility remaining within the Healthcare Governance Committee. It was agreed that work to develop an Acute Hospital Services Committee and the Governance roles within the Community Health Partnerships as they move forward into Health and Social Care Partnerships would be raised at the next Board development day.

2.1.5 Complaints Management was reviewed with particular reference to the information available to the Board. Mr Davison agreed it was currently a concern, and that Stuart Wilson and Alan Boyter were developing reporting. The Committee asked for a paper from Mr Wilson and Mr Boyter to be presented at the June Committee meeting.

2.1.6 The Committee agreed that it would be beneficial if all future reports distinguish why they were being presented to the Committee and any assurances sought should be specifically detailed within the recommendations.

2.1.7 Members requested that in future all appendices would be bookmarked in addition to the main items within the final PDF and the agenda split into relevant sections i.e. assurance, decision, for information etc.

3 Minutes of the Previous Meeting

3.1 Minutes of the previous meeting held on 4 February 2013 – previously circulated minutes were approved as a correct record subject to the following minor amendments:
- External Audit Section: Mr Perston’s and Mr McConnell’s names be reversed.
- 46.3.9: Should read Ms Blair not Ms Kay.

4 Matters Arising

4.1 Matters Arising from the Meeting of 4 February 2013 – the Committee noted the previously circulated paper detailing the matters arising from the Audit & Risk Committee meeting held on 4 February 2013, together with the action taken and the outcomes.

4.2 Members were advised that following the incorporation of the guidelines a report on the mapping of activities to the terms of reference of the Audit and Risk Committee would be brought forward for consideration in June.
4.3 In respect of Whistleblowing, guidance had just been received, and this was expected to be actioned for the next Committee meeting in June.  

4.4 The Committee agreed to accept the Running Action Note.

5 Internal Audit

5.1 Internal Audit – Progress Report January 2013

5.1.1 Mr Woods gave a brief overview of the report and highlighted progress made towards completing the remaining audits from the 2012/13 audit plan. Meanwhile, early progress has been made in starting audits from the 2013/14 plan.

5.1.2 The Committee noted the Internal Audit Progress Report - March 2013.

5.2 Reports with “Fully Satisfactory” or “Satisfactory” ratings: Child Protection – January 2013; Staff Performance – January 2013; Patient Records Management – January 2013; Staff Performance Management (Medical) – February 2013; Review of Information Received by the Board – March 2013.

5.2.1 Mr Woods went through each report individually giving a brief overview and highlighting the main issues that had been identified during the audits.

5.2.2 Child Protection – In response to a question, Mr Woods advised that delays in removing staff leavers’ access rights to the Child Protection register was mitigated by employees having their access rights to the network removed, as well as access to the register being restricted to a small number of NHS computers.

5.2.3 Patients’ Records Management – Members noted that following the previous audit NHS Lothian had spoken to Balfour Beattie Workplace regarding the granting of access to the Health Records library at the Royal Infirmary. However, Balfour Beattie had pointed out that referring to Health Records before granting access was not practical. The issue is to be raised again with Balfour Beattie.

5.2.4 There was some discussion surrounding the Data Protection Act and the length of time that electronic records are kept on TRAK. It was noted that the Information Governance Assurance Board had been sighted on the matter and agreed that, for practical purposes, records are to be retained on TRAK indefinitely. Recognising that TRAK is a national system, the Director of eHealth has agreed to approach the supplier of TRAK about the possibility of developing an archiving function.

5.2.5 Staff Performance Management – Medical – Mr Woods advised that whilst a policy and procedure is in place, line managers were not checking registrations at the stipulated time. Instead, registrations are being checked when annual appraisals are carried out, by which point registrations may have lapsed.
Mr Woods noted that Dr Farquharson had commissioned a specific check during June and July 2012 which confirmed that all doctors were registered. Also, Dr Farquharson has put in place a programme of monthly sample checks of registrations, as well as undertaking to review current practices. It was agreed this was a pragmatic approach, but Mrs Goldsmith would follow this up.

5.2.6 Review of Information Received by the Board – Members noted the strategic approach taken in response to the report on Review of Information Received by the Board issued in April 2012, with the 19 actions brought together into 4 main actions within the Management Culture Work Programme. Mr Woods advised that the 19 actions have either been completed or are being progressed, with the restructuring of governance committees having set the foundation to provide strengthened assurances.

5.2.7 The Committee agreed to accept the reports with “Fully Satisfactory” or “Satisfactory” ratings: Child Protection – January 2013; Staff Performance – January 2013; Patient Records Management – January 2013; Staff Performance Management (Medical) – February 2013; Review of Information Received by the Board – March 2013.

5.3 Follow-up of Management Actions

5.3.1 Mr Woods reported that since the last update, Internal Audit had issued 4 final reports containing 5 Significant and 5 Important issues. During the same period, 23 Management Actions had been closed of which 52% had missed their target dates. As at 19 March, 27 Management Actions remained outstanding, compared to 40 in February and 67 in November. Also, Mr Woods noted that the percentage of Management Actions being closed by their target dates has been steadily improving.

5.3.2 Mr Brettell acknowledged the improving trend in relation to Management Actions and expressed his appreciation for the extensive work that has led to the progress that has been made to date, reiterating that he recognised the conflicting priorities and pressures on management within NHS Lothian.

5.3.3 Mr Brettell requested that Mr Woods includes a brief summary of the headline figures for outstanding Management Actions in future versions of Internal Audit Progress Reports presented at each Committee meeting.

5.3.4 The Committee agreed to accept the report on follow-up of Management Actions and the information therein.

5.4 Public Sector Internal Audit Standards

5.4.1 Mr Woods advised the Committee that as at 1 April 2013 the Scottish Government had adopted new Public Sector Internal Audit Standards. From the results of the mapping exercise presented by Mr Woods, the Committee agreed to note the Internal Audit team’s compliance with the standards.
6 Counter Fraud

6.1 CFS – Referrals & Operations – March 2013

6.1.1 Mr Woods introduced the previously circulated summary of CFS referrals and operations as at March 2013. Also, Mr Woods highlighted progress with the National Fraud Initiative, as outlined in the Internal Audit Progress Report.

7 External Audit

7.1 Review of Internal Controls 2012/13

7.1.1 Mr Perston spoke to the previously circulated report; he advised that the purpose of the report was to provide assurance that there were adequate internal controls and highlight any material findings. He noted that the main concerns had related to the reconciliation of payroll to the Human Resources system following the implementation of the new Human Resources system being deferred until it was fit for purpose. Human Resources were seeking to implement interim checks until this matter was resolved. Mrs Goldsmith agreed to bring forward a brief paper on this matter to the June meeting for consideration.

7.1.2 Mr Perston advised that the good standard of work and processes in place allowed Audit Scotland to place reliance on the work of the Finance Department, Chief Internal Auditor and the Internal Audit Team.

7.1.3 The Committee agreed to accept the report on the review of internal audit controls from Audit Scotland.

8 Corporate Governance

8.1 Waiting Times Progress and Performance –

8.1.1 Mr Jackson presented a detailed update on the actions taken following the submission of the Waiting Times actions discussed previously at the meeting in November and February. He drew attention to the draft letter in appendix 3 and sought clarity on the reporting procedures as the Board moves forward with waiting times.

8.1.2 The Committee agreed to accept the letter in appendix 3 subject to the inclusion of the following amendments:
- Issue 3 – should be explicit in relation to the availability statistics.
- The report should mention the forensic dashboard as a key tool in improving the accurate reporting of waiting times.
- Issue 5 – Should state that the session was held on 25 March and a follow-up session would be held after the April Board Meeting.
- Issue 5 - remove last line about action being complete.
- Add comment regarding the development of the SOPs to comply with the requirements of the Treatment Time Guarantee.
8.1.3 The chair requested that all future updates on Waiting Times at the Audit and Risk Committee be a brief summary highlighting progress with training, statistics and waiting list; the Board would remain to monitor progress against the waiting times actions from the internal audit report.  

8.1.4 Following the inclusion of the changes to the letter in appendix 3 Ms Goldsmith would circulate it to Scottish Government colleagues to seek an opinion on the content and language before its formal submission.  

8.1.5 The Committee acknowledged the progress to date against the actions from the Internal Audit Report on Waiting Times arrangements.

8.2 Accounting Policies –

8.2.1 The Committee noted the report that advised them of the changes to the accounting policies and the changes detailed therein. The Committee agreed to accept the minor changes to the standard accounting policies and recommend to the Board that they are fit for purpose and be adopted at the April 2013 Board meeting.

8.3 Year End Accounts Process –

8.3.1 The Committee noted the report that set out the year end accounts processes and arrangements that underpinned the production of the Annual accounts and the information therein.

8.3.2 In response to Ms Blair’s query regarding the release of guidance on the presentation of Board Annual Accounts Mr Martin advised that no guidance had been received in relation to the presentation of the accounts.

8.3.3 Members agreed that the annual accounts be issued in a timely matter giving new Non-Executive Board Members time to digest the information detailed therein and provide material comments in advance of the meeting. Mr Martin proposed that it would be prudent of the new non-executive members to look at the Annual Accounts 2011/12 which are in the public domain. Members agreed that any comments provided in advance of the June meeting would be shared with all members.

8.3.4 Mr McConnell advised the committee that Audit Scotland would circulate ISA 260 at the earliest opportunity.
8.4 Move to Lothian Financial Management System to National Single Instance –

8.4.1 Ms Goldsmith briefed the Committee on the move to a single general ledger for Scotland from 1 April 2013. She advised that following the move to a single general register the two key issues were that:

- NHS Lothian would lose their disaster recovery fund.
- That the national systems team would be hosted by another board.

8.4.2 The Committee noted the impact of the loss of the disaster recovery fund and agreed to await a report on continuity planning from Mrs Goldsmith before discussing the matter further.

SG

8.5 Update on National Performance Audits –

8.5.1 The Committee noted the update on national performance audit and the information therein.

8.6 NHS Lothian Audit and Risk Committee – Meeting Timetable and Associated Agenda Items –

8.6.1 The Committee noted that the meeting Timetable and Associated agenda items would be:

**Late Winter Meeting (February)**

Meeting Specific

- **External Audit Plan** - consider the external auditor’s plan to review the annual accounts for the preceding financial year.
  The Board’s external auditors are appointed by the Auditor General for Scotland, and are required to discharge their responsibilities under the Code of Audit Practice (which is approved by the Auditor General). The external audit plan considers the risks and priorities facing NHS Lothian, current national risks relevant to local circumstances, the impact of changing international auditing and accounting standards, and issues brought forward from previous audit reports.

- **External Audit Plan** - receive a report from the external auditors on their review of the Board’s internal audit function, and the extent to which the external auditors will rely on their work.

- **Internal Audit Plan** - consider and approve the internal audit plan and intended outputs for the year ahead.

- **Other** - consider the latest Scottish Government guidance on the Governance Statement.

- **Private session** - with external audit, internal audit and the clinical governance & risk manager

Routine

- **Internal Audit Reports** - receive any internal audit reports that have been completed since the last meeting, as well as an overall progress report on the current year plan.

- **Counter Fraud** - receive an update from the Chief Internal Auditor (in his capacity as Fraud Liaison Officer) on Counter Fraud Service Referrals & Operations.

- **Agreed Audit Actions Update** - receive a report from the Chief Internal Auditor on the implementation of agreed audit actions.
• **Corporate Risk Register** - review the Corporate Risk Register and any supplementary reports on risk management that it may require, including a “deep dive” as agreed.

• **Assurance Needs** – management reports prepared in response to requests from the Committee.

**Spring Meeting (April)**

**Meeting Specific**

• **Accounting Policies** - will review the Board’s accounting policies.

• **Governance Statements** - may receive assurance reports to support the Governance Statement (if they are ready).

• **Audit Scotland** - will receive a 6 monthly update on the distribution and consideration of Audit Scotland national performance audit studies.

• **Terms of Reference Review** - perform a preliminary review of its Terms of Reference and its own effectiveness.

**Routine**

• **External Audit Reports** - receive any external audit reports that have been completed since the last meeting

• **Internal Audit Reports** - receive any internal audit reports that have been completed since the last meeting, as well as an overall progress report on the current year plan.

• **Counter Fraud** - receive an update from the Chief Internal Auditor (in his capacity as Fraud Liaison Officer) on Counter Fraud Service Referrals & Operations.

• **Corporate Risk Register** - review the Corporate Risk Register and any supplementary reports on risk management that it may require, including a “deep dive” as agreed.

• **Agreed Audit Actions Update** - receive a report from the Chief Internal Auditor on the implementation of agreed audit actions.

• **Assurance Needs** – management reports prepared in response to requests from the Committee.

**Summer Meeting (June)**

**Meeting Specific**

• **Annual Accounts** - review the annual accounts for the preceding financial year, including the Governance Statement and the associated sources of internal assurance which include:
  - Annual reports from other Board Committees key to governance and internal control, namely Healthcare Governance, Staff Governance, Information Governance and Finance & Resources.
  - Annual report on risk management
  - Assurance Statement on Best Value
  - Summary of assurances from executive directors that adequate & effective systems of risk management and internal control are in place for their area of responsibility.
  - SFR 18.0 – Summary of Losses and Special Payments for the Year

• **Chief Internal Auditors Annual Report** - will receive and consider the Chief Internal Auditor’s annual report.
• **National Services Audit** - receive a summary of the opinions of the service auditor, in relation to the systems managed by NHS National Services Scotland on the Board’s behalf.

• **External Audit** - receive and consider the *Report to those Charge with Governance* on the external audit for the preceding financial year, and the proposed external audit opinion therein.

• **Governance Statement** - review the draft Governance Statement, and recommend any required changes after consideration of the above assurances.

• **Reps & Warranties** - review the draft Representation Letter to the external auditors, and make a recommendation to the Board.

• **Committee Annual Report** - review and finalise its own annual report, including its recommendations to the Board with regard to the approval of the annual accounts.

• **Health & Wellbeing Audit Letter** - will review the Committee Chair’s draft letter to the Scottish Government’s Health & Wellbeing Audit Committee on matters of significant interest

**Routine**

• **External Audit Reports** - receive any external audit reports that have been completed since the last meeting

• **Internal Audit Reports** - receive any internal audit reports that have been completed since the last meeting, as well as an overall progress report on the current year plan.

• **Counter Fraud** - receive an update from the Chief Internal Auditor (in his capacity as Fraud Liaison Officer) on Counter Fraud Service Referrals & Operations.

• **Corporate Risk Register** - review the Corporate Risk Register and any supplementary reports on risk management that it may require, including a “deep dive” as agreed.

• **Agreed Audit Actions Update** - receive a report from the Chief Internal Auditor on the implementation of agreed audit actions.

• **Assurance Needs** – management reports prepared in response to requests from the Committee.

**Autumn Meeting (September/October)**

**Meeting Specific**

• **Private Patients Funds** - review the audited patients’ private funds annual accounts for the preceding financial year, and make a recommendation to the Board.

• **Audit Scotland National Performance** - will receive a 6 monthly update on the distribution and consideration of Audit Scotland national performance audit studies.

• **Private session** - with external audit, internal audit and the clinical governance & risk manager

**Routine**

• **External Audit Reports** - receive any external audit reports that have been completed since the last meeting

• **Internal Audit Reports** - receive any internal audit reports that have been completed since the last meeting, as well as an overall progress report on the current year plan.
• **Counter Fraud** - receive an update from the Chief Internal Auditor (in his capacity as Fraud Liaison Officer) on Counter Fraud Service Referrals & Operations.

• **Corporate Risk Register** - review the Corporate Risk Register and any supplementary reports on risk management that it may require, including a “deep dive” as agreed.

• **Agreed Audit Actions Update** - receive a report from the Chief Internal Auditor on the implementation of agreed audit actions.

• **Assurance Needs** – management reports prepared in response to requests from the Committee.

**Early Winter Meeting (November/December)**

*This meeting has been cancelled in previous years due to limited agenda items. Nevertheless the meeting is scheduled at the start of the year just in case it is required, and a decision is made nearer the time whether it needs to proceed.*

**Meeting Specific**

• **No Specific Matters**

**Routine**

• **External Audit Reports** - receive any external audit reports that have been completed since the last meeting

• **Internal Audit Reports** - receive any internal audit reports that have been completed since the last meeting, as well as an overall progress report on the current year plan.

• **Counter Fraud** - receive an update from the Chief Internal Auditor (in his capacity as Fraud Liaison Officer) on Counter Fraud Service Referrals & Operations.

• **Corporate Risk Register** - review the Corporate Risk Register and any supplementary reports on risk management that it may require, including a “deep dive” as agreed.

• **Agreed Audit Actions Update** - receive a report from the Chief Internal Auditor on the implementation of agreed audit actions.

• **Assurance Needs** – management reports prepared in response to requests from the Committee.

8.6.2 Mr Woods requested that his annual report on Fraud, Referrals and Operations for the year ending 31 March be added under the Counter Fraud section of the June agenda.  

8.6.3 Members agreed that the June 2013 meeting should be extended to 1 pm take into account the volume of business involved in approving the annual accounts. The Committee Administrator agreed to discuss organising a business lunch with the Corporate Services Manager out with the meeting.

8.7 **Review of Terms of Reference of Audit and Risk Committee and Statement of Assurance Needs** –

8.7.1 The Committee noted the previously circulated document that tracked the changes to the terms of reference and statement of assurance needs.
8.7.2 The Committee agreed that the changes were reasonable clarifications and suitably minor that they could be accepted and submitted to the Board for adoption at its next meeting.

_Councillor Henderson and Ms Blair left the meeting._

8.8 Advice on Seeking Assurance on Quality and Internal Control –

8.8.1 The Committee reviewed the draft guidance on seeking assurance on quality and internal controls; no feedback was provided at this time.

8.9 Preliminary Draft of Audit and Risk Committee Annual Report 2012/13 –

8.9.1 The Committee reviewed the draft Audit and Risk Committee Annual Report 2012/13. Members requested the following amendments:

- Page 2, and in October.
- Page 4 include 3 years subject to ten year.
- Page 6 Make risk a separate item in point 3.

8.9.2 The Committee agreed to accept the draft Annual Report subject to the addition of the changes discussed.

9 Items for Information

9.1 Annual Notification to Scottish Government Health and Wellbeing Audit Committee –

9.1.1 Ms Goldsmith advised the Committee that this item offered an opportunity to advise the Health and Wellbeing Audit Committee. Members acknowledged the opportunity and requested that Ms Goldsmith highlight this matter at the April Board meeting.

10 Any Other Competent Business

10.1 There were no other items of competent business.

11 Date of Next Meeting

11.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 24 June at 9.00am in Waverley Gate, Edinburgh. Committee members only are asked to attend by 8.45 for the scheduled 15 minute pre-meeting.
Minutes of the Meeting of the Finance & Resources Committee held at 9am on Wednesday 17 April 2013 in Meeting Room 7, Waverley Gate, 2 - 4 Waterloo Place, Edinburgh.

Present: Mr P Johnston (In the Chair); Mrs K Blair; Mr J Brettell; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson and Professor J Iredale.

In Attendance: Dr M Douglas; Mr P Gabbitas; Mr I Graham; Mr P Reith; Mr D A Small; Ms L Tait and Mr S Wilson.

Apologies for absence were received from Mr G Walker, Mrs M Hornett and Dr A McCallum.

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. Councillor Henderson declared a non financial interest in item 4.1 as he was a member of the Scottish Health Council.

1. Minutes of the Previous Meeting

1.1 The previously circulated minutes and action note of the Finance & Resources Committee meeting held on 13 February 2013 were approved.

2. Matter Arising

2.1 Terms of Reference and Statement of Assurance Needs – A previously circulated report outlining proposed amendments to the terms of reference and introducing the statement of assurance needs was received. Members commented on the absence of a reference to the delegated levels of authority to the Committee which could approve capital projects between £500k and £5m and of the information that would populate the statement of assurance needs. It was noted that the statement of assurance needs should be a general statement of what information the Committee required to undertake its role and when that information was required.

2.1.1 It was agreed that the terms of reference should clearly set out the Committee’s role and delegated powers as well as making it clear that the route for capital projects over £5m to the Board was through the Committee. It was agreed that Mrs Goldsmith would bring an amended paper back to the next meeting and that Alan Payne should attend to assist the committee in its deliberations.
2.2 Visits to Other Areas – The Committee agreed that a programme of visits to NHS sites in Lothian relating to specific agenda items, such as the Magnetic Resonance Scanner at St Johns Hospital, should be arranged and that consideration should be given to the possibility of an all day visit to NHS sites in Lothian for all Board members. It was agreed that the next meeting should be held at St Johns in West Lothian.

3. Financial Position to 31 March 2013

3.1 Mrs Goldsmith advised the Committee that whilst the year end was still being finalised, she was confident that there would be no particular surprises and that there would be a final underspend of around £400k. Application was being made to the Scottish Government to carry this forward into the next financial year.

3.2 The Committee noted the financial position.

4. NHS Lothian 2013/14 Local Reinvestment Plan

4.1 The Committee received a previously circulated report providing assurance on the progress made to date on developing Local Reinvestment Plans to meet the 2013/14 target.

4.2 Mrs Goldsmith explained that the report set out the overall target and that the 2013/14 Local Reinvestment Plan combined specific workstream plans plus a small Local Reinvestment Plan target across all areas. It was fully recognised that a mixed economy to savings delivery could give rise to confusion around identified savings opportunities and whether these could be set against the local target. To mitigate this, a detailed statement of key principals had been developed in consultation with budget holders and workstream leads and shared widely.

4.3 The Committee noted that whilst improvements in prescribing costs and a reduction in the Clinical Negligence and Other Risks Scheme provision had resulted in financial savings, outpatient services still required a significant amount of work and the alignment of the clinical strategy with efficiency and productivity would be monitored through the financial plan.

4.4 Mr Brettell commented that it would be useful to identify unachieved Local Reinvestment Plan savings carried forward from the previous year in the report.

4.5 Dr Farquharson advised the committee that the potential for improvements in efficiency in dealing with outpatients was significant and a number of areas were being examined and change would need to be incremental. A number of areas of service redesign were being examined including the possibility of ‘advice only’ referral using email. One difficulty was that redesign invariably took longer than one year to achieve and returns would not necessarily be achieved within the timeframe of a single year’s Local Reinvestment Plan.
4.6 Mrs Goldsmith agreed that it would be useful to show where achievement of targets had to be carried over and, where specified, would take longer to achieve.

4.7 The Committee noted that previously the pre-eminent priority had been to achieve financial targets. This had been relaxed and as a result of increased NHSScotland Resource Allocation Committee allocations it had been possible to reduce the level of savings to be achieved. The financial environment was now different and the majority of pressure was on the acute services and work was ongoing to examine the way in which these were delivered.

4.8 Dr Douglas advised that Public Health was currently looking at the cumulative effect of changes in service over the past few years of local reinvestment plans to ensure that these were not inadvertently discriminating against specific groups. The outcome of this study would be reported to the committee. SKM

4.9 Mr Davison emphasised that the clinical strategy framework would be pulling together a cohesive strategic plan based on how to maximise services on the 4 major sites. It was well documented that the current model of care was not sustainable as the rate of growth in demand exceeded the rate of growth of resources and new models of care were being explored.

4.10 Mrs Blair emphasised the importance of linking the local reinvestment plan with the communication strategy so that staff were kept informed and involved.

4.11 The Committee agreed to note the report.

5. East Coast Costing Model

5.1 A previously circulated report providing an overview of the East Coast Costing Model and the impact on service level agreements with other NHS Boards in Scotland was received.

5.2 Mrs Goldsmith advised the Committee that because activity in Lothian was continuing to increase whilst activity in other NHS Boards was levelling off NHS Lothian now received less for treating patients of other Boards because its share of the activity was increasing. The Committee agreed to note the report and recognised the risks associated with changing activity and the impact on service level agreement income.

6. Update on the Development of the Royal Edinburgh Hospital and Associated Service Redesign

6.1 Mr Small introduced a previously circulated report giving an update on the first phase on the redevelopment of the Royal Edinburgh Hospital, the Masterplan Review and the Associated Service Redesign.

6.2 Mrs Goldsmith apologised for the late distribution of the report and explained that whilst this was effectively a Public/Private Partnership Scheme it would carried
out through Hubco and NHS Lothian would be working directly with them to re-provide the facilities on the Royal Edinburgh site.

6.3 Mr Small reminded the committee that NHS Lothian had a long-standing commitment to re-provide services on the Royal Edinburgh Hospital site which had some of the poorest facilities remaining in Lothian. One important factor was the need to break down barriers between age groups in the treatment of mental health problems.

6.4 The Committee noted that the number of beds to be re-provided in phase 1 had increased from 90 to 185 and included 90 beds for adult acute mental health and intensive psychiatric care, 20 beds for brain injury rehabilitation, 15 beds for mental health rehabilitation and 60 beds for older peoples mental health assessment and treatment. This would resolve almost all of the key issues for those occupying poor accommodation and bring two separate services into a single facility. It was planned that the work would be completed by February 2017.

6.5 It was noted that the scheme should attract £25m per annum revenue support from the Scottish Government with a further £17m being provided by NHS Lothian. In addition, reductions in the number of delayed discharges would be achieved through re-providing more appropriate accommodation in the community. The Masterplan allowed for part of the site to be retained for potential expansion should this be required.

6.6 The Committee agreed to note the changes to phase 1 of the redevelopment of the Royal Edinburgh Hospital and that work continued in relation to service redesign to ensure that enhanced and robust community developments were in place to support the inpatient provision.

7. **Partnership Commissioning of Step-Down Beds Capacity and Associated Issues**

7.1 The Committee received a previously circulated report detailing the plan to commission downstream capacity to replace current boarding ‘capacity’, using additional care home beds coming on stream and funding from the change fund as a facilitator.

7.2 Mr Gabbitas advised the Committee that for the first time in five years there would be a significant increase in capacity with 168 additional beds being provided. In future it would be unusual for patients to be discharged from an NHS bed straight to a Care Home bed and they would instead go to the Step-Down facility where arrangements would be made to support them in their own homes.

7.3 Mr Gabbitas was able to reassure the Committee that monitoring and quality control systems of home care had been introduced and discussions would be held with the Scottish Government on any consultation requirements for moves to better accommodation for patients that would enable the better use of NHS facilities.
7.4 The Committee noted the position.

8. Progress Update on Property and Asset Management Strategy

8.1 The Committee received a presentation from Mr I Graham, Director of Capital Planning & Projects on the Property and Asset Management Strategy. This dealt with property issues, medical equipment, information management and technology and the transport fleet. The presentation highlighted the current positioning in respect of recent investments and the estate condition and Risk as well as Backlog Maintenance and Investments.

8.2 The Committee noted the proposed developments in respect of the four main sites in Lothian and the work in progress on smaller facilities and Community Hospitals. A number of supporting strategies that would have an impact on the Property and Asset Management Strategy were noted, together with the delivery tools available and the partners with which NHS Lothian would be working.

8.3 The Chair thanked Mr Graham for his presentation.

9. Update on Royal Infirmary of Edinburgh Additional Beds

9.1 Mrs Goldsmith advised the Committee that she would be bringing a Business Case for the creation of an additional 31 beds at the Royal Infirmary of Edinburgh to the next meeting and to this end a supplementary agreement with Consort was being finalised.

10. Date and Time of Next Meeting

10.1 It was noted that the next meeting would be held at 9:00 a.m. on Wednesday 12 June 2013 in the Pentland Room, Education Centre, St Johns Hospital, Howden Road West, Livingstone.
Minute of Meeting

Shadow Health and Social Care Partnership
NHS Lothian Headquarters, Edinburgh, 11 January 2013

Present:- Councillor Ricky Henderson (Convener); Shulah Allan (Vice-Convener); Councillors Elaine Aitken, Cammy Day, Paul Edie, Adam McVey and Norman Work; Lynda Cowie, Wanda Fairgrieve, Ian McKay, Michelle Miller, Ella Simpson, Richard Williams and Robert Wilson.

Also present:- Monica Boyle, Colin Briggs, and Peter Gabbitas.

In attendance:- Gordon Dodds, Carol Kelly, Stephen McBurney, Katie McWilliam, Claire Stein, Julie Tickle and the Project Team.

Apologies – Councillor Maggie Chapman, Kay Blair and Tim Montgomery.

1 Welcome and Introduction

The Convener welcomed everyone to the meeting.

2 Minutes

Decision

To approve the minute of the Shadow Health and Social Care Partnership of 19 November 2012 as a correct record.

3 Matters Arising from the minute of 19 November 2012

3.1 Procedural Matters – items 3.5 (Quorum) and 3.6 (Substitutes) of the minute

An update was provided on procedural matters on Partnership governance in relation to the Partnership “Operating Statement”.

8.3
Decision

1) To approve the procedure for quorum of the Shadow Health and Social Care Partnership as detailed in the report by the Director of Health and Social Care.

2) To approve the procedure for the attendance of substitute members as detailed in the Director’s report.

3) To commence the procedures on 15 February 2013.

4) To note the preparation of the Shadow Partnership Operating Statement.

(Reference – report by the Director of Health and Social Care, submitted.)

3.2 Meetings in public – item 3.8 of the minute

Meetings of the Health and Social Care Partnership would be held in public from April 2013.

3.3 Deputations – item 3.11 of the minute

Michelle Miller to incorporate proposals in a future report on service user engagement.

3.4 Political Whip – item 3.14 of the minute

An update on the removal of the political whip from the Council’s elected members at Partnership meetings was provided as follows:

- The Labour Group had agreed removal of the political whip;
- The SLD Group did not operate a political whip;
- The SNP and Conservative Groups did not foresee any problems; and
- The Green Group to advise on their Group’s position.

3.5 Hosted Services

Evaluation and joint performance management – item 4.2 of the minute

Michelle Miller to report to the Shadow Partnership in March 2013.
Inclusion of other Council services – item 4.3 of the minute

The Council (Peter Gabbitas) was investigating the engagement of other services in the Partnership.

4 Governance

4.1 Professional Advisory Committee

Ian McKay and Michelle Miller gave a progress update on setting up the Committee. Richard Williams provided an overview of the operation of professional advisory committees in the Lothian area.

Decision

1) To note the update.

2) To note that nominations to the Professional Advisory Committee would be sought at its first meeting and that formal appointment processes would be implemented.

4.2 Service User and Carer Engagement and Sector Representation - Update

Michelle Miller gave an update on developments to ensure the representation of service users and their carers in policy development review and performance monitoring.

Options were set out for provider representation and other forms of voluntary sector representation on the Partnership.

Ella Simpson explained EVOC’s advisory and supporting role for the third sector and existing mechanisms for engagement. During discussion about provider representation, a suggestion was made that both public and private sectors should be represented on the Partnership.

Decision

1) To note that a refined mechanism for service user and carer engagement was currently being developed and would be presented for consideration and approval by the Partnership at a later date.
2) To appoint EVOC as a permanent ‘non-voting’ member of the Partnership as the representative of the voluntary sector in its “non-provider” role.

3) To agree that Michelle Miller would report to the February Partnership meeting on options for provider representation on the Partnership.

(Reference – report by the Chief Social Work Officer, submitted.)

5 Pharmacy – Prescribing Overview and Performance

Colin Briggs introduced Stephen McBurney and Claire Stein who presented an overview of the process for setting the prescribing budget, maintaining quality and cost effectiveness, support and performance measurement activity and current financial performance.

Edinburgh was the most cost effective area in Scotland and because of efficiency work carried out over the past 20 years there was little scope for further savings. There was discussion about the inclusion of the prescription costs in the Partnership’s budget; if included prescription costs would amount to approximately 14%-15% of the overall budget. The Partnership would be required to look at financial pressures on a corporate basis and scrutinise the management of the budget.

Decision

To note the presentation.

6 Progress Update from Sub-Groups

6.1 Finance and Resources

Monica Boyle updated the Shadow Partnership on the development of joint budgets and progress towards mapping joint assets. The Council and the NHS were working towards aligning their different budget setting processes. A question was raised about the possibility of public consultation on the joint budget similar to that carried out by the Council.

6.2 Performance Management and Quality

Michelle Miller updated the Shadow Partnership on progress towards a shared CEC/NHS performance framework which would also incorporate quality assurance.
6.3 Engagement and Organisational Development

Colin Briggs advised that work was underway. Resolution of HR issues remained outstanding and was dependent on both organisations reaching agreement on joint working. The creation of common values for CEC and NHS staff was progressing.

Questions were raised on the schedule for meeting targets and Shadow Partnership objectives and strategy.

Decision

1) To note the updates on the work of the sub-groups.

2) To ask Monica Boyle to provide budget mapping information for the April meeting of the Partnership.

3) To ask Colin Briggs to submit a paper on values to the February meeting of the Shadow Partnership.

4) To ask Monica Boyle, Michelle Miller, Colin Briggs and the Project Team to submit a co-ordinated report on all strands of work detailing progress in all areas and mapping out timelines towards completion.

7 New Developments in Carer Support

Gordon Dodds and Carol Kelly presented an update on new developments in carer support which included:

- the appointment of Councillor Work as Carers’ Champion
- the carers’ Emergency Card scheme
- pilot carer support payment scheme
- the vision, objectives and review of “Towards 2012”, the strategic action plan for carers
- carers’ assessments
- the new carer support hospital discharge team
- research report on older carers and carers of older people.

The presentation also highlighted what was working, the changes which were required and key priorities for 2012/13.
Decision

1) To ask Monica Boyle and Gordon Dodds to provide feedback to the Partnership on an evaluation of the carer support payment pilot scheme.

2) To ask Gordon Dodds to provide to Partnership members with the research report commissioned into older carers and carers of older people.

8 Risk Management Update

Michelle Miller provided an update on progress towards the integration of the Council and NHS risk management systems.

Decision

To note the update.

9 Away Day and Partnership Meeting on Unscheduled Care at the Royal Infirmary of Edinburgh

Decision

1) To note that information on an Away Afternoon on 17 January 2013 had been circulated electronically.

2) To ask Peter Gabbitas to submit to the February meeting a programme of proposed visits to Social Care and NHS facilities, including the Royal Infirmary of Edinburgh for consideration.
Minute of Meeting

Shadow Health and Social Care Partnership

NHS Lothian Headquarters, Edinburgh, 15 February 2013

Present: -
Councillor Ricky Henderson (Chair)
Shulah Allan (Vice Chair)
Councillor Elaine Aitken
Councillor Maggie Chapman
Councillor Cammy Day
Councillor Paul Edie
Councillor Norman Work
Wanda Fairgrieve
Richard Williams

In attendance: - Monica Boyle, Tricia Campbell, Lynda Cowie, Peter Gabbitas, Dorothy Hill, Michelle Miller, Tim Montgomery, Ella Simpson, Julie Tickle and the Project Team.

Apologies – Councillor Adam McVey, Kay Blair (NHS Trustee), Robert Wilson (NHS Trustee), Colin Briggs, Ian McKay, Alex McMahon, Katie McWilliam and Susanne Harrison.

1 Welcome and Introduction

The Chair welcomed everyone to the meeting.

2 Minutes

Decision

To approve the minute of the Shadow Health and Social Care Partnership of 11 January 2013 as a correct record subject to the replacement of the word “prescription” in the second paragraph of item 5 with “prescribing”.
3 Proposal for Joint Strategic Work Plan

Michelle Miller gave an update on the development of the Partnership’s strategic framework. A draft framework was proposed which set out the Partnership’s overall pledge, its strategic vision, desired outcomes and objectives, and how objectives would be met. The framework was intended to demonstrate that strategic objectives accorded with jointly agreed national outcomes.

There was discussion on ensuring that a focus on early intervention was included in the framework. Members would be invited to provide feedback on its content.

Decision

1) To note the update.

2) To circulate the outline draft Strategic Framework electronically to Shadow Partnership members.

3) To invite members to provide feedback on the Strategic Framework to Michelle Miller.

4) To agree that Michelle Miller would submit a report to the next Shadow Partnership meeting on 15 March 2013 for more detailed consideration of the Strategic Framework.

(References – Shadow Health and Social Care Partnership 11 January 2013 (item 6.3); draft Edinburgh Health and Social Care Partnership Strategic Framework, submitted.)

4 Health and Social Care Draft Engagement and Communications Strategy 2013-2014

A draft over-arching strategy which would fulfil the engagement and communication needs of the change programme within health and social care was proposed. The strategy was intended to be flexible and would be subject to adjustment as issues which required to be addressed arose.

Approval was sought to adopt a joint approach to engagement and communications involving the Council, the NHS and the voluntary sector, and for the activity plan for the implementation and monitoring of the strategy.
There was discussion on the language and terminology used in the document and on ensuring EVOC’s involvement in engagement and communication activities.

**Decision**

1) To agree the draft Engagement and Communications Strategy 2012-2013.

2) To agree the activity plan detailed in appendix A to the report as a working document.

3) To draft a statement of ambition to raise stakeholder awareness of the Engagement and Communications strategy.

4) To approve the option of taking forward a joint approach to engagement and communications as outlined in paragraph 7 and appendix B of the report.

(Reference – report by the Project Team, submitted.)

**5 Older People’s Services**

The range of services and supporting mechanisms delivered jointly to older people by NHS Lothian, the City of Edinburgh Council and partners in the voluntary and independent sectors was outlined. Details were also given of progress towards achieving a shift in the balance of care in line with the national strategy on Reshaping Care for Older People.

Tricia Campbell gave a presentation on older people’s services in Edinburgh which focused on the Joint Commissioning Plan for Older People for 2012-22, the development of new models of care and the challenges ahead for health and social care services in light of projected demographic changes.

There was discussion on the provision of information to improve public understanding of the services available for older people, quality assurance systems and guarantees on quality of care in the face of the projected 25% increase in demand for services.

**Decision**

1) To note that the development of older people’s services was multi-faceted and that the report outlined just some of the achievements and challenges ahead.
2) To incorporate the development and implementation of the following into the Shadow Health and Social Care Partnership’s work programme for older people’s services and to receive further detailed reports and updates as required, the first of which to be submitted to the Partnership meeting on 19 April 2013:

- whole system capacity planning, including workforce and finance;
- the Edinburgh Dementia Implementation Plan;
- the Joint Commissioning Plan for Older People, including the Change Fund Plan; and
- a report on quality assurance frameworks across the whole system.

(Reference – report by the Director of Health and Social Care, submitted.)

Declaration of Interests

Councillor Elaine Aitken declared a non-financial interest in the above item as a Director of Oxgangs Care and Life Care (Edinburgh) Ltd.

6 Service Provider Contribution to the Health and Social Care Partnership

An effective mechanism for ensuring service provider contribution to the work of the Shadow Partnership was proposed. Options on how provider organisations might best be facilitated to contribute to the Partnership’s work were set out.

Decision

1) To agree that service provider engagement with the work of the Partnership should be via the established provider forums detailed in paragraph 4 to 9 of the report.

2) To note that a review of this as an effective engagement mechanism would be undertaken after a year of operation, with the full involvement of the providers, and reported to the Partnership in March/April 2014.

(References – Shadow Health and Social Care Partnership 11 January 2013 (item 4.2); report by the Chief Social Work Officer, submitted.)

Declaration of Interests

Councillor Elaine Aitken declared a non-financial interest in the above item as a Director of Oxgangs Care and Life Care (Edinburgh) Ltd.
7 Health and Social Care Integration

A status report on the programme for the integration of health and social care was provided, together with an outline of the terminology used in presenting this information. The reporting style conformed to guidance from the UK Government and sound programme and project management principles. This had been adopted by the City of Edinburgh Council, and, if approved, would be used to provide regular status updates to the Partnership.

The question of Council Trade Union staff representation on the Partnership was discussed; NHS staff already had a representative on the Partnership.

Decision

1) To note the format and terminology associated with the status report.
2) To note the progress to date.
3) To agree to receive regular updates.
4) To invite a City of Edinburgh Council Trade Union representative to attend meetings of the Shadow Partnership in an advisory capacity.
5) To agree that a draft Partnership Agreement be submitted to the next meeting of the Shadow Partnership on 15 March 2013.
6) To agree that the Scottish Government’s response to the consultation on integration would be discussed at the next meeting on 15 March 2013.

(References – Shadow Health and Social Care Partnership 11 January 2013 (item 6); report by the Director of Health and Social Care, submitted.)

8 Future Meetings – Format and Frequency

The Partnership discussed format and venue options for future meetings.

Decision

To agree that Peter Gabbitas would submit proposals for a programme of meetings for the next 12 months to the next meeting of Shadow Partnership on 15 March 2013.
Minute of Meeting

Shadow Health and Social Care Partnership

NHS Lothian Headquarters, Edinburgh, 15 March 2013

Present:-
Councillor Ricky Henderson (Chair)
Shulah Allan (Vice Chair)
Councillor Elaine Aitken
Councillor Cammy Day
Councillor Norman Work
Wanda Fairgrieve
A Kay Blair
Kirsten Hay
Ian McKay
Robert Wilson

In attendance: - Colin Briggs, Lynda Cowie , Wendy Dale, Peter Gabbitas , Janice Handley, Susanne Harrison, Dorothy Hill, Tim Montgomery, Ella Simpson, Julie Tickle and the Project Team.

Apologies – Monica Boyle, Councillor Maggie Chapman, Alex McMahon, Katie McWilliam , Michelle Miller and Richard Williams.

1 Welcome and Introduction

The Chair welcomed everyone to the meeting.

2 Minutes

Decision

To approve the minute of the Shadow Health and Social Care Partnership of 15 February 2013 as a correct record.
3 Matters Arising

3.1 Service User and Carer Engagement

Peter advised that a very positive meeting had been held with the Public Partner Forum and that a meeting with the Carers Forum was scheduled for next week.

3.2 Professional Advisory Committee (PAC)

Ian Mckay advised that the PAC which had met in February was a multi disciplinary committee which would gather professional advice for the Health and Social Care Partnership Board.

Interviews were being held to appoint a Chair and Vice-Chair who would be NHS employees and would be appointed for up to 3 years.

Decision

To note the updates and that a further update on Service User and Carer Engagement would be submitted to the next meeting.

4 Integration Programme Status Report

The integration status report for the period to March 2013 was presented. The report included the RA(G) Reason for Status table together with the risks associated, an action plan and key milestones.

There were currently no major difficulties, however concern was expressed that the ICT Group was not yet progressed. Peter Gabbitas advised that the Pilot Scheme for the integrated IT system was progressing.

During discussion concern was expressed at the removal of the E-assess system in City of Edinburgh Council without a replacement and the issues this raised.

Decision

1) To note the status report.

2) That monthly reports on the Integration programme should include the key milestones and the critical path.

3) That the Director of Health and Social Care report to the next meeting in relation to the withdrawal of the E-assess system in City of Edinburgh Council.
5 Edinburgh Health and Social Care Partnership Values

Information was provided of the workstreams ongoing to capture the values of the organisations contributing to EHSCP organisations, together with a suggested workplan for approval.

There was discussion on the importance of the values statement but also the need for the values to be embedded into the organisation.

Decision

1) To note the work undertaken by worksreams in both the City of Edinburgh Council and NHS Lothian, and their constituent parts, and work still outstanding

2) To note how the outputs from these workstreams complemented each other and where there may be further work required to bring these together

3) To establish a short-life working group of Partnership members and officers to work together on a “Values Statement” for the Partnership

4) That Colin Briggs liaise with partnership members to agree composition of the Group and meeting dates and report back on progress to the meeting in April

5) To approve the adoption of the strapline “Working Together for a Caring, Healthier and Safer Edinburgh” for the Partnership.

(References – report by the General Manager, Edinburgh Community Health Partnership, submitted.)

6 Integration of Adult Health and Social Care Consultation: Scottish Government Response

The Scottish Government had published its response to the key points made by respondents to the consultation on the integration of health and social care services.

Details of the response, the intentions for legislation and a comparison of the approach for Edinburgh Health and Social Care Partnership (EHSCCP) were presented.
Peter Gabbitas advised that the EHSCP arrangement was aligned completely with the points raised, however some members expressed concern that the Partnership was progressing too quickly and that there was a need to ensure that there was clarity on the detail.

Decision

1) To note the Scottish Government response and the intention to legislate.

2) To note the current alignment of the approach in Edinburgh.

(References – report by the Director of Health and Social Care, submitted.)

7 Framework Partnership Agreement

An update was provided on the preparation of the Framework Partnership Agreement. The Agreement would establish the principles of operation of the new Health and Social Care partnership for 2013/14. A draft timetable was presented.

During discussion the following points were raised

- The relationship with Community Planning
- The timetable had been extended to May
- There was to be an additional announcement from the Scottish Government in relation to legislative intent
- Financial accountability and aligned budgets
- Strategic virements that would require business cases to the NHS and Local Authority
- The need for a draft before the Agreement was submitted to the Board and the Council

Decision

1) To note that a draft of the Agreement would be presented to the next meeting of the Partnership in April.

2) That a revised timetable be produced to allow the Council and the NHS Board to consider a Draft Agreement before being finalised.

(Reference – report by the Director of Health and Social Care, submitted.)
8 Joint Strategic Framework

A draft joint strategic framework was presented. The framework set out the specific actions to be undertaken by the services within the Partnership to achieve the outcomes.

Wendy Dale introduced the document as a work in progress which was to enable the workforce to see how their role contributed to the bigger picture. The document would also provide a useful overview of the work of the Edinburgh health and Social care Partnership for partners in the statutory, voluntary and independent sectors and for interested members of the public. It was intended that there would be a single joint workplan from next year onwards.

During discussion the following points were raised

- The layout could be changed to put the principles and objectives at the front of the document
- Some detail was not included ie The Golden Thread
- General Practice staff had not been included
- The terminology
- Need for branding for the Partnership

Decision

1) To agree the general content of the draft Strategic Framework at Appendix 1 of the report.

2) To note that further revisions would be made following comments from the Partnership

3) To note that from the first year, the appendices would represent the work plans for each of the constituent parts of the Partnership (health and Social Care, the Community Health partnership and the Royal Edinburgh and Associated Services), and that the 2014/15 revision would combine these work plans into a single, integrated plan.

(Reference – report by the Director of Health and Social Care, submitted.)


An update was provided on the development of an integrated Quality Assurance Framework. The integrated framework would be implemented with effect from April 2014.
Decision

1) To note the existing quality assurance framework for Health and Social Care and the quality improvements arrangements in the Edinburgh Community Health Partnership and Royal Edinburgh Associated Services.

2) To develop an integrated quality assurance framework for the Edinburgh Health and Social Care Partnership during 2013/14

3) To implement the integrated framework from April 2014 or sooner, if appropriate.

4) To agree the proposal for managing complaints relating to integrated health and social care services

5) To agree a single complaints reporting framework and that quarterly reports be presented to the Health and Social Care Partnership from 2013/14.

(Reference – report by the Chief Social Work Officer, submitted.)

10 Future Meetings – Format and Frequency

A proposed programme of visits for the Partnership was submitted.

Decision

1) To note that every alternate meeting would be a formal public meeting of the Partnership

2) To agree the programme of visits for 2013 as submitted.

3) That members advise the Director of Health and Social Care of other venues they wished to visit in the future.

(References – Minute of H&SCP 15 February 2013 (Item 8), report by the Director of Health and Social Care, submitted.)
Minutes of the West Lothian Sub Committee held on 28th March 2013, 1400 – 1600, Strathbrock Partnership Centre.

Present

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Frank Toner (FT)</td>
<td>Chair, West Lothian CHCP</td>
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<tr>
<td>Alison Mitchell (AM)</td>
<td>Non-Executive Member, NHS Lothian</td>
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<tr>
<td>Jim Forrest (JF)</td>
<td>CHCP Director</td>
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<tr>
<td>Marion Christie (MC)</td>
<td>Head of Health / General Manager, WLCHCP</td>
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<tr>
<td>James McCallum (JMc)</td>
<td>Clinical Director</td>
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<tr>
<td>Gill Cottrell (GC)</td>
<td>Chief Nurse</td>
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<tr>
<td>Jennifer Scott (JS)</td>
<td>Head of Social Policy, WLC</td>
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<tr>
<td>Alan Bell (AB)</td>
<td>Senior Manager, Community Care Support</td>
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Apologies

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Moira Niven (MN)</td>
<td>Depute Chief Executive</td>
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<tr>
<td>Claire Kenwood (CK)</td>
<td>Assoc. Clinical Director</td>
</tr>
<tr>
<td>Jane Houston (JH)</td>
<td>Partnership Lead</td>
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<tr>
<td>Sandra Mair (SM)</td>
<td>Deputy Chief Operating Officer, NHS Lothian</td>
</tr>
<tr>
<td>Jane Kellock (JK)</td>
<td>Senior Manager, Children &amp; Early Intervention</td>
</tr>
<tr>
<td>Lindsay Seywright (LS)</td>
<td>Assistant Principal, West Lothian College</td>
</tr>
<tr>
<td>Alistair Shaw (AS)</td>
<td>Head of Housing, Construction &amp; Building Services</td>
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<tr>
<td>Mary-Denise McKernan (MMc)</td>
<td>Manager, Carers of West Lothian</td>
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<tr>
<td>Annabel Ross (AR)</td>
<td>GP Rep</td>
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<tr>
<td>Julie Cassidy (JC)</td>
<td>Public Involvement Co-ordinator</td>
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<tr>
<td>John Richardson (JR)</td>
<td>PPF Representative</td>
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In Attendance

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<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tr>
<td>Marjory Brisbane</td>
<td>CHCP Administrative Manager</td>
</tr>
<tr>
<td>Raj Rashid</td>
<td>Paediatrician T4H Project</td>
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<tr>
<td>Lorraine Gillies</td>
<td>Community Planning Partnership</td>
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1. **APOLOGIES**

As above.

2. **ORDER OF BUSINESS INCLUDING NOTICE OF URGENT BUSINESS**

MB informed the chair that the meeting was not quorate and it was agreed to carry on with today’s meeting highlighting that all papers could be noted but no decisions carried out.

T4H was moved to the beginning of the agenda.

3. **ANY OTHER BUSINESS FOR TODAY**

No other business notified.

4. **DECLARATION OF INTEREST**

FT declared he is chair of the CHCP and non executive member of NHS Lothian.
5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**
The minutes of the meeting held on 31 January 2013 were approved as being an accurate record.

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

7. **CONFIRMATION OF ACTION POINTS**
JS and MC confirmed they will ensure they will connect with the PPF where applicable. All other actions completed.

8. **MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING**
No minutes available

9. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**
Minutes of the PCJMG dated 13th December were discussed.

JMC confirmed the Polypharmacy Project has been viewed as reasonably successful and will continue for the rest of this year. Single handed practices were discussed highlighting there is good verbal support but no written plan is available.

10. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT**
Minutes of the CFMG dated 29th January were discussed.

The meeting is now taking a different format starting with a presentation of a relevant project and update progress.

11. **TOGETHER FOR HEALTH**
RR talked to the paper commenting that the project is now working on sustainability and replication. Models have been developed to carry out similar activities across West Lothian with Run for Fun, Fruity Friday and Cyber Coach.

RR gave a summary of the activities currently running and the requirement for integration with other services and local businesses. Work is being undertaken jointly with local businesses that have representation on the T4H group. RR commented that it is essential that the voluntary sector is involved in this project.

Evaluation is currently being undertaken through a Food Behaviours study run by Edinburgh University, community customer survey, BMI data, Youth Health Club evaluation of attendance and KPI monitoring through covalent.

The report was noted by the Committee.

12. **REVIEW OF SINGLE OUTCOME AGREEMENT 2012/13**
AB talked to the paper giving an update on performance management within the CHCP which has been developed as an integrated approach over the last 2 years.

There has been a broad suite of key operational performance indicators identified to monitor activity within the CHCP. Due to the recent migration from CIS to TRAK some of the indicators have limited data. Work is still ongoing to extend the range of performance indicators to include measures related to GP practices and community nursing.
There are currently 64 key indicators of which 55 are to target or better, with only 2 below target both of which are being addresses by management action. Looked After Children and Average waiting time in memory clinic.

The paper was noted by the Committee

13. SINGLE OUTCOME AGREEMENT DEVELOPMENT UPDATE
LG talked to the paper stating the draft SOA has been submitted to the government.

LG detailed the strategic assessment process that had been followed to develop the draft SOA.

There are 8 new outcomes which have been identified using more evidence based data. The CHCP have responsibility to deliver 3 clear outcomes

- Our children have the best start in life and are ready to succeed
- Older People are able to live independently in the community with an improved quality of life.
- We live longer, healthier lives and have reduced health inequalities

and a cross cutting responsibility for

- People most at risk are protected and supported to achieve improved life chances

A special Board meeting is planned for mid May 2013 to finalise the SOA pending feedback from the government and to plan the next steps and implementation. Final SOA must be in place by the end of June 2013.

A cycle of the above outcomes will be reported on at every second meeting of the Sub Committee to ensure monitoring of the outcomes.

The paper was noted by the committee.

14. INTEGRATION OF HEALTH AND SOCIAL CARE
JF talked to the paper updating the Sub Committee on the progress of the Health and Social Care Integration agenda.

A CHCP Integration group made up of representation from secondary care, health and council trade unions and senior staff from CHCP meets on a regular basis to discuss the integration agenda.

The CHCP director has been actively involved in a range of Scottish Government Groups.

The West Lothian Reshaping Care for Older People Programme Board is progressing work to shift the balance of care by developing more community-based services and support that will help older people to lead more independent lives at home.

Key elements of the agreement include governance, joint accountable officer, integrated budget and acute sector.
Timescale for legislation

Draft Bill to parliament  March 2013
Scrutiny  Autumn 2013
Enactment  March 2014
Duty to Establish  April 2015

West Lothian CHCP arrangements embody many of the key criteria proposed by the Scottish Government and will continue to build on this success and good progress is being made to further advance the integration of health and social care services in West Lothian.

Further updates will be brought back to the Sub Committee as development takes place.

15. KEEP WELL IN WEST LOTHIAN

JMC talked to the paper asking the Sub Committee to continue their support with the ongoing delivery of the Keep Well in West Lothian and note achievements in 2012/13.

There are currently 5 practices involved across West Lothian from the most deprived areas. This is now being moved across other areas of deprivation including uptake from 3 Bathgate practices within the next month. JMc is working with other practices to encourage involvement in the project.

This project is tied in to the outcome under the SOA ‘ We live longer, healthier lives and have reduced health inequalities’

The paper was noted by the Committee

16. ANY OTHER COMPETENT BUSINESS

No other business was discussed

17. DATE, TIME OF NEXT MEETINGS

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

23.05.2013
29.08.2013
17.10.2013
05.12.2013

Meeting closed at 3pm