NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 24 JULY 2013
TIME: 9:30 A.M. - 12:30 P.M.
VENUE: BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

AGENDA

Welcome to Members of the Public and the Press

Apologies for Absence

1. Minutes of the Previous Meeting of Lothian NHS Board held on 26 June 2013  BH *

2. Matters Arising (9:35am - 9:55am)
   2.1. Medical Workforce Risk Assessment  DF *

3. Strategic Development (9:55am - 11:10am)
   3.1. Renewing NHS Lothian’s Values  TD *
   3.2. Strategic Planning - Next Steps  AMcM *
   3.3. Waiting Times Performance, Progress and Elective Capacity Investment  DF/SG *
   3.4. Little France Campus Redevelopment  SG *
   3.5. Legionnaires’ Disease Outbreak in Edinburgh June 2012  AKM *

4. Performance Management and Governance (11:10am - 11:45am)
   4.1. Quality Report  DF *
   4.2. Unscheduled Care  MH *
   4.3. Performance Management  AMcM *

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

For further information please contact Peter Reith, 35672, peter.reith@nhslothian.scot.nhs.uk
4.4. Healthcare Associated Infection Update MH *
4.5. Financial Position to 30 June 2013 SG *
4.6. Corporate Objectives 2013/14 AMcM *
4.7. Integration of Adult Health and Social Care in Scotland Consultation AMcM v
4.8. Keep Well Annual Report 2012/13 AKM *
4.9. Anti Bribery Statement SG *
4.10. Healthcare Governance Committee Terms of Reference BH *
4.11. Schedule of Board and Committee Meetings for 2014 BH *

5. Committee Minutes for Adoption (11:45am - 12:00pm)

5.1. Audit & Risk Committee - Minutes of the Meeting held on 24 June 2013 JB *
5.2. Finance & Resources Committee - Minutes of the Meeting held on 12 June 2013 GW *
5.3. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 27 June 2013 MA *
5.4. Edinburgh Shadow Health & Social Care Partnership - Minutes of the Meeting held on 14 June 2013 RH *
5.5. Midlothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 30 May 2013 PJ *
5.6. West Lothian Health & Care Partnership Board - Action Note of the Meeting held on 25 June 2013 FT *

6. Any Other Competent Business

7. Date, Time and Venue of Next Meeting: Wednesday 25 September 2013 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh. (No August meeting)

8. Resolution to take items in closed session

9. Minutes of the Previous Private Meeting held on 26 June 2013 BH r

10. Matters Arising

11. Annual Review Arrangements - Update AMcM v

Dates of Meetings in 2013:
- 23 October 2013
- 27 November 2013
- No December Meeting
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 26 June 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: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mr J Brettell; Ms K Blair; Dr M Bryce; Councillor D Grant; Councillor R Henderson; Mr P Johnston; Mr A Joyce (Employee Director); Mrs J McDowell; Mrs A Mitchell; Councillor F Toner; Mr G Walker; Mr G Warner.

In Attendance: Mrs S Ballard-Smith (Shadowing the Nurse Director), Mrs M Christie (Representing Mr J Forrest, Director of West Lothian Community Health & Care Partnership), Mr J Cook (Chairman British Homeopathic Society for item 43), Mr P Gabbitas (Director of Health & Social Care, City of Edinburgh Council); Mr A Jackson (Associate Director of Strategic Planning for item 44), Professor A McMahon (Director of Strategic Planning, Performance Reporting & Information), Ms A Malone (Strategic Planning Manager for item 43), Mr R Martin (Head of Corporate Reporting (for item 47), Mr D A Small (General Manager, East & Midlothian Community Health Partnerships), Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications & Public Affairs).

Apologies for absence were received from Professor J Iredale, Councillor C Johnstone, Mr B Peacock, Dr R Williams and Mr R Wilson.

Declaration of Financial and Non-Financial Interest

The Chair reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. The following declarations of interest were received:-

- Ms K Blair declared an interest as a Non Executive Director of NHS24 which might impact on a number of agenda items.

- Mr J Brettell declared an interest under agenda item 3.2 ‘NHS Lothian Homoeopathy Service’ as his partner was a complementary therapist. He was also a Trustee of the Lothian Health Foundation as were all other Board members.
• Mr G Walker declared an interest in agenda item 2.1 ‘Medical Workforce Risk Assessment’ as his partner worked as a Consultant at St John’s Hospital.

• Mr P Johnston declared an interest under agenda item 3.1 ‘Public Bodies (Joint Working) (Scotland) Bill’ as he was the COSLA spokesman on the Health and Wellbeing Strategy and also in agenda item 3.2 ‘NHS Lothian Homoeopathy Service’ as he was member of the Scottish Health Council.

39. Welcome to Members of the Public and Press

39.1 The Chairman welcomed members of the public and press to the meeting. He also welcomed Ms Ballard-Smith, Deputy Nurse Director who was shadowing the Nurse Director. In addition Mr J Cook, Chairman British Homeopathic Society was welcomed and the Chairman explained he would address the Board for 5 minutes prior to the discussion on agenda item 3.2 ‘NHS Lothian Homoeopathy Service’.

40. Minutes of the Meeting held on 22 May 2013

40.1 The Minutes were approved as a correct record.

40.2 Councillor Toner asked the Chair for clarification on the minutes. He understood there might have been some confusion after the last Board meeting and subsequently there had been discussion in various Public Forums with the Board potentially being misrepresented. He sought clarification that both his motion and Mr Johnston’s recommendations had not been accepted at all by the Board and the Board had accepted recommendations 2.1 and 2.2 of the circulated paper and in respect of 2.3 a paper would be brought back for final discussion that reflected Board member concerns. The Chair and Corporate Services Manager confirmed this position.

40.3 Mr Johnston commented he had welcomed the Chief Executive’s summing up at the previous meeting and felt the minute was an accurate record of the meeting.

41. Matters Arising

41.1 Medical Workforce Risk Assessment – The Chairman commented there were a number of underlying issues that needed to be addressed and that the Board would need to satisfy itself that the policy direction was correct and that no stone had been left unturned in respect of possible solutions. It was also important that the Board approved any fresh proposals.

41.1.1 The Medical Director advised that the circulated paper detailed the roll-out of Phase 2 of the Medical Workforce Risk Assessment process which was almost complete. The most significant factors highlighted were difficulties in sustaining training grade rotas, difficulties in the recruitment of trained doctors, lack of workforce capacity, single handed specialists / skills shortages and the lack of
non medical replacements. Specific progress reports were provided in respect of emergency medicine, obstetrics and gynaecology as well as paediatrics.

41.1.2 The Medical Director advised that the Tailored Workforce Support Team (TWST) report jointly commissioned between the Scottish Government and NHS Lothian had highlighted “it is clear to the team that a great deal of time, effort and financial resource had been put in to developing solutions to staffing the service at St John’s. In reviewing the current rota the report indicated that compared to other rotas this was not a robust rota and remains fragile. It is also expensive given the small number of paediatric patients particularly out of hours”.

41.1.3 Mr Walker commented that recent media coverage suggested that the Southern General Hospital was able to cover all specialties and grades on a 24/7 basis. The Chief Executive reported he Co-chaired the National Reshaping Medical Workforce Board. He advised in respect of 24/7 Emergency Response Services that staffing pressures existed across Scotland and the UK. The Chief Executive commented Lothian remained very closely in touch with every other Board in Scotland and in his opinion no one was undertaking any activities that were not also being done in Lothian.

41.1.4 The Medical Director in response to questions from Councillor Toner advised that the current A&E model at St John’s was based on the use of consultants and trainees. The proposal was that a consultant would be on site until 11pm as opposed to the current position of 8pm with overnight cover provided by the hospital at night service and other additional staff including the use of clinical fellows when appointed.

41.1.5 The Medical Director in response to Councillor Toner confirmed there was no intention to change the current diversion policy. Councillor Toner sought clarification on whether this meant there was still a need to explore plans to transfer patients into Edinburgh. The Medical Director commented that while there was absolutely no current plans to transfer patients, it was essential to maintain contingency plans for any such service in order to protect patients against extreme, unforeseen circumstances.

41.1.6 The Medical Director assured Councillor Toner despite no middle grade trainees being allocated to St John’s there would be no repeat of the service change experienced the previous summer as stable staffing arrangements were now in place.

41.1.7 Councillor Tonner agreed no stone had been left unturned and welcomed the investment made. He sought clarification around option 1 in respect of the TWST report. The Chief Executive reiterated the policy of the Board was and would continue to be to provide safe and sustainable paediatric inpatient and A&E services at St John’s. It was stressed that the current model was fragile and expensive and time would be needed to develop a safe, sustainable and affordable model. He commented only ‘in extremis’ would there be a need to consider a contingency position but as the Medical Director had previously stated this position was not currently anticipated.
41.1.8 The Chairman stressed it would be for the Board to be satisfied that an appropriate policy was in place and appropriate efforts made to deliver its requirements under the umbrella of the agreed policy.

41.1.9 The Director of Human Resources & Organisational Development advised in respect of the consultant contract and junior doctors in training that new Department of Health negotiations were underway with the BMA.

41.1.10 The Vice Chair commented the paper had been useful to her as a lay-member and clearly set out the issues. She felt there was a need to take a 5-7 year view to reflect the fact many issues were outwith NHS Lothian’s direct control.

41.1.11 The Chief Executive provided details of significant work underway in respect of sustainable models around the trained workforce at national level. He advised that NHS Education for Scotland (NES) were responsible for the training of medical staff and Nurse Practitioners and were adopting a strategic approach to recruiting and retaining staff in Scotland. It was noted the Director of Human Resources & Organisational Development was engaged in this process.

41.1.12 Mr Johnston thanked the Chairman and Chief Executive for clearly setting out the position of the Board. The Medical Director clarified the position in respect of additional whole time equivalent staffing provided to St John’s Hospital as a consequence of NHS Lothian and Scottish Government investment. An update was provided in respect of the ongoing recruitment programme which required to be delivered by August whilst it was noted that the reconfiguration of the building would take longer.

41.1.13 Mr Johnston in respect of paediatrics welcomed the additional staffing at the Royal Infirmary of Edinburgh and St John’s Hospital. He questioned whether the St John’s Hospital Stakeholder Group could be utilised to increase the speed of the integration of the St John’s Hospital services into the wider integration of Health and Social Care agenda. Councillor Toner suggested West Lothian was making good progress advising that the integration of Mental Health Services had already been agreed with discussions ongoing in respect of other services.

41.1.14 Mr Walker commented whilst he welcomed the paper he remained concerned that the Board were treating the symptoms of the problem rather than the underlying cause. He felt a lot of issues were outwith the control of the Board even although they were being set the task of implementing policy and there was a need to influence this in future. Mr Walker declared an interest in this agenda item on the basis his partner was a Consultant at St John’s Hospital.

41.1.15 Mr Walker commented that the Medical Director had identified challenges in respect of 46 posts being reduced down to 42 posts and the difficulty in recruiting additional consultants. He questioned therefore what the Board was doing to improve targeted workforce measures when trainee numbers reduced. He felt currently there was a fundamental mismatch which impacted in the sustainability of service provision in general.
41.1.16 The Chief Executive commented although it had not yet been discussed there were opportunities to control patient flow to direct activity to St John’s and he would welcome further discussion around this issue in order to help to develop the sustainability and cost solutions. He explained the background to the policy decision to reduce the number of trainees advising that the South East and Scotland (SEAT) Planning Group felt the case could be made to increase the number of trainees in some specialties. A decision on trainee numbers for the 2014 round would be made by the Scottish Government in October.

41.1.17 Mr Walker felt there was a need for a Board paper on this issue which should include detail around what was being done at policy level to make trainee posts attractive to applicants. He sought clarification on whether the Board paper was incorrect or whether obstetrics and gynaecological posts were being reduced. The Chief Executive commented for 2013 obstetrics and gynaecology had not been one of the areas where the reduction in trainee posts had been paused.

41.1.18 The Chief Executive commented in respect of zoning that one of NHS Lothian’s corporate objectives was to produce a strategy for NHS Lothian by the end of the year and zoning would be part of these considerations to look at sustainable solutions and the capacity needed to provide this with options around individual sites. The Chief Executive commented proposals would be brought to the Board setting out broad options for further work by the end of March 2014.

41.1.19 It was agreed the strategic document referred to by the Chief Executive would detail specific options to address the issues discussed. The Chairman commented that medical workforce was a significant issue that would be considered at each Board meeting as well as other national fora.

41.1.20 Cllr Toner referred to the motion he had moved at the previous meeting and advised he was still not satisfied about the need for contingency plans around the diversion policy. In addition in respect of the TWST report on Paediatrics the only option he felt able to support was option 1.

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

41.2 Legionnaires Disease Outbreak 2012 – The Director of Public Health & Health Policy reminded the Board that 91 people had been affected by the previous year’s legionnaires outbreak. She commented it had been her intention to bring a full report to the current Board but a review of the agenda had suggested this would provide insufficient time to devote to a proper discussion as well as recognising that there remained ongoing investigations by the Health and Safety Executive and Police Scotland.

41.2.1 The Director of Public Health & Health Policy advised she had been in contact with the leader of the City of Edinburgh Council and would also be meeting with Councillor Henderson and would be offering meetings with members of groups of people in the areas affected. She would hope to share with them the draft report before bringing a copy to the next Board for further consideration.
42. Public Bodies (Joint Working) (Scotland) Bill

42.1 The Director of Strategic Planning, Performance Reporting and Information advised that the Public Bodies (Joint Working) (Scotland) Bill had been published on 28 May. The Board noted that in advance of a ‘go live’ date to be agreed, an integration plan and strategic commissioning plan needed to be consulted on and submitted to Scottish Ministers for approval.

42.2 The Board noted that a workshop on Integration was being organised for 5 September for Directors and those Non Executive Directors involved in shadow boards. The Board noted that the 4 Joint Director posts had now been appointed to within the Partnerships and further work continued to be done in developing a Children’s Integration Joint Board in Edinburgh.

42.3 Mr Ash commented that he welcomed the update report noting that stage 3 was due early in the New Year at which point there should be further clarity around the legislation. He felt therefore that the autumn Development Session was appropriately timed. He commented that there would merit in pulling together the current position in respect of the Single Outcome Agreements to provide an overview. It was agreed that the Director of Strategic Planning, Performance Reporting & Information would progress this.

42.4 Dr Bryce commented that she welcomed the paper which signalled significant change in Health and Social Care Delivery which she would welcome being further expanded upon at the September Workshop. She commented that as detailed in the paper there was a requirement for those at the top of the organisation to rise to the challenge.

42.5 Mr Johnston declared an interest as the COSLA Health and Wellbeing spokesman and also as a member of the Scottish Health Council. He commended the report advising that NHS Lothian was leading the field noting that it’s Shadow Health and Social Care Partnerships were all now in place. He advised that this advanced position provided advantages and opportunities and that as part of COSLA he sat on the Bill Advisory Group where a consistent direction of travel was to take forward the agenda on a very localised basis. He advised that the Integration Plan and the Strategic Development Plan would need to be locally consulted upon before being signed of by the Cabinet Secretary. The Board agreed Mr Johnston’s suggestion that there would be benefit in working with the Scottish Health Council in this regard.

42.6 Mr Brettell commented that he was still concerned about Governance aspects between the NHS and local authorities as at this point the Governance picture was unclear and in that regard the paper should be proposing a recommendation to the Board. He also questioned whether the Shadow Partnership Boards were operational or strategic bodies and in that regard suggested there was a need for clarity around matters reserved to the Board and how this impacted on the working of the Audit & Risk Committee and the Finance & Resources Committee as formal Committee’s of the Board.

42.7 The Director of Strategic Planning, Performance Reporting & Information suggested that over the summer period he would digest all of the current
outstanding issues and use the workshop session in September to engage with key Stakeholders prior to bringing back a paper to the September Board. He advised that work was already underway to look at some of the issues raised by Mr Brettell and that the proposed paper would give a timescale for the conclusion of this work.

42.8 Mrs McDowell commented that under the recommendations there was a request to support the proposal that there be a Shadow Children’s Integration Joint Board in Edinburgh and that it be in shadow form from April 2014 and live from April 2015 although she could not see this discussed in detail in the circulated paper. The Director of Strategic Planning, Performance Reporting & Information advised there would be a need to formally bring a proposal in this regard through the Board. The Chief Executive commented that in the previous year he and the former Chair and the Vice Chair had met with local authority colleagues and in that regard the proposals to move to a Shadow Children’s Integration Joint Board had been discussed at the highest level and he felt that the recommendation in the paper should be to support the development of the proposal.

42.9 Councillor Toner provided an update to the Board on developments within the West Lothian Partnership Board advising that the previous day significant issues around the Francis Report had been discussed. The Director of Finance in response to a question from Councillor Toner advised that the September development session would address issues around finance, budgets and governance although the position was that the NHS Lothian Standing Financial Instructions were currently extant although there would be a requirement to develop these as the position became clearer through further legislation.

42.10 Councillor Henderson commented that there was a significant amount of work currently in development not least in respect of the passage of legislation and that he would welcome the September workshop. He commented that in the paper there was little mention of locality planning and he would welcome a 30 minute slot on this important area as part of the development session. The Director of Strategic Planning, Performance Reporting & Information undertook to arrange.

42.11 The Chief Executive commented the pathway of the Bill progressing to an Act was still undergoing Parliamentary process. He advised NHS Lothian was trying to stay at the front end of the curve although it was important to recognise currently there was no delegated authority to Shadow Partnership Boards from the NHS Lothian Board. He commented moving forward consultation would be important and that the Partnership Integrated and Strategic Development Plans should sit alongside the NHS Lothian Plan and not compromise it. He advised that the current role of the Shadow Board was therefore to develop the Integration and Strategic Plans and the consultation process leading to this. Essentially Shadow Boards would operate in a planning function until legislation clarified the position around delegated authority. The Chief Executive suggested that NHS Lothian should continue to embrace the philosophical concept and inform the detail recognising that some aspects remained uncertain.
42.12 In response to a concern from Ms K Blair about the two thirds Council majority status and the implications for NHS Lothian in the Edinburgh partnership, the Director of Health & Social Care, City of Edinburgh Council advised that Council lawyers and not the Council itself had identified that under the 1970 Local Government Act that there was a requirement for a two thirds Council majority in Partnership arrangements. He commented there were practical ways in the meantime of working around this position and that the new legislation would supersede the 1970 Act and allow the Council to move into a 50/50 partnership.

42.13 Mr Walker commented that he had found the Chief Executive’s summary helpful in respect of the current function of the Shadow Partnership Board. He commented that from a finance viewpoint that the issue around budgeting had been discussed at the Finance & Resources Committee and that it would be important to maintain a level of caution in the planning stages until the necessary clarification had been received through legislation.

42.14 The Board agreed the recommendations contained in the circulated paper and that the Director of Strategic Planning, Performance Reporting & Information should pick up the points raised in the discussion for further reflection at the September Development Session.

43. **NHS Lothian Homeopathy Service**

43.1 The Chairman commented he would invite the Director of Strategic Planning, Performance Reporting & Information to introduce this item and then ask Mr Cook, Chairman of the British Homeopathy Society to address the Board for 5 minutes.

43.2 The Director of Strategic Planning, Performance Reporting & Information advised that the recommendation following the outcome of the public consultation had been supported by the Health Care Governance Committee on 4 June 2013. The recommendation was to cease the provision of a Homeopathy Service in Lothian and referrals to the Glasgow Homeopathic Hospital from 1 April 2014. The recommendation was to honour the current service level agreement (SLA) with NHS Greater Glasgow and Clyde for 2 years following which the SLA could be renegotiated. It was noted that during the phased withdrawal of the service a review of patient clinical needs would be undertaken and funds released would be reinvested in routine NHS Healthcare such as chronic pain and chronic fatigue.

43.3 The Board received details of the background to the review of the Homeopathy Service which had started in 2012 and concluded with the public consultation. It was noted that 74% of Lothian residents felt NHS Lothian should not pay for homeopathy. The service received 200 new homeopathy referrals per annum with 1300/1500 review appointments per annum. The cost of the Homeopathy Service was currently £240k with the estimated closure releasing savings of around £110,400.

43.4 The Director of Strategic Planning, Performance Reporting & Information advised that the withdrawal of service provision might increase potential for GP
appointments, referral to secondary care and prescribing costs for conventional medicine. These issues would be considered as part of the process in considering where to reinvest the funds released. It was noted that GPs had indicated they were unlikely to refer to secondary care but might continue to prescribe in the absence of the service. The Director of Strategic Planning, Performance Reporting & Information commented that any increased burden to Primary Care was not considered to be significant in the context of 5.4 million Primary Care appointments per year across Lothian.

43.5 Mr Cook joined the meeting and thanked the Chairman for letting him make a five minute statement.

43.6 Mr Cook commented this was a very contentious proposal and noted on page 354 of the Board papers homeopathy was listed as a ‘hot topic’, more than half way up the list, one ahead of ‘death’. Mr Cook hoped that before a decision was made the Director of Strategic Planning, Performance Reporting & Information would cover the very considerable volume of recent correspondence which had identified - material cost inaccuracies; a non-existent benefit analysis against other potential investments; a flawed analysis of the consultation results which has been presented to the Board by lumping together of statistics for users of the homeopathic services (response rate some 40% - statistically significant) with that of non-users (response rate from Lothian’s population of 800,000 (response rate of well under 0.5% - statistically insignificant); a conflation of responses which did not compare like for like.

43.7 Mr Cook felt it was sad that there had been a ‘hate campaign’ against homeopathy as practised in the NHS as a complement to mainstream medicine through qualified doctors. This appeared to be whipped up by sceptics disappointed that the UK Government rejected the House of Commons Science and Technology (S&T) Committee Report that NHS Homeopathy should be banned on grounds of ‘evidence’. He pointed out that the Lothian Report cited the S&T Report but omitted to mention the UK Government’s rejection of its conclusions. Mr Cook advised that evidence in modern medical integrative practice did not adopt rigid straight-jacketing into hierarchies as in the S&T Report but considers the totality of evidence including the embedding of patient reported outcomes. Mr Cook noted in Scotland, the Scottish Executive circular HDL (2005) 37 set out the framework for provision of complementary medicine such as homeopathy. This circular was mentioned by name in the January 2012 Homeopathy Review but it omitted to spell out the concluding paragraph which read “Complementary and Alternative Medicine is an area in which there is increasing public interest. Chief Executives are asked to take this into account in the planning of services. The Executive is aware that a number of NHS Boards already provide some form of CAM”. Mr Cook felt any decision to cease the provision of the established Lothian homeopathy service went against the direction of travel set out by the Scottish Government.

43.8 Mr Cook recalled much had been said including by the NHS Lothian Chairman about the long term sustainability of NHS expenditure. This was a subject also covered in a CIPFA Publication “NHS Prioritisation – Delivering World Class Practice” which states “So in summary, the approach to prioritising investment must be systematic, rational, holistic and robust” He commended this approach;
noting that NHS Lothian’s review did not live up to this approach. In addition to existing users, in December 2012 at the request of Mr Cook the existence of the Lothian Homeopathy service clinics was shown for the first time on the Board’s website (alongside other services in the A-Z guide). Since then an increase of new referrals of some 6 per week had been reported roughly doubling the previous new referral rate. Mr Cook felt this clearly demonstrated the voice of prospective patients added to the voice of existing patients who value the service, having now been told of its existence.

43.9 Mr Cook commented his organisation did not deny that NHS Lothian had the right to evaluate any established front-line services. However he felt the review as conducted made no proven case for the adoption of any option other than option 1 (retention of the status quo). If a proper thorough cost / benefit review were to be carried out, users and prospective users would need to be involved from the outset, and any options developed to build into the decision-making process should also include an option for an increase in NHS homeopathy. He felt this might not be a big issue for NHS Lothian but the threatened withdrawal (Option 2) would be an enormous blow to the healthcare of users and prospective users and their expectations from NHS Lothian. Mr Cook thanked the Board for its time and would be happy to answer any questions with the permission of the Chairman.

43.10 The Chairman advised that the issue now fell to the Board for discussion.

43.11 The Director of Strategic Planning, Performance Reporting & Information advised that the paper and proposals before the Board focussed on Homeopathy and not other complementary therapies. He commented that the usage of outpatient attendance as articulated in the paper was small in relation to the totality of GP activity. It was noted that NHS Lothian also used the Glasgow service although this usage was incredibly small.

43.12 The Board noted the comprehensive consultation process which had included the Scottish Health Council and other stakeholders. The Director of Strategic Planning, Performance Reporting & Information advised that the Health Council had confirmed that they were content with the standard of the process adopted in respect of the consultation and that this had been advertised widely and subject to public meetings. A detailed analysis of the outcome of the consultation exercise was reported to the Board.

43.13 The Director of Strategic Planning, Performance Reporting & Information advised that recommendation 2 had been supported by the General Practitioners Sub-committee, The Community Health and Care Partnerships, The Strategic Planning Group and the Healthcare Governance Committee.

43.14 The Board noted that whilst the GP Sub-committee had supported that NHS Lothian should not provide homeopathy that a review of patients would be undertaken in respect of their current and future needs and General Practitioners did not see this as an onerous task. In addition applications could be made to the exceptional cases panel Chaired by the Medical Director if there was felt to be a need for continual treatment. The Board noted that consideration had also been given on how best to reinvest the funds invested in
homeopathy to include chronic pain, fatigue and palliative care services which would benefit patients.

43.15 The Chairman commented that most colleagues around the table had had the opportunity through the Board’s Internal Governance Processes to consider the detail of the recommendations. He commented that five absent Board members, Professor John Iredale, Dr R Williams, Mr R Williams, Mr R Wilson and Mrs A Meiklejohn had all recommended support for the option in the paper as proposed.

43.16 Mr Brettell declared an interest in this item as his partner was a Complementary Therapist and also declared an additional interest as a Trustee of the Lothian Health Foundation on the basis that the withdrawal of the services might have funding implications for Trustees. It was noted that this declaration applied to all other Board members who were by definition Trustees. Mr Brettell commented in respect of the medical case that as a lay member of the Board he would rely on the advice of medical colleagues which was persuasive. He commented that he was not convinced about the validity of the reported increase in referrals following the inclusion of details of the service on the website as this would be expected.

43.17 The Chief Executive commented if there were unintended consequences which would lead to additional approaches for Trustee funding then there would be an opportunity for these bids to be considered as part of the normal way that the Foundation operated.

43.18 Councillor Toner noted as a point of clarity that the West Lothian Community Health & Care Partnership had not endorsed the paper but simply noted its recommendation. He commented that the consultation exercise had been an exemplar of good practice and should be considered as a model for future consultation. The Director of Strategic Planning, Performance Reporting & Information commented that a paper would be submitted to the Healthcare Governance Committee for comment in respect of the range of potential services that could be provided to replace homeopathy using the available funding.

43.19 The Vice Chair advised the recommendations had been considered without comment at the Edinburgh Community Health Partnership. She advised as a lay member she was not confident in challenging the medical evidence. She felt however in terms of health and inequalities that access to the service was not equitable and to address this would require significant additional resources which were not available. She therefore supported the direction of travel.

43.20 The Director of Public Health & Health Policy commented that the consultation was a model of good practice, that much of the evidence cited had involved users in the design and delivery of the research reviews, that there was no evidence base for the use of Homeopathy yet the Board faced difficult decisions regarding the extent to which it was able to provide all of the essential evidence based health services identified by the World Health Organisation. She commented that there was a duty to provide evidence based care for patients
with multiple and complex needs including patients with medically unexplained symptoms.

43.21 Mr Walker commented that whilst he supported the proposals in the paper that he recognised the disappointment this would cause to users of the service. He commented that he did not think this would be the final chapter in a range of difficult decisions that the Board would require to take. The Director of Finance provided details of the Service Level Agreement with the Glasgow service.

43.22 Dr Bryce commented as Chair of the Healthcare Governance Committee that she was familiar with the databases and material on which the recommendations had been based. She commented she had ensured that all data was capable of being accessed and had allowed 50% of a meeting to discuss homeopathy which had included participation by 4 lay members of the Committee. It was noted that the recommendations had been supported in a consensus manner with it having been agreed that an exemplary job had been undertaken in managing the consultation process. Dr Bryce commented that she accepted that the Boards decision would disappoint people and it was important to acknowledge this.

43.23 The Chief Executive commented that the decision on the withdrawal of Homeopathy Services was for the Board alone to approve as it did not represent a major service change as confirmed by the Scottish Health Council.

43.24 The Board agreed the recommendations contained in the circulated paper and in particular approved option 2 to cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014.

43.25 The Chairman thanked Mr Cook for his contribution.

44. Waiting Times Performance, Progress and Elective Capacity Investment

44.1 The Chairman commented that this was an important item and that approval in principle was being sought to the investment required subject to scrutiny on behalf of the Board by the Finance & Resources Committee. It was noted that the detail of the Finance & Resources Committee scrutiny would come back to the Board.

44.2 The Board noted that the rise anticipated in April’s Board paper from the March position had been realised. Operational information suggested that the overall position was likely to remain reasonably stable over the next few months although there had been particular difficulties in ophthalmology. Alternative staffing had now been sourced and the ‘See and Treat Pathway’ would be recommencing from 29 June.

44.3 It was reported that 95.7% of patients treated in May had been seen within the treatment time guarantee. 340 patients waited over this threshold in the month, of whom 221 had been admitted or no longer required treatment and 98 had
dates identified or were with external providers to find a suitable date. Arrangements for the remaining 21 were being explored.

44.4 The Board noted that there had been a temporary increase in the outpatient position particularly in respect of the colorectal 'see and treat pathway' which was being addressed. It was noted that data in respect of pain management had only recently started to be reported at the Board and it was anticipated once this data was adjusted and validated that the position would improve considerably.

44.5 The Medical Director advised that Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies were being reported for the first time. While data for CAMHS was adjusted for non attendance in line with the guidance, Psychological Therapies did not take account of non attendance, unavailability or reasonable offer.

44.6 Mr Jackson provided the Board with a presentation focussing on progress to date and areas for further progress. The presentation covered diagnostic scopes, waiting time complaints by quarter and outcome, forensics, unadjusted inpatient waits and details of inpatients and outpatients over 12 weeks by specialty. The reasons for movements within each specialty area and mitigating action were explained in detail to the Board.

44.7 The Director of Finance advised in respect of training that an update had been provided to the Audit & Risk Committee based on the Internal Audit Report with a further report being submitted in September. The Director of Finance provided the Board with a presentation covering delivery sustainability / use of independent sector, investments in capacity, key risks around sustainability, use of the independent sector and other capacity as well as funding for the independent sector.

44.8 The Director of Finance commented that it had been difficult in the current year to make an assessment on the use of the independent sector particularly given the outstanding backlog of outpatients and the ongoing imbalance of some specialties. The proposed investments in capacity were highlighted for tranche 1 and tranche 2 with details of the funding source being provided. It was noted there was a shortfall of £1.85m which would be covered through slippage and a first call on National Resource Allocation Committee (NRAC) Funding in the following year. It was noted that full details of this issue would be discussed at the Finance and Resources Committee.

44.9 The Director of Finance advised in respect of funding for the independent sector that this would be covered on a non-recurring basis and there was a need for further work in respect of covering the small shortfall. It was noted that national and local procurement framework agreements for contracting with the private sector had been anticipated although this had slipped resulting in NHS Lothian taking Central Legal Office advice in respect of ongoing procurement to ensure consistency of approach.

44.10 Councillor Toner commented that he welcomed the investment in NHS Lothian’s own capacity and questioned when evidence would be available of a
reducing spend in the private sector. The Director of Finance commented that it was difficult to be specific about this but she would anticipate an ongoing requirement to use the private sector whilst the Clinical Strategy developed and reminded the Board that once investment had been made there was a timeline for benefits coming to fruition particularly in respect of capital projects. Mr Jackson commented however on a year by year basis a reduction in private sector spend should become evident.

44.11 The Chief Executive commented that the ageing population and other demographic issues had an impact on specific service demand that would require a strategic solution. This was particularly true in respect of services like ophthalmology where service usage was predominantly amongst older patients. The same was true in respect of orthopaedics where £3m had been invested in the previous year.

44.12 Mr Brettell commended the management team on the excellent progress reported through the paper advising that the data provided in the forensic dashboard provided confidence based on facts and analysis. He commented in future iterations of the paper it would be useful to show a red line of monthly capacity.

44.13 Mr Johnston commented that orthopaedics remained an area of significant spend in the private sector and he felt there was a need for a step change in the way this was addressed and he hoped this would be discussed in the options paper to the Finance & Resources Committee. The Chief Executive commented that there were many interdependent issues many of which were being discussed at the current meeting which would be considered during the development of the composite strategic plan to be produced by the end of March 2014. He commented it would be important in advance of the plan not to take decisions in isolation.

44.14 Mr Walker commended colleagues on the significant progress being made and commented it would be helpful to understand when the equilibrium point would be reached in respect of investment and a noticeable reduction in private capacity usage. There was also a need to demonstrate the benefits received from investment. The Chief Executive concurred advising this was the constant challenge he set his team. He reminded the Board that the lead time from making an investment decision and progress being evident was largely dependant upon the availability of medical staffing. The Chief Executive commented that the £6m of investment being proposed in the current paper would have an implementation lead time. He felt it might be another year before major impacts became evident and this was part of the reason why the Director of Finance had signalled the ongoing need for engagement with the private sector. He assured the Board that not withstanding these real challenges that no stone remained unturned. The Director of Finance suggested there would be merit in looking at a small number of specialties in detail.

44.15 Mr Walker advised that the cost of internal waiting time activity needed to be captured to give the full picture. In this respect he advocated the production of
a trend report. Mr Jackson undertook to reintroduce the activity report back into the Board paper.

44.16 The Board approved in principle the further investment outlined to support both reduction in those patients waiting beyond standards and the onward sustainable delivery subject to further scrutiny by the Finance & Resources Committee.

45. Unscheduled Care – Local Unscheduled Care Action Plan (LUCAP)

45.1 The Nurse Director advised she was seeking the support of the Board for the submission of the Unscheduled Care Action Plan (LUCAP) to the Scottish Government. She commented that the current position in respect of the 4 hour access target had been 88.5% in April rising to 94.8% in May with the position expected to be maintained moving into June. This was noted as positive progress. The Nurse Director commented that as improvements were made in the Unscheduled Care 4 hour target similar positive impacts were evident in the stoke targets.

45.2 The Board noted that attendance and admission rates were stable and had benefitted from seasonal changes and the reduction in norovirus and respiratory illness as well as a reduction in the length stay of patients waiting more than 28 days benefitting from the increased social care capacity provided particularly in Edinburgh. The Nurse Director commented that anecdotal evidence was available that the site management focus on the front door and patient flow was also yielding benefits. She commented however that it was important to be cautious about the ability to sustain this position.

45.3 The Nurse Director commented that Mr Brettell at a previous Board meeting had asked for details of the Unscheduled Plan and at the same time a request had been received from the Scottish Government Health Department to all Boards to submit Unscheduled Care Action Plan which would be produced quarterly and be a 3 year plan. The Nurse Director commented that the action plan although a detailed document had largely been reported and shared with the Board previously. The Nurse Director commented that the key part of the plan was that the Unscheduled Care trajectory of 95% whilst being sustained on a site basis was required to continue over the winter period. She advised that the system was currently trying to close down winter beds with there being plans in place to provide additional beds in wards 109 and 209 at the Royal Infirmary of Edinburgh prior to the winter period (26 additional beds).

45.4 The Board noted that the Scottish Government Health Department target was to achieve and sustain 95% performance by September 2014 and then to move to 98% as rapidly as possible. The Director of Nursing commented that the stretch target date had been reflected in the paper as being reached in March 2014 although the Unscheduled Care Group had suggested it would be more prudent to set a target of December 2014. Following detailed debate it was agreed that the target date of September 2014 should be set.
45.5 Councillor Toner commended the good work that had been undertaken and commented that in general terms he broadly supported the vast majority of the action plan.

45.6 Mr Walker commented he also supported this work and suggested that capital aspects needed more detail around what could actually be executed given complexities around the Royal Infirmary of Edinburgh site in respect of Unscheduled Care challenges. The Chief Executive commented that this work would be part of the composite strategic planning document to be brought back to the Board by the end of March 2014.

45.7 The Director of Public Health & Health Policy requested that the findings of the Quality and Impact Assessment be included in the plan for submission to the Scottish Government given the significant socioeconomic and ethnic gradients in unscheduled care use as well as identifying additional support needed to provide best effect. The Nurse Director undertook to make this inclusion.

45.8 The Board supported the submission of NHS Lothian’s LUCAP to the Scottish Government by the deadline date of 30 June 2013.

46. Strengthening the Relationship between NHS Lothian and Third Sector Organisations

46.1 The Director of Strategic Planning, Performance Reporting & Information advised this was the first paper submitted to the Board on relationships with third sector organisations. It was noted currently around £12m was invested per annum on services delivered by third sector organisations on behalf of NHS Lothian. This position could be multiplied several times if Local Authority spend was included.

46.2 The Director of Strategic Planning, Performance Reporting & Information advised that he was seeking to improve engagement with third sector organisations and to understand what real and perceived barriers existed in order to develop policies and operating practices to improve future engagement.

46.3 Mrs McDowell supported the recommendations in the paper and advised in Midlothian a meeting had been held with a carers and advocate organisation. She suggested there would be merit in the Board holding a similar Outreach Event with the third sector.

46.4 Ms Blair advised she supported the recommendations and commented there would be a need to develop a process to ensure actions to improve engagement were evaluated to demonstrate real benefits were being achieved. The Director of Strategic Planning, Performance Reporting & Information commented that current service level agreements provided a good platform on which to build. It was noted in respect of key risks further work was being undertaken on how to procure services and this would include a focus for ongoing revaluation.
46.5 Mr Ash commented that the paper proposed acceptable and rightful influence and that the Board could only benefit through working with the third sector where there was a legitimate interest.

46.6 The Vice Chair felt this was a timely and important piece of work. She advised the third sector had in the past been innovative around issues like HIV and the closure of Gogarburn. She commented that the third sector could be beneficial in campaigning work and also in bringing together resources to progress work in future.

46.7 The Board agreed in principle to the recommendations contained in the circulated paper in respect of improved engagement with third sector organisations.

47. **Governance Report and Annual Accounts for year ended 31 March 2013**

47.1 The Director of Finance advised that the draft Annual Accounts had been subject of separate confidential circulation with the Board papers and reported that NHS Lothian had achieved all 3 of its financial targets for the year 2012/13. In addition the Board’s external auditors, Audit Scotland, intended to issue an unqualified opinion on the accounts. The Audit & Risk Committee had also considered the annual accounts at their meeting as well as the circulated annual report of the Chair of the Audit & Risk Committee for the period year ending 31 March 2013.

47.2 Mr Brettell as Chair of the Audit & Risk Committee confirmed that the accounts and governance statements had been discussed with external auditors having highlighted no issues of concern other than minor comments.

47.3 The Board: -

- Approved and adopted the Governance Report and Annual Accounts for the year ended 31 March 2013.
- Authorised the designated signatories (Chief Executive, Chair and the Director of Finance) to sign the Governance Report and accounts on behalf of the Board, where indicated in the document.
- Authorised the Chief Executive’s signature on the representation letter to the auditors on behalf of the Board.

48. **Quality Report**

48.1 The Medical Director advised that compliance with the evidence based stroke standard for admission to stroke units within 1 day of admission and Swallow Screen on day of admission remained an issue and detailed the actions underway to improve compliance on the 3 acute sites.

48.2 The Board noted that the Patient Safety Programme continued to increase with respect to the number of additional work streams and changes in the measurement framework. In order to deliver the depth and coverage of these
new and existing workstreams, increasing infrastructure was required in terms of capacity and capability building of service teams, reporting and frontline support to embed reliable safety practices. In addition, there were increasing requirements to organise learning sessions for individual workstreams, locally and nationally, along with an increase in visits from Healthcare Improvement Scotland for the programmes as a whole plus individual programmes.

48.3 The Board noted that meeting the HEAT target for clostridium difficile infection remained a challenge. The Medical Director provided more detailed updates in respect of other aspects of healthcare associated infection. In addition the 3 day and 20 day complaints response rate remained a challenge although there had been improvement in March for the 3 day response rate. It was noted that a more detailed paper on complaints was included on the Board agenda.

48.4 The Medical Director advised the Scottish Patients Safety Programme Clinical Lead was organising a conference for clinical teams on Friday 23 August 2013 at Heriot Watt University which focused on using Human Factors to enhance the patient safety culture and deliver reliable high quality care. Board members were invited to attend the event.

48.5 The Medical Director commented in response to Mrs Mitchell that the Royal Infirmary of Edinburgh would like other sites adopt the patient briefing model which was a World Health Organisation requirement.

48.6 The Board agreed the recommendations contained in the circulated paper which updated on existing and new Patients Safety Programmes for mental health, paediatrics, neonatology and maternal health along with proposed national measures.

49. Healthcare Associated Infection Update

49.1 The Nurse Director commented that there might be further debate on this issue as part of the Board’s Development workshop on the Francis Report later in the day. She commented that generally good progress was being made although further work was needed in respect of the clostridium difficile infection target. She also commented that the norovirus position continued to improve as reported elsewhere in the meeting.

49.2 The Board noted that the Health Environment Inspection report on the Royal Infirmary of Edinburgh had been published the previous day with the main significant issue being the condition of some mattresses and that plans were in place to address the recommendations in the report.

49.3 The Board agreed the recommendations contained in the circulated paper.
50. **Performance Management**

50.1 The Director of Strategic Planning, Performance Reporting & Information advised that this represented his regular report to the Board and provided highlights in respect of CAMHS; psychological therapies; detect cancer early; cancer performance on 62 and 61 days; delayed discharges and stroke.

50.2 The Vice Chair welcomed the introduction of the CAMHS data commenting on the importance of faster access to psychological therapies.

50.3 The Joint Director of Health & Social Care, City of Edinburgh Council advised that delayed discharges had been discussed at the Shadow Health & Care Partnership meeting and this was reflected in the cover note of the minutes of that meeting to be discussed later.

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

51. **Financial Position to 31 May 2013**

51.1 The Director of Finance commented that this was a very early financial position report to the Board which was showing an overspend of £0.7m as at 31 May 2013 largely as a consequence of drugs overspend and local reinvestment plans slippage both of which required focus.

51.2 The Director of Finance advised that an exercise was currently underway to develop a robust year end forecast, and in particular, to review the extent of non recurrent funding available to support in year pressures and emerging priorities for investment.

51.3 The Board noted in respect of superannuation auto enrolment that the key issue previously reported to the Board had been around the number of people who would opt out of auto enrolment. It was noted that NHS Lothian had set aside £4m for the increase in costs in respect of the employer's contribution based on a 50% uptake. April and May figures were reporting that only 15% of people were opting out of auto enrolment although the position in NHS Greater Glasgow and Clyde who where one month ahead of NHS Lothian suggested that due to timing issues that the opt out rate would increase with this probably becoming evident in July and August. The Chief Executive commented given that this would have a signified impact on the finances of NHS Lothian that the Board would be kept up to date on progress.

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

52. **Corporate Risk Register**

52.1 The Medical Director advised that the paper had been updated since it had been considered at the March Board meeting and that the summary paper highlighted emerging risks previously noted particularly in respect of data quality
and compliance with stroke standards and equality reports. The plans to mitigate risk were explained in detail.

52.2 The Board agreed the recommendations emerging from the Risk Management Workshop on 22 May and that these should be taken forward by the Medical Director and his team.

52.3 Mr Brettell commented that risk had been looked at within the Audit & Risk Committee and with hindsight the Workshop had probably tried to achieve too much although he supported the recommendations particularly in respect of the risk appetite and the desire for shorter Board papers.

52.4 Mr Walker commented that the process was a positive step forward and suggested given the risk matrix for staffing that this might represent an additional risk to reflect in the risk register moving forward.

52.5 The Chief Executive commented in respect of medical staffing that the final outcome of the South East and Tayside Planning Group (SEAT) risk assessment was awaited and as an outcome of this it was anticipated that the risk around paediatrics would be subsumed more broadly into medical staffing in general.

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

53. **Customer Relations and Feedback Performance Report**

53.1 The Director of Human Resources & Organisational Development reported that consideration was being given through the establishment of a Short Life Working Group to introducing an early resolution triage model similar to that used by the Scottish Public Services Ombudsman. The Short Life Working Group would also consider the future direction of travel for the department with preliminary discussions already having been held with Dr Bryce and Mr Brettell. It would be important any developments included the involvement of the Nurse Director and staff side representatives. The Short Life Working Group recommendations would be reported to the Board to include an indication of whether there were any resource implications around any proposed change of direction.

53.2 The Vice Chair welcomed the report although she questioned the rationale for renaming the department as the Customer Relations and Feedback Team. The Board discussed in detail the use of the ‘customer’ terminology. The Director of Communications & Public Affairs commented that the term customer was correct because the feedback received was not just about complaints and in many cases feedback came from carers, relatives of patients, politicians and members of the public who had a comment to make on the service.

53.3 The Board agreed the recommendations in the circulated paper.
54. Committee Minutes for Adoption

54.1 Healthcare Governance Committee – minutes of the meeting held on 4 June 2013 – The Board adopted the minutes and noted the Chair’s covering report. Dr Bryce commented as detailed in her covering report that homeopathy which had been discussed earlier on the agenda had been subject to due governance. She commented that the Quality Report featured as a significant issue on the agenda and was the main vehicle when looking at the audit trail in respect of governance and where it was reported.

54.2 Staff Governance Committee – minutes of the meeting held on 29 May 2013 – The Board adopted the minutes and noted the Chair’s covering report. Mr Joyce commented that auto enrolment had been discussed in detail as had been the slow completion rate in respect of the Staff Survey where NHS Lothian’s performance was 16% against a national target of 50%. It was noted that the Director of Communications and Public Affairs and his team had regularly sent reminders to staff and that Unison had also put out 2 emails urging people to fill in the survey. It was noted that the Staff Governance Committee would consider this issue further.

54.3 East Lothian Community Health Partnership Sub-Committee – minutes of the meeting held on 25 April 2013 – The Board adopted the minutes and noted the Chair’s covering report. Mr Ash commented that the Health and Social Care Partnership continued to be developed and was in an embryonic state. Mr Ash proposed revised reporting arrangements for Committee minutes from September onwards which were agreed.

54.4 Edinburgh Community Health Partnership Sub-Committee – minutes of the meeting held on 10 May 2013 – The Board adopted the minutes and noted the Chair’s covering report. It was noted that the Edinburgh Community Health Partnership would continue to meet quarterly to discharge Corporate Governance responsibilities.

54.5 Edinburgh Shadow Health & Social Care Partnership – minutes of the meeting held on 19 April 2013 – The Board adopted the minutes and noted the Chair’s covering report. Councillor Henderson advised he had nothing to add to the summary.

54.6 Midlothian Community Health Partnership Sub-Committee – minutes of the meeting held on 12 April 2013 – The Board adopted the minutes and noted the Chair’s covering report. Mr Johnston commented that the Midlothian Community Health Partnership continued to meet in respect of operational issues.

54.7 West Lothian Health & Care Partnership Sub-Committee – minutes of the meeting held on 23 May 2013 – The Board adopted the minutes and noted the Chair’s covering report. Councillor Toner commented that the previous meeting had been dangerously close to being inquorate and he had issued an email asking members in future to indicate whether or not they would be attending and it was hoped this would resolve the issue downstream.
55. Date and Time of Next Meeting

55.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 24 July 2013 in the Board Room, Waverley Gate, 2-4 Waterloo Place, Edinburgh

56. Invoking Standing Order 15.2

56.1 The Chairman sought permission to invoke standing order 15.2 to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke standing order 15.2.
SUMMARY PAPER – MEDICAL WORKFORCE RISK ASSESSMENT - UPDATE

The full paper aims to address the concerns raised at the June Board meeting and provide an update on workforce issues.

The key points discussed in the full paper are summarised below:

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Paediatrics</td>
<td>The estimated start date for two of the successful candidates from Myanmar for the Clinical Fellow posts in Paediatrics is August 2013, and for the other two candidates, December 2013. It is anticipated that the acute paediatric/neonatal rotas in Lothian are covered for the next three months. Work is ongoing to address the staffing shortages affecting the Community Child Health Service.</td>
</tr>
<tr>
<td>3.2</td>
<td>Obstetrics &amp; Gynaecology</td>
<td>The out of hours rota at the Royal Infirmary will continue to be dependent on a mix of internal locums, external agency locums, and consultants acting down into middle grade vacancies. The appointment of two fixed term Clinical Fellow posts to sustain the out of hours rota is being explored.</td>
</tr>
<tr>
<td>3.3</td>
<td>Emergency Medicine – Progress against actions in the May and June 2013 Board Papers</td>
<td>Five acute Clinical Development Fellows have been appointed to support the out of hours emergency medicine rotas. The planned model of care from August to December 2013 for St John’s Emergency Department is outlined with no significant change to the pre-existing diversion policy that has been in place for several year.</td>
</tr>
</tbody>
</table>
Additional guidance for a model of care to be put in place in the Emergency Department at St John’s Hospital is outlined to ensure that there is appropriate support for the Clinical Fellows.

David Farquharson
Medical Director
18 July 2013
david.farquharson@nhslothian.scot.nhs.uk
MEDICAL WORKFORCE RISK ASSESSMENT - UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on workforce issues in NHS Lothian arising out of the June Board paper.

2 Recommendations

2.1 Note the links between NHS Lothian and the Scottish Government on workforce planning.

2.2 Approve the actions underway to mitigate the risks associated with the current shortage of medical staffing in Paediatrics, Obstetrics & Gynaecology, and Emergency Medicine.

3 Discussion of Key Issues

3.1 Medical Workforce Planning

3.1.1 Background

Workforce planning has been a statutory requirement in NHS Scotland (NHSS) since 2005. HDL 52 (2005) ‘National Workforce Planning Framework 2005 Guidance’, provided boards with a base for establishing workforce planning as a key element of the wider planning processes along with service and financial planning. This guidance was updated in December 2011 with the publication of CEL 32 (2011) ‘Revised Workforce Planning Guidance 2011’. The revised guidance provides a recommended methodology, a framework for board workforce plans and a requirement that Chief Executives adopt the guidance and framework in producing their board workforce plans.

As a strategic aim NHS Lothian is moving towards a service which is less reliant on doctors in training in the longer term, and will therefore result in a safe, sustainable and high quality service.

3.1.2 Workforce planning

NHS Lothian, along with all boards, is required to provide the Scottish Government (SG) with the following annually:

- Local Delivery Plan – March

A brief narrative on the workforce implications of each of the HEAT targets is required where appropriate and relevant. This should include an assessment of staff availability, the need for any training and development and consideration of affordability.
• **Workforce Projections - June**
Workforce projections for all staff groups, using SG supplied templates, must be completed and returned to the SG by June. These will be subject to further discussion and refinement prior to the SG publication of all boards’ projections at the end of August.

• **Board Workforce Plans – August**
Boards publish their workforce plans at the end of August. This will include the projections as well as a wider analysis of the current and future workforce issues and a detailed action plan to address known workforce risks.

Workforce data from the above is used by the SG for national workforce planning purposes. For example the boards’ nursing and midwifery workforce projections will feed into the SG nursing and midwifery student intake modelling in order to help determine the undergraduate numbers required to be commissioned each year. Similarly the projected changes in trained doctors requirements will feed into the national medical workforce reshaping programme to help determine the numbers of post graduate medical training places.

The NHS Lothian Executive Lead for workforce planning is Alan Boyter, HR and OD Director. The SG Health Workforce and Performance Directorate lead on NHSS workforce planning. The key groups that support the national workforce planning process are:

• **HR Executive Strategic Forum**
HR Directors and SG workforce meet on a monthly basis to provide strategic leadership on HR issues including workforce planning.

• **National Workforce Planning Forum**
Board/regional workforce planners and SG workforce planning leads meet every 6-8 weeks to address operational and technical issues. This group reports to the HR Executive Strategic Forum.

Workforce planning is carried out nationally for the controlled groups, doctors, dentists, nurses and midwives. The SG directly commissions undergraduate education for these occupations and post graduate training for doctors and controls entry numbers based on assessed future need.

Workforce planning for other staff groups is sometimes managed on a national basis when/if there is a perceived need for a coordinated national planning approach. This is also the case for nursing and midwifery post graduate education i.e. Neonatal and Paediatric Advanced Nurse Practitioners. The education provision for other non controlled staff groups is not directly commissioned by the SG but can be influenced through the links with the Scottish Funding Council and via NHS Education Scotland and their role in commissioning education and training provision for the NHSS. Boards will also have direct contact with local providers and will commission education locally as appropriate.

3.1.3 **Nursing and midwifery** pre registration training is managed at a national level. The SG Workforce and Performance Directorate manage the planning process. The SG nursing and midwifery intake modelling uses a combination of data sources
to assess future demand (i.e. board workforce projections) and supply (i.e. education attrition rates).

The NHS Lothian Executive Lead is Melanie Hornet, Nurse Director and NHS Lothian senior nurses and workforce planners are involved in the planning process which also involves NES and Information Services Division (ISD). The Cabinet Secretary signed off and announced the student intake numbers for 2013-14 in February of this year.

3.1.4 Medical workforce planning is a more complex process. NHS Lothian is involved in all stages of the planning process; Dr David Farquharson is the NHS Lothian Executive lead for medical workforce planning.

The SG Workforce and Performance Directorate manage the planning process which determines the overall intake to the foundation, core and post graduate speciality training programmes. It is driven by its policy aim to move towards a trained doctor delivered service.

NES are responsible for managing the education provision through their Deanery (West, South East, East and North) structure in Scotland. The GMC are the UK wide regulatory body for training and approve training programmes, training capacity and assure overall quality standards are met.

Foundation training numbers are determined by the SG and are driven by the number of medical graduates leaving university. The recent increase in medical graduates from Scottish Universities will require an increase in Foundation places in Scotland of around 40 from 2013-14.

Core and speciality training intake numbers are determined by the SG. The SG has developed a methodology to determine intakes which assesses future demand for trained doctors and matches this against supply from the training programmes on a speciality by speciality basis.

Supply is based on information from NES. NES have established Speciality Training Boards (STBs) to advise on the coordination and management of all aspects of the training programmes. STBs are chaired Associate Deans, with PG deans attending to provide advice. There is representation from Medical Directors & HR teams, as well as senior clinicians, trainees and BMA. Their membership is made up primarily of senior clinicians who lead either training or services within their boards/regions. Clinicians from NHS Lothian/SEAT will be present on all the STBs. The information from STBs will provide detail on the attrition rates from training, recruitment rates for each programme, forecasts of training outputs, etc. This information has been highly variable given the number of changes in the training programmes over the last 5-10 years.

Demand is based on workforce projections from board workforce plans, as described above. Data from ISD is also used to look at trends in trained doctor numbers by speciality and forecasted retirement/leavers rates. Intelligence on future demand is also collected from the STBs. The SG methodology also adjusts this data to reflect future employment trends i.e. given the growth in part time working it assumes a retiring consultant will need to be replaced by 1.4 to 1.6 new consultants.
The following committee structure supports the planning process.

- The National Medical Workforce Reshaping Board is jointly chaired by Tim Davison, NHS Lothian Chief Executive and John Connaghan, NHSS Director of Workforce and Performance. This group has board, training, royal college and BMA representation. Dr Gordon Birnie, Chair of the SEAT Regional Medical Workforce Group and Derek Phillips, SEAT Workforce Planning Director are members of the Board. The Board advises the Cabinet Secretary on future medical training numbers.

- The National Medical Workforce Governance Group provides the detailed work and technical advice on medical workforce issues to the Reshaping Board. It is chaired by Alison Graham, Medical Director of Ayrshire and Arran. Dr Gordon Birnie, Chair of the SEAT Regional Medical Workforce Group, Dr David Farquharson, Medical Director, NHS Lothian and Derek Phillips, SEAT Workforce Planning Director are members of the Group.

3.1.5 Regional Medical Workforce Planning

Each of the three regional planning groups (SEAT, West and North) were requested by the SG to establish regional medical workforce groups (RMWG) to support national planning and implementation of the policy to move to a trained doctor delivered service.

- The SEAT RMWG is one of three regional groups. The RMWG reports into SEAT and its remit is to advise SEAT and SEAT boards on all matters relating to the regional aspects of medical workforce planning in the context of wider workforce and clinical solutions, to provide effective partnership working between NHS Boards, the SE Deanery and the SG and to link medical workforce planning with wider workforce and service planning/ redesign solutions. Dr Gordon Birnie, NHS Fife chairs this group supported by Derek Phillips, SEAT. Group membership includes Tim Davison, Dr David Farquharson, and Dr Tracy Gillies from NHS Lothian as well as senior representatives from Borders, Fife, SE Deanery and SEAT.

- The RMWG reports into the SEAT Regional Planning Group. Minutes from the RMWG and a written update on key medical workforce issues are provided to each SEAT meeting. The chair of SEAT is rotated around the Chief Executives; the current chair is Calum Campbell, NHS Borders. NHS Lothian members of SEAT include Tim Davison, David Farquharson, Melanie Hornet, Alan Boyter, Susan Goldsmith and Alex McMahon. There is also senior representation from other SEAT boards as well as the SAS, NHS24, NES and the SG.

3.2 Paediatrics

Gaps in middle grade registrar rotas caused by maternity leave, less than full time training and out of programme training continue to 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.

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 in to child protection concerns in Lothian. This situation is particularly difficult in West Lothian.

Recruitment within paediatrics and neonatology over the last few months comprises:

One consultant paediatrician and a specialty doctor based at St John’s, both with out of hours resident shifts in the job plans.

Four clinical fellows (ST3/4 level) 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.

Two clinical fellows (ST7/8 level) in neonatology based at RIE.

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

Two further clinical fellow posts (ST1 level) where the post holders will rotate between RHSC and RIE.

One clinical fellow (ST1/2 level) based in the paediatric intensive care unit at RHSC.

This recruitment is in addition to two consultant paediatricians and three consultant neonatologists recruited in 2012 to support services across Lothian.

Unless there are unforeseen developments we anticipate being able to cover all the acute rotas over the next three months. However, in order to do this 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.

In the Community Child Health Service:

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.

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

We have recently recruited a consultant who will be based in West Lothian with a start date in the autumn. We will advertise another two consultant posts later in the year with clinical commitments split between West Lothian and Edinburgh.
Nurse advisers are being trained to take on some of the child protection work in order to develop a multidisciplinary team approach to the health component of child protection concerns but are not yet working independently.

3.3 Obstetrics & Gynaecology

The South East Scotland O&G training programme experiences a high level of gaps due to trainees going OOP for research/experience, maternity leave and less than full time working. The numbers of gaps varies on a month by month basis. The service has been heavily dependant upon locums to sustain OOH rotas, with currently 8-9 WTE gaps out of a minimum of 39 trainee slots locums employed across the region. This situation at RIE has deteriorated recently with an inability find competent external locums and some unanticipated sickness absence. This has resulted in increased internal locum usage and consultants acting down in to resident middle grade OOH shifts is now required several times a month with a consequent impact on day time availability.

NHS Lothian decided in 2012 to fund and appoint two new consultant posts and two specialty doctor posts followed by a further three consultant posts in 2013. This is in the context of a competitive recruitment situation with widespread recruitment to new consultant posts across Scotland and the UK and not all the Lothian posts have been filled. The posts include out of hours resident shifts in place of an experienced trainee.

Recruitment within obstetrics and gynaecology over the last year comprises:

Two specialty doctors based at St Johns

Two consultants based at RIE (late 2012)

Two further consultants based at RIE (appointed but still to take up post)

For the foreseeable future rotas at RIE will continue to be dependent on a mix of internal locums, external agency locums and consultants acting down in to middle grade slots. The situation at St John’s is more stable.

Should there be deterioration in the above then consultants would be required to cover any OOH gaps with the corresponding adverse impact upon “in hours” work. As a short term measure we will investigate the feasibility of appointing two fixed term clinical fellow posts (ST7/8 or post CCT level) to help sustain the service at RIE pending discussion on funding for further consultant posts. Given the experience in paediatrics it is likely that suitable applicants may only be found out with the EU and the experience gained from paediatrics will be helpful with visa and work permit issues.

The Scottish Government target for the South East Scotland O&G Training Programme is to reduce from the current 46 posts to 42 posts. A further four posts will therefore be disestablished over the next 2-3 years with the funding being returned to the service. In this context further disestablishment of posts which will reduce the pool of candidates applying for new consultant posts may need to be reconsidered.
3.4 Emergency Medicine

3.4.1 Background
NHS Lothian is facing significant challenges in maintaining safe and sustainable staffing within its three Emergency Departments.

This is an issue affecting nearly all Health Boards including NHS Lothian and is caused by two main factors. Firstly the reduction of training posts as part of Modernising Medical Careers (MMC) and secondly the difficulty in attracting applicants to the remaining Emergency Medicine trainee posts.

The current position within Emergency Medicine staffing is a product of both factors, with the inability to fill all posts due to the attrition rate at core training level for Emergency Medicine. The training numbers, have not been increased to allow for this attrition. South East Scotland have filled 80% of the allocated ST4 posts, so the current situation being faced is largely attributable to the reduction that has been planned. The model used by MMC was based on 1% growth and retiral of consultants, however the required level of growth in emergency medicine consultants is closer to 100% in Scotland to achieve College of Emergency Medicine recommendations for senior cover and a consultant-led service.

Last year, the Cabinet Secretary for Health and Wellbeing approved a pause in Reshaping in 13 specialties, including Emergency Medicine and Paediatrics. The pause was introduced in recognition of the concerns expressed by the Service in respect of the potential impact of further trainee reductions on the stability of middle grade rotas.

However, unfortunately due to the points above the pause is not able to prevent the situation currently being faced. In Emergency Medicine there is a single stream of training through core training into higher training, therefore “pausing” higher training reduction without a corresponding increase of the core training intake does nothing to change the ability to actually recruit, as the output from core training, with attrition, is the determining denominator for recruitment, and is currently too low. NHS Lothian believe that there needs to be a wider review of the intake numbers and the expectations placed upon Emergency Medicine in order to attract people into the specialty in order to make the pause most effective.

At a national level The Reshaping Governance Working Group is currently considering the next steps in respect of the 13 paused specialities and will be providing advice to the National Reshaping Medical Workforce Project Board (chaired by John Connaghan and Tim Davison) in the autumn which, in turn, will submit recommendations to the Cabinet Secretary in respect of trainee numbers for 2014 and onwards.

The reduction in the number of training posts is part of a national policy. The numbers of doctors in training in Emergency Medicine have reduced by 50% over the last 3 years across South East Scotland, with the majority of this reduction at senior trainee level. (35 in August 2010 reducing to 14 August 2013). This reduction has been proportionately spread across all sites in South East Scotland.
The number of emergency medicine trainees at St John’s Hospital will fall from 5 to 3 at the Royal Infirmary from 12 to 8 in August 2013 and at Royal Hospital for Sick Children from 9 to 4.

The distribution of the reduction is due to both the reduction in trainee numbers and the failure to recruit as mentioned above. In addition the distribution of trainees across SE Scotland is based on the specific training requirements of trainees. Trainees are not distributed to sites based on the service requirement but, are distributed based on their training needs which are set out by the Training Standards Committee of the College of Emergency Medicine. The impact is also felt most strongly on SJH because it is less able to attract specialty doctors to work in that particular Emergency Department in comparison with RIE and RHSC.

Health Boards across the UK are finding it increasingly difficult to attract applicants into acute care specialties such as Emergency Medicine. The UK vacancy rate of doctors in training in Emergency Medicine is 60%.

The model of staffing up to this point in Emergency Departments has relied on senior trainees or trained specialists to be the main senior doctor in the out of hours periods with support from on-call consultants based at home. The effect on the core staffing of the reduction in senior trainees in Emergency Medicine at SJH means that from August there can no longer be a senior trainee presence overnight at SJH Emergency Department and at the RIE as well. There are insufficient senior trainees left in NHS Lothian to provide cover at RIE, RHSC and SJH. This represents a real patient safety threat for critically unwell patients attending the Emergency Department between 2300hrs and 0800hrs if no action was taken to address it.

NHS Lothian have committed to developing over time core senior staffing in Emergency Medicine to deliver consultant-led care for unscheduled patients on all three sites. NHS Lothian are currently fulfilling that commitment.

NHS Lothian has received £250k as part of a national allocation from the Scottish Government to support funding additional consultants. This funding is being put towards recruitment of additional consultants who will be recruited in 2013/14 to supplement the existing investment made in the Emergency Medicine workforce plan. This £250k funding forms part of the national work being undertaken to support improvement in Emergency Care over the coming three years. This work includes developing the Local Unscheduled Care Action Plan (LUCAP) which was presented to the Board for approval in June and submitted to Scottish Government thereafter. At a national level work is underway to identify and disseminate best practice in improving Unscheduled Care.

3.5 Actions taken so far and options considered
NHS Lothian has repeated its commitment to ensuring 24/7 Emergency Services at RIE, SJH and RHSC.
NHS Lothian has recognised the challenge brought about by the reduction in trainees and the shortage of applicants to the remaining training posts and has taken the following steps to attempt to address this issue.
3.6 **Emergency Medicine Workforce Plan**
This has been developed and invested in by NHS Lothian to reduce the impact on the Emergency Medicine service brought about by the reduction in availability of trainees. Since 2011 it has resulted in investment specifically for St John’s Hospital in:

a. 4 additional consultants in Emergency Medicine (2 with an interest in Paediatric Emergency medicine and 1 with an interest in Toxicology)
b. 2 new specialty doctors in Emergency Medicine (however these post holders have since moved on and replacement recruitment has not been successful)
c. 3.5 additional Band 6/7 senior nurses (Emergency Nurse Practitioners)
d. 6 additional Clinical Development Fellows (new initiative)
e. Additional investment in Emergency Medicine posts on other sites which has been described elsewhere.

3.7 **Changes to St John’s Emergency Department staffing models**
Options considered have included night shift working for consultants, resident on-call for consultants and the regional re-configuration of senior trainees.

These options have been discounted at present because there are not enough consultants (even with the expansion of 10 consultants across all of NHS Lothian) to provide both daytime and night time cover. To achieve a safe reliable daytime consultant service supported by a resident consultant service would require an additional 8 consultants at SJH and 10 at RIE.

Between 23.00hrs and 0700hrs an average of 2 patients per hour attend the Emergency Department at St John’s Hospital. Of these, around 30 per cent require to be admitted to hospital. The majority of acutely unwell patients attend Emergency Departments before 23.00hrs and so consultant resource has been prioritised to ensure consultant presence for the day time (0900-2300 hrs) when their skills can be used for the greatest number of patients. For the reasons outlined above, there are insufficient senior trainees within Lothian to staff each of the sites. Re-staffing distribution is also reflective of the volumes of patients seen on the different sites (RIE 113,000 attendances, SJH 51,000 attendances, RHSC 42,000 attendances).

3.8 **Changes to St John’s Emergency Department patient pathways**
These options have included looking at the physical reconfiguration of the acute medical receiving and utilising the Hospital at Night (HaN) team to provide additional support for the Emergency Department.

These options have not been successful. The physical relocation of the Primary Assessment Area (PAA) from the second floor to next to the Emergency Department would not resolve the overnight staffing issue (although is still being considered for the medium term to improve patient pathways). The HaN team could not take on the responsibility for managing additional volume of workload in light of recent concerns about their existing workload. The existing SJH Critical Care team can provide some support to patients in cardiac arrest or those requiring immediate critical care intervention.
3.9. **Other site developments at St Johns Hospital**

There are a number of other developments happening on the St John’s site which contribute to the overall resilience of the service to deal with unscheduled care. Respiratory medicine will be increasing the consultant presence on the St John’s site (moving from 2.7wte to 4 consultants) once appointments are made. An additional locum consultant physician post in Acute Medicine will be made substantive once interviews take place in September 2013. Funding has been made available to support the increase in Nurse Practitioners as part of the Unscheduled Care funding to improve the ability to provide urgent ambulatory care in the Primary Assessment Area. In view of the success of the Outpatient Parenteral Antimicrobial Treatment (OPAT) service based at WGH a St John’s service will be available from October which will support patients who do not need to be inpatients, thereby supporting patient flow and the availability of in-patient beds.

3.10. **Other steps to influence the supply of suitable Emergency medicine workforce**

Further alternative workforce measures continue to be explored by NHS Lothian at a national level. These include seeking Scottish Government support for increasing training numbers in Emergency Medicine, seeking a review of the distribution of Foundation Year Doctors to enhance staffing levels of acute specialties, reviewing national terms & conditions for specialty doctor contracts and locum pay scales to enhance recruitment likelihood. In addition while recognising the current pressure on recruitment nationally to Out of Hours GP services, NHS Lothian continues to explore recruitment of trained GPs on enhanced out-of-hours rates to work in the Emergency Medicine.

3.11 **Planned model of care from August 7th 2013 for SJH ED:**

Based on data supplied by SAS about 999 patient activity and in light of the situation above the proposed plan from 23.00hrs on the 7th August 2013 is as follows:

1. No change for patients self-presenting to ED
2. Extension of Emergency Medicine consultant presence to 2300hrs 7/7
3. No change in Emergency Medicine consultant on call support 2300hrs-0700hrs
4. Increase in junior doctor numbers (Clinical Development Fellows) in overnight period 7/7
5. Ensure ENP presence in department 24/7
6. No change for cardiac arrests in WL catchment – all to SJH with pre-alert by SAS and hospital 2222 cardiac arrest bleep activation to ED
7. Lowered threshold for critical care call in period 2300-0700hrs to provide additional support
8. There will be no change to the pre-existing diversion protocol that has been in place successfully with the Scottish Ambulance Service for several years, however this will be reviewed in one month’s time. The following additional guidance to the model of care will be put in place to ensure that there is appropriate support for the Clinical Fellows working in the Emergency Department. These are:

   i) That the SAS pre-alert for any cardiac arrest or unwell patient that might need immediate intervention, and that Hospital at Night, or the Critical Care Team are alerted to assist in the immediate management of these patients in the Emergency Department.
ii) That there is some modification of the physiological markers to be used at triage in the ED for signposting the Clinical Fellow/FY2/GPST towards early discussion with the Emergency Medicine consultant on call who can advise on patient management.

iii) That based on this plan of action, review by Hospital at Night, Paediatric or Critical Care teams may be requested, and should be delivered wherever possible in as timely a fashion as possible (as is currently expected).

iv) That SAS are asked to divert patients with obvious requirement for procedural sedation (for example shoulder dislocation) in the overnight period as the staff in the ED and in the hospital overnight will not have the skills to safely sedate and manipulate these cases.


1. There will be a prospective audit of referral patterns, timeliness of response, emergency medicine consultant calls and call in, and critical incidents or near misses, which will be reviewed the week beginning the 2nd September 2013.

2. Work will continue towards developing a sustainable trained staffing model for all Emergency Departments in Lothian.

3. Continue to work towards closer working between Emergency and Acute Medical Receiving at the front door as a key service improvement.

5. Key Risks

5.1 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 provide a safe service in that unit.

5.2 Inadequate medical staffing of the Edinburgh Paediatric Intensive Care Unit impacting emergency admissions and complex planned surgery.

5.3 Inadequate medical staffing at the Edinburgh Neonatal Intensive Care Unit impacting on the provision of neonatal intensive care for South East Scotland.

5.4 Inadequate Emergency Medicine staffing impacting on patient safety and the ability to meet the expected Emergency Care standard.

6. Risk Register

6.1 The NHS Lothian risk register contains a “Medical Staffing” risk which will be reviewed and updated when necessary on a six monthly basis, or where there are significant changes.

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 emerge as part of the process.
8. **Involving People**

8.1 Before any planned changes in service provision across any site in NHS Lothian are made, NHS Lothian would ensure there was full engagement and consultation with appropriate audiences with the guidance of the Scottish Health Council.

9. **Resource Implications**

9.1 There are potential resource implications, which are identified as part of the planning process within specialties to reduce the level of workforce risk. These will be progressed through the appropriate local management structures to secure necessary support.

David Farquharson  
Medical Director  
17 July 2013  
david.farquharson@nhslothian.scot.nhs.uk
## SUMMARY PAPER - RENEWING NHS LOTHIAN’S VALUES

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1-3.4</td>
<td>Work to develop a new set of values and behaviours for NHS Lothian which convey the common purpose of staff in NHS Lothian has been undertaken over the last 18 months.</td>
</tr>
<tr>
<td>3.5</td>
<td>NHS Scotland has also developed a set of values which are closely mirrored in the Lothian work</td>
</tr>
<tr>
<td>3.6 Appx 1</td>
<td>It is proposed to adopt the NHS Scotland value statements, and link to these Lothian statements on behaviours we expect, examples of those that are not acceptable and commitments to staff on what they can expect from the organisation</td>
</tr>
<tr>
<td>3.7</td>
<td>The implementation actions for embedding our values and behaviours in all that we do will be developed through local engagement with services</td>
</tr>
<tr>
<td>3.9</td>
<td>Along with the values a renewed vision for NHS Lothian is proposed which will provide the context for the Strategic Clinical Framework and the developing strategic plan.</td>
</tr>
<tr>
<td>2.1-2.5</td>
<td>The Board is asked to approve the values and vision statements and to receive regular updates on progress with “living our values”.</td>
</tr>
</tbody>
</table>

Libby Tait  
Associate Director, Modernisation  
15 July 2013  
Libby.tait@nhslothian.scot.nhs.uk
RENEWING NHS LOTHIAN’S VALUES

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board agree to adopt a renewed set of values and behaviours for the organisation, and to model and promote these as part of our organisational ethos.

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

2 Recommendations

2.1 Recognise the contribution staff have made to the development of the Lothian values and behaviours, and those of NHS Scotland

2.2 Agree and adopt the values and behaviours, staff expectations, and behaviours which are not acceptable, and agree to own and support as role models

2.3 Agree to the approach to engage with teams at service and site level in order to involve them in developing an implementation plan for embedding our values

2.4 Support a new organisational vision based on the NHS Scotland Quality ambitions and 2020 vision

2.5 Agree to receive regular reports on progress and implementation.

3 Discussion of Key Issues

3.1 In an organisation like the NHS shared values are important to provide a common purpose for every member of staff whatever their individual role and responsibilities. The values that we share need to be explicitly stated to affirm how we expect to engage with patients, carers, relatives and with each other as staff members. As part of developing our organisation to meet the challenges of delivering high quality health and healthcare to the people of Lothian it was agreed in 2012 that there was a need to renew and refresh the core values held by NHS Lothian.

3.2 Between June and December 2012 through the “Values into Action” initiative nearly 12% (2,854) of the NHS Lothian workforce was involved through more than 150 meetings, workshops and staff induction sessions to help define a new set of values and ways of behaving to underpin everything we do. Staff considered the following questions:

Q1 When you come to work, what is important to you?
Q2 If you or a family member were a patient, what would be important to you?
Q3 When the NHS works at its best, what does that look like to patients?
Q4 And when working at its best, what does that look like for staff?

3.3. The outputs from this extensive staff engagement produced a number of common themes and ways of behaving which staff considered were important, resulting in a draft set of values and behaviours under the themes of caring, respect, sense of achievement, pride and team work. A further consultation during February and March 2013 confirmed support for these, with some minor changes.

3.4. Following support from NHS Lothian Staff Side Committee and the Joint Management Team a workshop was held in June 2013 involving representatives of senior management, Staff Partnership Committee, Lothian Area Clinical Forum and health board members to confirm support for the values and behaviours. This group agreed the importance of embedding these values and behaviours to delivery of our strategic clinical framework, and affirmed their willingness to identify and put in place practical steps which would put these values into action at all levels of the organisation.

3.5. In June 2013 NHS Scotland launched “Everyone Matters: 2020 Workforce Vision” based on a national staff consultation which included the input from NHS Lothian’s “Values into Action” work. This set out values shared across NHS Scotland which closely mirrored our draft version.

3.6. The detailed statements which the Board is asked to adopt, own and support are attached at appendix 1. These are:

- the NHS Scotland values, (earlier Lothian draft shown for comparison)
- the ways of behaving we expect
- examples of behaviour which is not acceptable
- commitments from the NHS on the support staff can expect to receive

3.7 The implementation of the statements across NHS Lothian will be critical to making our values live. This will be progressed through local engagement events with managers and staff across each of our main management units and sites including the four Community Health and Care Partnerships, the major hospital sites, the scheduled care directorates and corporate services. Implementation actions are likely to encompass the following, however embedding our values will require to be integrated into all our strategic plans and policies:

a) extensive use in internal and external communications
b) embedding in HR processes including recruitment and induction
c) incorporation in staff and management competencies, training, development and appraisal
d) to be the cornerstone of our organisational development plan

3.8 The values and behaviours development process took account of both staff experience as users of health services and feedback from a small number of patients. The values and behaviours are commitments to patients and the public on what they can expect from NHS Lothian and its staff. Embedding the values will be actively linked to patient and public involvement and the quality improvement work underway across the organisation including the Person Centred Care Hub and Patient Safety Programmes. An update on progress will be given at a future meeting.
It is proposed that we use this opportunity to renew the organisational vision, along with our values, as key anchor points on the NHS Lothian roadmap towards our future, closely aligned to the NHS Scotland 2020 vision. The vision is shown below, providing context for the Strategic Clinical Framework agreed earlier this year and the strategic plan in development.

<table>
<thead>
<tr>
<th>Purpose/ vision</th>
<th>Lothian Past</th>
<th>Lothian Future</th>
<th>NHS Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>at the level of Scotland’s best and among the world’s top 25 healthcare systems</td>
<td>To provide safe effective person-centred healthcare and healthier lives for all</td>
<td>Scotland’s Health Service aims to provide safe, effective and person-centred care. Our vision is that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Values</th>
<th>The Lothian Way</th>
<th>NHS Scotland Values and Lothian behaviours</th>
<th>NHS Scotland Values</th>
</tr>
</thead>
</table>

|-----------------|-------------------------------------|-------------------------------------------------|-------------------------------------|

<table>
<thead>
<tr>
<th>Strategic delivery programme</th>
<th>Specific strategies e.g. BACiL</th>
<th>NHS Lothian Strategic Plan 2014</th>
<th></th>
</tr>
</thead>
</table>

4 Key Risks

4.1 It is essential that the values and behaviours are manifested in the practical experience of staff and patients. Failure to progress practical implementation steps in all management units in the organisation could result in staff disengagement and risk poorer patient experience.

5 Risk Register

5.1 Failure to progress the work set out above will impact on the ability to mitigate corporate risks in relation to patient experience and delivery of key challenges such as waiting time targets and unscheduled care services.

6 Impact on Inequality, Including Health Inequalities

6.1 The values, behaviours and staff expectations are based on commitments agreed at national level and are focused on treating people with respect for individual choice, uniqueness and diversity. The implementation plans, as they develop, will be impact assessed to ensure they are promoting equality and supporting diverse needs.
7 Involving People

7.1 The extensive involvement of staff across the organisation which has already taken place and plans for further engagement are set out in section 3 above.

8 Resource Implications

8.1 There will be immediate resource implications in relation to the production of communication material from the recommendations in this paper. Significant personal commitment from managers and staff across the organisation will be required to change ways of working to embed the values and behaviours. If specific areas of work require additional resource this will be managed via the Joint Management Team.

Libby Tait
Associate Director Modernisation
16 July 2013
libby.tait@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Proposed NHS Lothian Values and Behaviour Statements
<table>
<thead>
<tr>
<th>NHS Scotland Values we will adopt</th>
<th>Care and Compassion</th>
<th>Dignity and Respect</th>
<th>Openness, Honesty and Responsibility</th>
<th>Quality</th>
<th>(and)</th>
<th>Teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Earlier Draft Lothian Values</em></td>
<td>Caring</td>
<td>Respect</td>
<td>Sense of Achievement</td>
<td>Pride</td>
<td></td>
<td>Teamwork</td>
</tr>
<tr>
<td>Living our values: Ways of behaving we expect</td>
<td>Demonstrate our compassion and caring through our actions and words</td>
<td>Be polite and courteous in our communications and actions</td>
<td>Build trust by displaying transparency and doing what we say we will do</td>
<td>Demonstrate a commitment to doing our best</td>
<td>Understand and value each other’s role and contribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Take time to ensure each person feels listened to, secure, understood and is treated compassionately</td>
<td>Demonstrate respect for dignity, choice, privacy and confidentiality</td>
<td>Commit to doing what is right – even when challenged</td>
<td>Encourage and explore ideas for improvement and innovation</td>
<td>Be fair, thoughtful, welcoming and kind to colleagues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be visible, approachable and contribute to creating a calm and friendly atmosphere</td>
<td>Recognise and value uniqueness and diversity</td>
<td>Welcome feedback as a means of informing improvements</td>
<td>Seek out opportunities to enhance our skills and expertise</td>
<td>Offer support, advice and encouragement to others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide a safe and caring setting for patients and staff, and an efficient, effective and seamless care experience</td>
<td>Be sincere, honest and constructive in giving and receiving feedback</td>
<td>Use our resources and each others time efficiently and wisely</td>
<td>Work together to achieve high quality services</td>
<td>Maximise each other’s potential and contribution through shared learning and development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meet people’s needs for information and involvement in all care, treatment and support decisions</td>
<td>Maintain a professional appearance</td>
<td>Maintain and enhance public confidence in our service</td>
<td>Use our knowledge and enthusiasm to implement positive change and overcome challenges</td>
<td>Recognise, share and celebrate our successes, big and small</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be a positive role model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To help you work to the best of your ability and live our values you can expect NHS Lothian to ensure that you:

- are managed fairly and consistently, with dignity and respect, valuing diversity
- are provided with a working environment which promotes your health and wellbeing
- are supported to make the best use of new technology
- have fair and appropriate access to mandatory training, learning and development opportunities
- have time for learning and are supported to develop your skills, knowledge and competence
- have a meaningful annual appraisal that helps to improve performance and encourages behaviours that reflect our core values through a personal development plan
- have the skills needed, including professional, technical and people skills
- have the tools, equipment and resources needed to work effectively
- have employment security through supportive organisational change policies and procedures
- are involved in decisions that affect you through team meetings, communications and team brief

Living our values, here are some examples of behaviour and conduct which are not acceptable:

- criticising colleagues or disagreeing with them in front of patients and relatives
- imposing personal beliefs, judgements and opinions on patients, families or staff
- blaming others or other departments for mistakes to patients and relatives
- wearing inappropriate dress or having an unprofessional appearance
- being unwilling to consider new ideas for improvement in your service
- moaning and demoralizing others without making an attempt to make things better
- failing to speak up about unsafe practice you see to your line manager
- failing to treat patients and staff with dignity and respect
SUMMARY PAPER - STRATEGIC PLANNING - NEXT STEPS

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5</td>
<td>That the next Board workshop is planned for 26 August.</td>
</tr>
<tr>
<td>3.5</td>
<td>That a session is planned with senior managers on 5 August in advance of the Board workshop to ensure that we are including all appropriate work streams and ageing recommendations for next steps against a set of agreed criteria.</td>
</tr>
<tr>
<td>3.6</td>
<td>That the Programme Office has been agreed and posts are being recruited to.</td>
</tr>
<tr>
<td>3.8</td>
<td>That a communications sub group has been established and that a communications plan and managers communication pack are well progressed and will be available by 26 August</td>
</tr>
</tbody>
</table>

Libby Tait
Associate Director, Strategic Planning
11 July 2013
Libby.tait@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the work underway and progress being made to identify key strategic workstreams, timelines and actions and to progress internal and external communication about the Strategic Clinical Framework.

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

2 Recommendations

2.1 Note the work underway to progress development of the Strategic Plan to deliver the aims of the Strategic Clinical Framework.

2.2 Note that a programme office is being established to support the development and subsequent delivery of the Strategic Clinical Framework and plan due by 14 March.

2.3 Note that a communications sub group of the Strategic Planning Group has been established, chaired by the Director of Communications and Public Relations.

2.4 Note that a communications plan along with a ‘managers communication pack’ is near final development and will be used to engage and facilitate discussions in a number of pilot areas, particularly with the new Hospital Site Directors.

2.5 Note that the next Board session on the emergent strategic plans is set for 26 August.

3 Discussion of Key Issues

3.1 At its meeting on 22 May 2013 NHS Lothian Board agreed to develop a Strategic Plan for NHS Lothian’s medium and long-term ambitions in the context of the NHS Scotland 2020 Vision, the expected growth in the Lothian population including increasing numbers living with long term conditions and constrained public sector resources. The Board has asked for the plan to be developed for approval by March 2014. Detailed work to progress this is being overseen by the NHS Lothian Strategic Planning Group and the purpose of this paper is to provide a brief update to Board Members on actions underway.

3.2 Work has commenced to collate the baseline information including the range of services currently provided on each of the hospital sites, linked to information about clinical activity, staffing levels and resource use within services.
3.3 The major workstreams underway to address our immediate strategic priorities are:

- Improving unscheduled care
- Achieving waiting time standards and sustainable elective service capacity
- Reviewing primary and community care resources and capacity
- Improving the management of long-term conditions

3.4 In addition to these immediate priorities the range of work underway to deliver agreed national strategic change service priorities, public health and health inequalities improvements, HEAT targets and efficiency and productivity work streams is also being collated to allow us to review the relative prioritisation and resource allocation across these programmes and projects.

3.5 It is intended to bring a comprehensive statement of these activities to the next Board Development Workshop on the Strategic Clinical Framework implementation scheduled for Monday 26 August 2013. In advance of this an interactive session has been arranged with senior service representatives on Monday 5 August to test the completeness of information collated, consider timescales, interdependencies and priorities, and identify leadership responsibilities and resources allocated and required.

3.6 It has been agreed to establish a Programme Office function within the Strategic Planning Directorate to lead the development of an agreed approach to planning, supporting, monitoring and reporting on the delivery of key work streams and projects, ensuring that there is a single strategic point of oversight for the extensive range of work both underway and required to deliver the organisation’s strategic objectives. The resources identified to support this function at present are:

- Associate Director, Strategic Planning - (secondment, no funding required)
- 2 x Programme managers - Band 8A, part funding required (£80K)
- Asset/Capital project manager - Band 8A, funding required (£55K)
- Admin support, 0.5WTE at band 4, funding required (£13K)

3.7 This will be provided in part from re-allocation of existing staff time, with some additional resource to be allocated for a 2 year period initially to deliver the strategic plan and establish the organisational delivery structure.

3.8 Communication, engagement and involvement of staff, patients and public, and other stakeholders will be crucial to developing, agreeing and implementing a strategic plan which delivers the changes and improvements in health and healthcare needed. A Communications sub-group of the Strategic Planning Group has been established, chaired by the Director of Communications and Public Relations, and the communication plan has been developed.

3.9 To date initial internal and external communication has taken place using established mechanisms focusing on the need for change, and the opportunities and challenges we have. More detailed engagement will now take place with staff and patient groups, at site and service level, and a manager’s “toolkit” of information has been developed which will be trialled with a number of services over July and August. This will allow more local engagement about the change and provide the opportunity to consider local proposals in an interactive way.
4 **Key Risks**

4.1 Failure to progress the work set out above will impact on the delivery of the corporate objectives in the current year, and the ability to achieve the aims of the Strategic Clinical Framework.

5 **Risk Register**

5.1 Failure to progress the work set out above will impact on the actions to mitigate many of the corporate risks, particularly in relation to the delivery of patient services, financial targets, and capital plans.

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

6.1 An impact assessment was carried out on the Strategic Clinical Framework, and will be undertaken on specific proposals, workstreams and plans as these are identified.

7 **Involving People**

7.1 The arrangements to involve people are summarised above and will be developed and led by the Communications Sub-group of the Strategic Planning Group.

8 **Resource Implications**

8.1 The immediate resource implications are set out in 3.6 above. The resource implications of specific change programmes and projects will be developed through individual business cases.

---

**Libby Tait**  
**Associate Director Modernisation**  
**11 July 2013**  
[libby.tait@nhslothian.scot.nhs.uk](mailto:libby.tait@nhslothian.scot.nhs.uk)
**SUMMARY PAPER - WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT**

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

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

| 3.1 | At the end of June, 303 patients waiting for procedures covered by the treatment time guarantee remained on the waiting list over 12 weeks |
| 3.2/3.3 | Ongoing difficulties in capacity related last month for Ophthalmology are now beginning to impact on numbers over 12 weeks, masking an underlying improvement in areas, such as neurosurgery and plastics |
| 3.5 | 95.8% of patients treated in June were seen within the 12 week treatment time guarantee. 338 patients waited over this threshold in the month, of whom 190 have been admitted or no longer require treatment, 114 have dates identified or are with external providers to find a suitable date and 11 are unavailable. Arrangements for the remaining 23 are being explored. |
| 4 | The outpatient position over 12 weeks improved in June to 2614. Neurology and Urology saw improvements, while Colorectal, Ophthalmology, Chronic Pain and Rheumatology did not. The Ophthalmology position will continue to be challenging. |
| 5 | Figures are not available at the time of writing for diagnostics, surveillance, 18 Weeks, CAMHS and Psychological Therapies for the month of June. These will be provided verbally if possible |
| 6 | Action is being taken to reduce long waits for those areas not covered by a standard. Progress on cystometrograms (CMG/VCMG) and sacral nerve stimulation will feature in future reports |
| 7 | Changes to the derivation of waiting time figures could introduce discontinuities in reported inpatient and outpatient figures from July onwards. This will be highlighted as appropriate in the next board report. |
| 3.8 | Activity information is included in the paper covering the Financial Position |

Andrew Jackson
Associate Director, Strategic Planning
22 July 2013
Andrew.C.Jackson@nhslothian.scot.nhs.uk
WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on recent performance on waiting times and outline proposed further investment to support sustainable delivery.

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

2 Recommendations

2.1 Receive this update on performance and progress on inpatient and outpatient waiting times;

2.2 Note that activity information has been included in the report on the Financial Position elsewhere on the agenda;

2.3 Request a verbal update on the latest position with respect to other areas;

2.4 Note work that has been commissioned to address areas with long waits not reported under national standards; and

2.5 Acknowledge that, with alterations nationally to reporting requirements and the Board’s decisions on the local access policy, the derivation of the figures reported for inpatient and outpatient waits from July 2013 onwards will change, leading to some discontinuities with figures reported to date.

3 Inpatients and Daycases

3.1 Table 1 outlines the recent trends in the unavailability, waiting list size and numbers waiting over 9 and 12 weeks since April 2012. Of those over 12 weeks, 303 were for procedures covered by the treatment time guarantee (May: 302)

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 12 Weeks</td>
<td>2000</td>
<td>1948</td>
<td>1963</td>
<td>1638</td>
<td>1932</td>
<td>1029</td>
<td>899</td>
<td>703</td>
<td>568</td>
<td>451</td>
<td>422</td>
<td>310</td>
<td>381</td>
<td>441</td>
<td>430</td>
</tr>
<tr>
<td>Over 9 Weeks</td>
<td>2670</td>
<td>2671</td>
<td>2467</td>
<td>2196</td>
<td>1969</td>
<td>1477</td>
<td>1387</td>
<td>1160</td>
<td>984</td>
<td>1086</td>
<td>895</td>
<td>792</td>
<td>722</td>
<td>896</td>
<td>998</td>
</tr>
</tbody>
</table>

3.2 As indicated last month, the number of patients over 12 weeks was expected to remain static, although difficulties were highlighted in Ophthalmology. Board members will recall this specialty had experienced problems with sourcing staffing
to support theatre sessions on the “see and treat” pathway, impacting on both inpatient and outpatient capacity by approximately 200 patients. Provisional management information shows that this capacity loss is now feeding through (Figure 2), masking, along with to an extent Urology, an underlying improvement in performance for other areas. As one would expect recovery plans are being implemented in these areas.

3.3 The specialty breakdown in appendix one highlights the reduction of waits over 12 weeks in most markedly in recent months in neurosurgery and plastics.

3.4 As related at the last Board Meeting, the see and treat pathway recommenced at the end of June and capacity continues to be sought externally to address the shortfall.
3.5 95.8% of patients treated in June were seen within the treatment time guarantee. 338 patients waited over this threshold in the month, of whom 190 have been admitted or no longer require treatment, 114 have dates identified or are with external providers to find a suitable date and 11 are unavailable. Arrangements for the remaining 23 are being explored.

3.6 Table 2 below identifies the areas where unavailability was applied where those on the inpatient waiting list only wished to be seen by certain consultants or at particular hospitals, most likely having refused an offer elsewhere or with someone else. The Scottish Parliament’s Public Audit Committee highlighted this as an area to be monitored as it could highlight “pressure points” in service delivery.  

Table 2 – Inpatients with Unavailability “Patient Choice” Codes – June 2013

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Patient Advised - requests specific consultant</th>
<th>Patient Advised - requests specific location</th>
<th>Patient Advised - requests specific location Total</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Roodlands Hospital</td>
<td>Royal Infirmary of Edinburgh</td>
<td>Western General Hospital</td>
<td></td>
</tr>
<tr>
<td>Edinburgh Breast Unit</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Trak

3.7 At the last board meeting, when no activity figures had been included, it was asked that this detail be reinstated. These tables had initially featured in this previous versions of paper to the board and subsequently in the report on Financial Position.

---

1 This weekly timeline takes an immediate “snapshot” on the waiting list. It will overstate the overall position over 12 weeks due to the time delay in updating the system for patients attending external providers.

2 http://www.scottish.parliament.uk/S4_PublicAuditCommittee/Reports/paur-13-03w.pdf p.17
3.8 Board members should note that activity information can be found in appendix 3 of the Finance paper for this meeting.

4 Outpatients

4.1 Table 3 outlines the recent trends in the unavailability, waiting list size and numbers waiting over 9 and 12 weeks since April 2012 while Figure 3 shows similar information, starting a year previously.

### Table 3 - Outpatient Waiting List Trend

<table>
<thead>
<tr>
<th></th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 12 Weeks</td>
<td>4418</td>
<td>4605</td>
<td>5177</td>
<td>5669</td>
<td>4982</td>
<td>3627</td>
<td>3176</td>
<td>2655</td>
<td>2856</td>
<td>2942</td>
<td>2869</td>
<td>2426</td>
<td>2241</td>
<td>2147</td>
<td>2614</td>
</tr>
<tr>
<td>Available</td>
<td>39418</td>
<td>38541</td>
<td>38887</td>
<td>39346</td>
<td>39145</td>
<td>38226</td>
<td>37933</td>
<td>36917</td>
<td>36453</td>
<td>38012</td>
<td>38480</td>
<td>39745</td>
<td>39026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unavailable</td>
<td>963</td>
<td>1044</td>
<td>1060</td>
<td>1204</td>
<td>921</td>
<td>790</td>
<td>750</td>
<td>695</td>
<td>923</td>
<td>840</td>
<td>753</td>
<td>770</td>
<td>847</td>
<td>858</td>
<td></td>
</tr>
<tr>
<td>Waiting List Size</td>
<td>40381</td>
<td>39585</td>
<td>39947</td>
<td>40559</td>
<td>40664</td>
<td>39022</td>
<td>39230</td>
<td>38626</td>
<td>37840</td>
<td>37293</td>
<td>37493</td>
<td>38765</td>
<td>39250</td>
<td>39598</td>
<td>39884</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>2.4%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>3.0%</td>
<td>2.3%</td>
<td>2.0%</td>
<td>1.9%</td>
<td>1.8%</td>
<td>2.4%</td>
<td>2.3%</td>
<td>2.0%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.1%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

#### Figure 3 - Outpatient Waiting List Trend

4.2 The position at the end of June improved as anticipated last month, some specialties notably so, such as Urology and Neurology.

4.3 Continued challenges are anticipated in the areas highlighted at the last board meeting – Colorectal Surgery, Ophthalmology and, to a lesser extent Chronic Pain. Rheumatology also continues to be an area of focus.

4.4 The situation in Ophthalmology was outlined to the board last month where the necessary use of available capacity for those review patients, not covered by a
standard but of higher clinical priority, is exacerbating the capacity constraints for those seeking a new outpatient appointment.

4.5 This, plus the consequences over the break in see and treat provision, referred to in 3.2, are expected to result in an increase in outpatient numbers overall before further additional capacity is in place.

4.6 Table 4 shows the equivalent breakdown of areas of unavailability as described in 3.6, but for outpatients.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Patient Advised - requests specific consultant</th>
<th>Patient Advised - requests specific location</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleft Lip and Palate Service</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fertility and Rep Endocrine Centre</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Renal Medicine</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

5 Other Reported Waiting Times

5.1 Final figures are not available for a number of areas normally highlighted in this report to the board. Those concluded by the Board meeting will be related verbally.

5.2 Those outstanding are:
   o Diagnostic Waiting Times
   o Endoscopy Surveillance Waiting Times
   o CAMHS and Psychological Therapies

5.3 It is also intended that in future reports, this paper will include an update on performance against the 18 week RTT, previously included in the Performance Report. The figure for June is not expected to be available by the Board meeting. May’s figure of 86.4% was below the 90% level expected by Government.

5.4 As the 18 week target is a composite of outpatient, inpatient and other stage of treatment waits, Lothian’s performance in this area reflect the challenges associated with tackling the largest waiting time recovery exercise ever undertaken by a Health Board.

6 Waits not reported under a standard

6.1 As Board members will recall, an assessment was made of services not reported under nor covered by standards to identify where long waits existed. Many of these have been subject to investment to improve the situation over recent months, some – such as DEXA – were highlighted in last month’s board paper as components of “tranche 2” – others, such as sleep studies, in the months before that.
6.2 However two remaining areas require particular support with waits identified in excess of a year.

6.3 One is for diagnostic tests in urology which assess lower urinary tract dysfunction using pressure flow tests such as cystometrogram (CMG) and videocystometrogram (VCMG). This waiting list has been held on paper to date is in the process of being validated and transferred over to trak. With accurate information resulting from this exercise, the service will be better placed to anticipate timescales for shortening the wait and to put the necessary capacity in place, some sources of which have been identified. Although subject to further assessment, waiting times are anticipated to be near to 11 weeks in early 2014.

6.4 The second area is sacral nerve stimulation, a care pathway involving testing and subsequently implanting a device which can overcome faecal incontinence. As with the previous case, these cases are not held on a central waiting list and thus the same process of validation and mitigation to trak is being commissioned. Alternative capacity options are being explored and confirmation of these options will allow the recovery timescale to be concluded.

6.5 The ongoing status of recovery in these areas will feature in future board reports.

7 Changes in Approaches to Reporting Inpatient and Daycase Performance

7.1 The process for sourcing and reporting performance on waiting times was reviewed following the PricewaterhouseCoopers report in March 2012. At that time, the decision was taken to draw the information from the National Data Warehouse maintained by ISD. Data was extracted from the warehouse based on pre-defined queries constructed by ISD to replicate data which would appear in tables published nationally by ISD and to populate the Monthly Management Information (MMI) report which is to be submitted routinely to the Government.

7.2 Two recent events are requiring a change to this approach to reporting.

7.3 Firstly, the Health Department confirmed this month that the MMI report is to change for reporting performance nationally for the period July onwards. This will alter the breadth of the figures covered in the MMI submission – for example – excluding those patients, apart from those waiting for treatment for spinal conditions, not covered by the treatment time guarantee. 61 patients over 12 weeks reported in Table 1 earlier would fall into this category.

7.4 Secondly, as the Board recall in May when considering the Access Policy, it was agreed to move the notice period for a reasonable offer from 7 to 14 days in line with the best practice outlined in CEL(2012)33. This move is being implemented from August as agreed.

7.5 Discussions undertaken with ISD over the potential for whether this local adoption of best practice is likely to be reflected in waiting time calculations in the national data warehouse and in resulting reports on Lothian’s waiting time performance. This currently appears unlikely that this will be so.
7.6 It is therefore expected that the practice over the last year on reporting will need to alter from this point. Information is likely to be sourced directly from Trak, rather than via the Warehouse as was seen as preferable.

7.7 These changes are expected to introduce discontinuities in the next report to the Board. These will be highlighted to board members.

Andrew Jackson
Associate Director, Strategic Planning
22 July 2013
Andrew.C.Jackson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Trend in reported Waits

Please note activity information is reported in the Finance Report elsewhere on the Board agenda.
Trend in Long Waits 3

APPENDIX 1

BREACHES OF WAITING TIME STANDARDS REPORTED ON MONTHLY MMI RETURNS
Inpatients/day cases > 12 weeks

Urology
Neurosurgery
Plastic Surgery
Ophthalmology
General Surgery
ENT
Scoliosis
Gynaecology
Maxillofacial/Oral
Gastroenterology
Respiratory
Vascular Surgery
Orthopaedic Surgery
Others
Total > 12 weeks

95
291
693
903
854
729
4
14
22
28
26
2
34
104
199
409
470
5
6
31
148
343
411
326
250
21
109
134
172
229
305
324
210
195
176
178
63
60
68
70
62
70
67
67
65
67
62
58
2
5
34
39
10
10
33
61
105
131

63

81

177

204

234

299

500

53
17

132
88

134
134

136
106

92
29

950

1687

2160

2246

1979

Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13 Feb-13
673
598
593
536
430
361
277
216
182
102
103
30
40
31
35
21
21
30
41
55
79
88
573
625
696
561
524
361
314
238
203
116
97
18
28
40
46
38
23
19
7
2
2
9
218
190
177
131
99
58
64
60
30
35
31
192
201
170
141
134
85
67
45
25
29
10
56
52
57
52
49
35
35
35
31
30
23
11
14
10
9
9
7
14
11
7
22
30
110
120
140
117
107
54
39
20
15
7
8
6
19
22
20
6
4
4
4
1
4
1
27
1
1
1
1
2
1
0
2
3
53
34
15
3
4
4
4
7
1
3
2
29
23
10
2
6
10
11
3
3
8
4
4
3
1
4
4
6
13
15
13
12
13
2000
1948
1963 1658
1432
1029
893
703
568
451
422

Mar-13
47
77
70
9
43
12
22
23
6
1
0
1
7
12
330

Apr-13
52
94
80
13
63
6
26
17
6
1

Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13 Feb-13
844
965
1099 1080
972
493
407
393
441
491
670
103
105
111
60
96
130
123
136
134
187
210
1464
1506
1647 1610
1642
1265 1190
705
763
669
696
299
405
539
562
477
430
290
207
159
220
233
20
134
202
210
171
200
208
309
335
351
352
6
22
43
53
86
70
54
10
1
3
13
13
44
46
41
63
70
87
115
93
176
856
757
808
914
887
464
244
219
284
285
103
41
12
16
19
25
38
48
49
54
59
81
405
258
230
202
225
202
183
184
168
148
98
7
21
48
38
43
45
56
57
93
38
33
18
7
84
160
210
90
136
231
170
134
73
58
101
74
36
33
26
33
61
73
27
100
42
15
13
11
63
13
17
14
14
14
17
21
25
25
32
38
36
2
2
2
0
2
0
1
29
31
29
28
26
17
14
19
19
16
15
5
5
10
7
9
10
14
14
9
4
3
3
9
8
5
8
20
78
9
7
2
76
0
0
17
17
54
39
49
38
51
48
43
24
23
7
2
3
5
5
5
5
6
3
3
0
1
2
6
12
10
8
5
10
12
12
10
11
4418
4601
5177 5069
4962
3627 3176
2635
2856
2942
2869

Mar-13
579
156
596
217
266
84
148
94
77
40
23
42
20
3
39
3
14
3

Apr-13
483
215
528
161
275
20
141
111
81
19
35
21
34
13
60
6
9
8
9
9
2
1

3
2
18
381

May-13
99
84
63
36
40
27
22
15
4
2
22
4
2
21
441

Jun-13
112
68
66
45
37
28
20
15
6
6
3

May-13
592
303
490
199
259
214
141
137
88
56
71
14
35
15
30
38
9
16
5
5
3
2
25
2747

Jun-13
611
360
359
353
182
150
142
135
62
58
52
26
25
23
12
8
7
6
5
5
4
3
26
2614

24
430

Outpatients > 12 weeks
General Surgery
Rheumatology
Urology
Ophthalmology
Neurology
Pain control
Neurosurgery
Gastroenterology
Gynaecology
Orthopaedic Surgery
Med specialties
Respiratory - sleep
ENT
Plastic Surgery
Rehabilitation
Vascular
Scoliosis
Paediatrics
Other CTR
Dental specialties
Oral & Maxillofacial
Geriatric Medicine
Other
Total > 12 weeks

3

3
68
363
667
873
779
3
135
331
337
320
167
3
43
791
1226
1421
1403
2
88
25
63
103
4
47
118
153
232
217
1
1
2
2
23
28
25
6
5
6
13
2
7
0
5
226
654
808
909
848

124

34

39

29

120

28

76

26

117

31

283

23

23

50

608

806

856

616

3
16

26
47

79
53

61
3

1
69
16

462
0
1
86
21

19

29
25

90
29

55
37

51
42

0
37

3

1

0

6
112

3

24

18

43

18

8
1278

5
3348

4230

4607

1
4042

10
2
0
10
2426

2241

Historical figures relating to levels of attainment of the waiting times standard and levels of patient unavailability are known to be inaccurate.
Further information can be found in the Pricewaterhouse Coopers report published in March 2012. (http://www.scotland.gov.uk/Resource/0039/00390166.pdf)


The Board is asked to accept proposals from Consort for an amnesty from deficiency points for the Supplemental Agreements for Additional Beds, Renal Works and Chancellor's Building.

Consort have requested this amnesty as a result of a concern raised by their lenders that there is greater potential for defects to arise from construction on site and this may impact on Consort's ability to deliver its service obligations.

Deficiency points are applied to Consort when a service failure or unavailability occurs. The amnesty would only apply where there is a service failure as a consequence of defects in the additional works and not in relation to other aspects of poor performance. For all the additional works completed so far there have been no deficiency points due to construction fault.

This may put the Board in a worse position in terms of the contract with Consort and create a “patchwork” of arrangements for remedy of defects across the RIE. However the potential detriment is small, and there could be further risk mitigation creating a protocol for further change and incentives to assist with timely rectification.

There is an urgent requirement to deliver the additional beds, and a pipeline of other changes to support the development of RHSC/DCN and our strategy for capacity expansion. Any challenge to whether Consort have a contractual right to an amnesty is likely to be expensive, time consuming and would significantly delay these essential developments.
LITTLE FRANCE CAMPUS REDEVELOPMENT

1  Purpose of the Report

1.1 The purpose of this report is to update the Board on the most recent proposals received from Consort in relation to the Supplemental Agreement arrangements for changes to the Renal Unit, the provision of additional beds and changes to the Chancellor’s Building. In particular the paper addresses the key risks for the Board.

2  Recommendations

2.1 To note the contents of the paper.

2.2 To accept the proposals at this time for the Additional Beds, Renal Works and the Chancellor’s Building and instruct the Director of Finance to continue dialogue with Consort and their lenders with an objective to achieve betterment for future Supplemental agreements (SA).

3  Discussion of Key Issues

3.1 The Royal Infirmary of Edinburgh is operated under a Private Finance arrangement. The operational start date for this contract was February 2003 and the 25 year tenure of the Project Agreement comes to an end in February 2028, with an opportunity to extend for a secondary period.

3.2 Although NHS Lothian’s contractual arrangement is with Consort, governed by a Project Agreement, Consort is a Special Purpose Vehicle. It is funded by Lenders (11 Banks) and Investors/Shareholders (Balfour Beatty Capital and Barclays Infrastructure Funds). Consort in turn delivers its obligations for service delivery through Balfour Beatty Workforce and Meteor for Facilities Management and Lifecycle maintenance, and through a Construction Contractor for additional works. The Construction Contractor for the majority of the Additional Beds works is Balfour Beatty Construction Scottish & Southern Limited (as agent for and on behalf of Balfour Beatty Group Limited).

3.3 The Board and Consort require to agree Supplemental Agreements (SA’s) to the Project Agreement for RIE to allow for variations for additional works including those in the Chancellor’s Building (on behalf of the University).

3.4 The purpose of the Supplemental Agreement is to record the terms agreed for the variations and to vary the terms of the Project Agreement. Eight such SA’s have been signed to date, including the transfer of land (SA6) and the Enabling Works (SA7) for the RHSC/DCN development. Others cover the Birthing Centre (SA5), the Anne Rowling Centre (SA4) (on behalf of the University).
3.5 In addition to these current SA’s there is a further pipeline being prepared to deliver additional beds in the Medical Assessment Unit, and the clinical enabling works integral to the operation of the new RHSC/DCN hospital. The Board is also developing its Clinical Strategy, which will address how each of our main three acute sites can be further developed to support the capacity expansion essential to NHS Lothian.

3.6 Consort have now stated that the lenders have a concern that there is additional risk relating to variations, and that this concern can be alleviated if an amnesty from deficiency points for additional works is agreed. This concern relates to the potential for defects to arise from the construction required to deliver the additional works and the subsequent impact this may have on Consort’s ability to deliver its service obligations under the Project Agreement.

3.7 Deficiency Points (DP’s) are applied to Consort when a service failure or unavailability occurs, alongside a financial penalty. DPs can mount up until they reach a threshold that could lead to termination of the Project Agreement with Consort, although Consort are able to seek to rectify this by terminating their sub-contractors first if the fault lies with them.

3.8 This amnesty takes the form of an exemption from DPs and the Service Performance score. There would still be a right to apply financial penalties in certain circumstances up to an agreed cap for each contract year. For clarity, the amnesty would only apply to the additional works and specifically where there is a service failure as a consequence of defects in the additional works carried out (and not issues arising from other aspects of poor service or unavailability) and for a limited period of time (5 years from practical completion of the additional works).

3.9 The concept of an amnesty has been agreed previously in SA7, recognising the Enabling Works were largely external to the RIE and facilitating the development of the RHSC/DCN and SA8 lab cooling works. This was in relation to some very minor value works (£50K), and the amnesty is maintained throughout the remaining tenure of the project agreement.

3.10 In this instance Consort are asking that the Board accepts a permanent amnesty in the Renal SA, because the SA is being done retrospectively i.e. the works have been carried out with no lender involvement so they perceive a higher risk, and an amnesty of 5 years for the Additional Beds SA and the University of Edinburgh DCN SA. The latter delivers the changes to the Chancellor’s Building required for relocation of the DCN academic department.

3.11 The advice of both the Board’s legal and financial advisers has been sought and the options for the Board considered. Discussions have also been held with Scottish Futures Trust and colleagues from Scottish Government. Scottish Government colleagues have expressed the view that any amnesty should be limited in terms of both scope (directly related to the works undertaken) and time limited. Although consideration has been given to whether Consort have a contractual right to require this amnesty, the reality of challenge will be expensive and time consuming and more importantly will add significant delay to the creation of the additional capacity required on the site and the clinical enabling works required to deliver the RHSC/DCN. It may also compromise future development on the site.
4 Key Risks

4.1 If the Board accepts the amnesty or removal of deficiency points arising from a change, it is put in a “worse position” which goes against the Project Agreement mechanism. However, the potential detriment is small, and in reality both parties find the change mechanism impractical for anything other than minor changes.

4.2 As further works are undertaken on the site, a “patchwork” of arrangements for remedy of defects across the RIE is created making the Project Agreement more difficult to manage. However this could be mitigated by the creation of a protocol for future changes including putting in place other protection for the Board. It is proposed to test this with a smaller variation and to work closely with Scottish Futures Trust on this matter.

4.3 If the Board rejects the proposal this would stall any progress with the variation for the additional beds on the RIE site when this is urgently required to support activity levels. In addition, the Board requires Consort to deliver clinical enabling works which are integral to the RHSC/DCN project and to be able to negotiate further essential capacity requirements.

4.4 Since the commencement of the Project Agreement there have been other developments on the site. For all the additional works completed so far there has been no application of unavailability, or deficiency points due to a construction fault. Therefore having regard to previous additional works outcomes the risk to the Board in accepting the amnesty would appear small.

4.5 The next steps include the Board accepting the amnesty on deficiency points for Renal, Additional Beds and changes to the Chancellor’s Building, and tasking its negotiating team to continue dialogue on subsequent SA’s. There would also be a requirement that Consort put in place some additional incentive to assist with timely rectification should a defect arise. The Board would still retain a step in right captured in clause 21.6 which can be used when there is a Consort failure that gives rise to health and safety or clinical concern. This would be at our cost and we would have to demonstrate negligence should we choose to recover costs.

5 Risk Register

5.1 A risk register has been compiled for the additional beds contract and can be provided if necessary.

6 Impact on Health Inequalities

6.1 No inequalities impact assessment has been carried out, as it was viewed to be not necessary at this time.

7 Impact on Inequalities

7.1 An impact assessment has not been carried out, as it was viewed not necessary at this time.
8 Involving People

8.1 The above information and negotiations thus far have been conducted in a collaborative manner. Discussions have included the following parties, Staff side representation the project leads for the RHSC/DCN, Consort Healthcare and both our own and Consorts legal representatives.

8.2 A legal opinion and further reassurance has been sought from MacRoberts LLP, our project legal advisors. A copy of their advice and reassurance is available to Board members if required.

9 Resource Implications

9.1 The resource implications are not relevant unless the Board wish to challenge Consort. The estimated legal costs of this would require to be assessed separately. Legal fees associated with these most recent SA’s are within already approved capital investments.

Susan Goldsmith
Director of Finance
16 July 2013
Susan.Goldsmith@nhslothian.scot.nhs.uk
**LEGIONNAIRES’ DISEASE OUTBREAK IN EDINBURGH JUNE 2012**

This paper aims to summarise the key points in the full paper. The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further analysis has revised the number of confirmed, probable and possible cases 101 to 92, and confirmed cases from 53 to 56.</td>
<td>3.1</td>
</tr>
<tr>
<td>Over 1000 people were investigated and treated in primary care. There were 45 hospital admissions, 22 patients were admitted to intensive care.</td>
<td>4.1, 4.2 of interim report</td>
</tr>
<tr>
<td>70% of confirmed cases had a serious underlying medical condition, most were of working age.</td>
<td>2.3.5 of interim report</td>
</tr>
<tr>
<td>Four people died. The overall mortality rate was 4.3% overall, 7.1% in confirmed cases. Average mortality in European outbreaks in 2010, 10.1%</td>
<td>2.3.2 of interim report</td>
</tr>
<tr>
<td>The results are consistent with a common outdoor exposure with an estimated release end date of May 30.</td>
<td>2.3.8 of interim report</td>
</tr>
<tr>
<td>Further investigations which use new techniques involving whole genome DNA sequencing are currently being undertaken to generate information that might provide information on the timing and geography of likely acquisition by individual patients. Health and Safety enforcing authorities are investigating the circumstances of the deaths under the direction of the Crown Office and Procurator Fiscal Service Health and Safety Division.</td>
<td>3.3, 3.4, 7.2</td>
</tr>
<tr>
<td>Prompt, effective action was taken by experts from different agencies who combined efforts over an extended period. Authorities, including NHS Lothian, must practise sustaining a response of this nature and scale in future.</td>
<td>2.1-2.5</td>
</tr>
<tr>
<td>The direct costs of the outbreak to NHS Lothian were a minimum of £725,800 – the ability and authority to deploy resources rapidly is essential.</td>
<td>4.4</td>
</tr>
<tr>
<td>Rapid and ongoing communication with clinicians and public is vital; a suite of templates and procedures should available in advance for routine use.</td>
<td>2.5, 8.3</td>
</tr>
<tr>
<td>Current health protection guidance should be updated to reflect the current regulatory frameworks that impact on outbreak investigation and reporting.</td>
<td>2.1, 8.4</td>
</tr>
<tr>
<td>Guidance should be updated to incorporate common approaches to the recording and reporting of complex investigations across agencies.</td>
<td>2.1, 8.4</td>
</tr>
</tbody>
</table>

Professor Alison McCallum  
Director of Public Health and Health Policy  
23 July 2013  
Alison.mccallum@nhslothian.scot.nhs.uk
LEGIONNAIRES’ DISEASE OUTBREAK IN EDINBURGH JUNE 2012

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on recommendations and actions being taken following the Edinburgh Legionnaires’ outbreak which occurred in June 2012 and to provide the Board with an overview of the epidemiological and microbiological investigations. The focus of the attached report is the epidemiological and microbiological investigation and the impact on NHS Lothian. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Board is recommended to support staff in NHS Lothian and other agencies involved in managing the response and investigations into the outbreak to take forward the following actions:

2.1 Revise the Health Protection Network guidance to reflect current best practice and organisational arrangements regarding the responsibilities of regulators, other agencies and expert bodies to advise and/or address issues such as sampling (techniques and reporting results) and processes to be followed whether there is a potential for future investigation of the attribution of corporate responsibility, including homicide. **Lead:** Health Protection Advisory Group to advise Chief Medical Officer and Scottish Directors of Public Health Group on recommendations.

2.2 Develop a common approach to the recording of complex microbiological and environmental information across agencies such as the Health and Safety Executive, Local Authority Environmental Health and Scientific Services and National Reference Laboratories. **Lead:** Health Protection Advisory Group to advise Chief Medical Officer and Scottish Directors of Public Health Group on recommendations.

2.3 Review resources and facilities required for emergency planning and resilience to ensure that all agencies involved in the management of a major outbreak can respond formally to a major outbreak in a timely manner and maintain their response as required. **Lead:** All agencies involved to review against updated Scottish Government and United Kingdom guidance during 2013.

2.4 Rehearse the local multi-agency major outbreak plan on an annual basis and regularly review roles and agree tasks within and across agencies within the framework of the Joint Health Protection Plan. **Lead:** NHS Lothian and all partner agencies.
2.5 Develop a suite of templates/procedures to support rapid distribution of information to patients, public and professionals by all appropriate means.

**Lead:** NHS Lothian in line with Health Protection risk communication and Scottish Government guidance

3 Discussion of Key Issues

3.1 In June 2012, NHS Lothian led the incident management team that responded to one of the United Kingdom’s largest outbreaks of Legionnaires’ disease. Following detailed epidemiological analysis of the cases, the total number of confirmed, probable and possible cases has been revised from 101 to 92, with the total number of confirmed cases increasing from 53 to 56.

3.2 Epidemiological analysis indicates that the locally co-ordinated public health, environmental and clinical response helped prevent ongoing exposure of the population and mitigated associated mortality and morbidity.

3.3 Findings from the environmental investigations carried out have not yet been conclusive in identifying the exact source of the outbreak. Further investigations which use new techniques involving whole genome DNA sequencing are currently being undertaken to generate information that might provide information on the timing and geography of likely acquisition by individual patients. Similar sequencing may be possible on Legionella DNA isolated from environmental water samples. It is hoped that this detailed investigation will establish a relationship between the patient and environmental samples.

3.4 Health and Safety enforcing authorities are investigating the circumstances of the deaths under the direction of the Crown Office and Procurator Fiscal Service Health and Safety Division.

4 Key Risks

4.1 Preventable major infectious disease outbreaks can occur suddenly and adversely affect the health of local residents and visitors to the area. The key risk for NHS Lothian is the potential for insufficient capacity across the organisation to respond to a major infectious disease outbreak and to sustain an effective and appropriate response without compromising other aspects of the service.

4.2 Primary care emergency/business continuity plans are being updated to address the situation in which practices that provide mutual aid are also affected by an incident or outbreak. Primary care capacity is also being reviewed to take account of the increasing size and changing needs of the population.

4.3 Refresher training in emergency planning for major incidents and outbreaks is planned for the Joint Management Team during Autumn 2013 to reflect lessons learned and updated guidance.
5 Risk Register

5.1 NHS Lothian is a Category 1 responder under Civil Contingencies Act 2004. This issue is covered under the Corporate Risk Register as part of our preparedness in emergency planning.

5.2 Papers on clinical staffing have been presented to the Board but formal assessment of all areas is not complete.

6 Impact on Inequality, Including Health Inequalities

6.1 This outbreak occurred in an inner-city, relatively deprived area of Edinburgh.

6.2 The risks of outbreaks of communicable disease, exposure to environmental hazards and major incidents is greater for individuals and in areas that are less affluent.

6.3 Legionella infection is more likely to occur in people who are immuno-compromised or who have chronic cardiovascular or respiratory disease; not all of this population would consider themselves as disabled, though NHS Lothian would have a legal responsibility to ensure that services made reasonable adjustments to facilitate assessment, treatment and follow up by primary care and specialist services.

6.4 Although not a feature of this outbreak because of its locus, the preliminary data from the case control study indicate that, in addition to the expected socioeconomic gradient, people who are homeless or insecurely housed are at greater risk of exposure to potential future outbreaks of Legionella infection because of the greater prevalence of risk factors and time spent outdoors.

7 Involving People

7.1 During the outbreak, leaflets were distributed to all residents in the affected areas. Information was provided to the public via daily updates to the press and media involvement. NHS 24 responded to queries from members of the public and referred specific concerns to the Health Protection Team for response. The Health Protection Team also responded to queries and concerns raised by members of the public directly.

7.2 Since the Legionnaires’ outbreak in 2012 the local community in south west Edinburgh has been engaged in follow up epidemiological studies in order to inform the management of any future Legionnaires’ outbreaks.

8 Resource Implications

The resource implications are linked to the actions outlined above and include:

8.1 Ensuring resilience within NHS Lothian for the management of major outbreaks of infectious diseases, particularly the escalation of primary and secondary care, and the escalation of microbiological and public health services.

8.2 Ensuring at least annual rehearsal of the major outbreak plan across multi-agencies in Lothian.

8.3 The implementation of distribution networks for public information (for instance, rapid distribution of public information leaflets).
8.4 Supporting timely development and implementation of guidance by expert Public Health bodies including the Health Protection Network.

Dr Janet Stevenson
Consultant in Public Health Medicine
22 July 2013
Janet.stevenson@nhslothian.scot.nhs.uk

Dr Richard Othieno
Consultant in Public Health Medicine

Professor Alison McCallum
Director of Public Health and Health Policy
22 July 2013
Alison.mccallum@nhslothian.scot.nhs.uk

List of Appendices:

Appendix 1: Legionnaires’ Disease Outbreak June 2012 Summary of Results of Epidemiological and Microbiological Investigation - Interim Report 2013
Executive Summary

This is the second interim report of the Edinburgh Legionnaires’ outbreak in June 2012. It focuses on the investigations carried out, impact on NHS Lothian and recommendations from the Incident Management Team.

Investigation of the outbreak involved epidemiological and microbiological analysis, temporal and spatial modelling of patient and weather data and environmental sampling and analysis of potential water sources for Legionella organisms.

The outbreak largely affected a defined population in south west Edinburgh. It had considerable impact on NHS services during June 2012. Over 1000 patients were investigated and treated in primary care. Forty-five of the confirmed cases were admitted to acute hospitals in NHS Lothian. Twenty-two patients required admission to Critical Care; 19 were admitted to Intensive Care and three to a High Dependency Unit. In total, 92 cases were identified in the outbreak; 56 confirmed cases and 36 probable and possible cases. Seven of the confirmed cases and two in the probable and possible category were identified outwith NHS Lothian. Four deaths have been reported among formally confirmed cases. The case fatality rate was 7.1% among confirmed cases and 4.3% among all cases.

The proportion of patients presenting with severe disease, including altered mental state was higher than that reported in other recent UK or European outbreaks.

Follow up epidemiological investigations including seroprevalence and case-control studies are still being analysed. This report contains preliminary findings. As the science in this area is evolving, this has enabled further investigations that use new techniques involving whole genome DNA sequencing. These are currently being undertaken to generate information that might help provide more information about when and where individual patients acquired the disease. The final outcomes of these studies will inform further public health action and help us continue to improve the management of future outbreaks. We will share our findings across Scotland and internationally.

Health and Safety enforcing authorities are investigating the circumstances of the deaths under the direction of the Crown Office and Procurator Fiscal Service Health and Safety Division.
A multi-agency debrief held soon after the outbreak highlighted staff commitment and coordination as important lessons to be disseminated. Areas for improvement included revision of guidance, review of resources and facilities to be made available rapidly and for the duration of the outbreak, additional training and exercising of joint agency plans and additional means of communicating to the public.

This was a large outbreak of Legionnaires’ disease affecting the population of south west Edinburgh and caused considerable impact on NHS services during June 2012. A coordinated response and prompt action by Public Health, Primary Care, Acute Services, Environmental Health, and Lothian Unscheduled Care Services (LUCS) resulted in less morbidity and fewer deaths than in previous outbreaks of similar size.
1. Introduction

This is the second interim report of the Edinburgh Legionnaires’ disease outbreak in June 2012. It focuses on the epidemiological and microbiological investigation, impact on NHS Lothian and recommendations from the Incident Management Team. Health and Safety enforcing authorities are investigating the circumstances of the deaths under the direction of the Crown Office and Procurator Fiscal Service Health and Safety Division. This means that there are some limitations to the level of detail that can be disclosed at this time.

2. Epidemiological investigation

Timely and accurate epidemiological information is vital for providing evidence to inform outbreak control measures and monitoring the impact of these measures. The purpose of the epidemiological investigation was to determine the number and distribution of cases and identify any potential sources of the outbreak.

2.1 Objectives of the epidemiological investigation:

- To describe the epidemiology of the outbreak, with respect to people, place and time
- To generate hypotheses for testing potential source(s) of exposure and the effectiveness of remedial action
- To test these hypotheses

The epidemiological investigation was undertaken jointly by NHS Lothian, Health Protection Scotland, the Health Protection Agency and the Meteorological Office. The collection and processing of epidemiological data was undertaken by the NHS Lothian Health Protection Team with support from Health Protection Scotland for data management and analyses. Specialised temporal and spatial modelling support, provision of meteorological data and modelling was provided by the Bioterrorism and Emerging Disease Analysis, Microbial Risk Assessment Emergency Response Department, Health Protection Agency, Public Health England, Porton Down and the Meteorological Office respectively. Potential cases outwith Lothian were interviewed by the relevant Health Boards’ Health Protection Teams (for cases within Scotland) or the Health Protection Agency, Public Health England (for potential cases that had returned to England).
Key steps undertaken in the epidemiological investigation included:

- **Descriptive epidemiology** to determine the clinical and case status, age/sex, spatial distribution and dates of onset of illness.
- **Analytical epidemiology** to determine the association between cases and their likely exposure to the organism. This was carried out in the first instance by modelling of wind directions and speeds over the affected area and in-depth analysis of diaries that cases completed describing their movements.
- **Follow up analytical epidemiological studies** to examine the frequency and severity of illness in the community and the differences between those who became unwell and those who did not.

### 2.2 Methods of descriptive and analytic epidemiology and modelling

#### 2.2.1 Case ascertainment

- **Cases identified within NHS Lothian**
  Cases identified within NHS Lothian were reported to the Health Protection Team by clinicians in primary care or from local hospitals. Reported cases were line-listed and shared with Microbiology on a daily basis and updated as required.

- **Cases outwith NHS Lothian**
  During the course of the investigation a number of cases and potential cases were reported who were resident outwith NHS Lothian or were residents of NHS Lothian who became ill whilst outwith Lothian and were subsequently treated outwith Lothian.

  Details of such cases were reported to Health Protection Scotland by the relevant Health Protection Team in Scotland or via the Health Protection Agency for cases outwith Scotland. Health Protection Scotland established and maintained a line listing for cases outwith NHS Lothian. This was updated daily and shared with NHS Lothian Health Protection Team so that the master line listing was kept up to date. Trawling questionnaires were developed to generate hypotheses about the potential source of infection. These questionnaires were completed by the relevant Health Protection Team and emailed or faxed securely to Health Protection Scotland, who incorporated them into the trawling questionnaire database and sent a copy of the questionnaire to the Lothian Health Protection Team.

- **Case definitions**
  The following case definitions are based on European Centre for Disease Control definitions which were agreed by the Incident Management Team to be used in this outbreak.
Confirmed Case
An individual with clinical or radiological evidence of community acquired pneumonia, microbiologically confirmed *Legionella pneumophila* by either a positive *Legionella pneumophila* culture, *Legionella pneumophila* Sg1 urinary antigen test or fourfold rise in specific serum antibody, disease onset on or after 14 May 2012 and who has links to south west Edinburgh.

Probable Case
An individual with clinical or radiological evidence of community acquired pneumonia, a positive *Legionella pneumophila* Polymerase Chain Reaction (PCR) on respiratory secretions, disease onset on or after 14 May 2012 and who has links to south west Edinburgh.

Possible Case
An individual with clinical or radiological evidence of community acquired pneumonia, disease onset on or after 14 May 2012 and who has links to south west Edinburgh.

2.2.2 Line Listings
A line listing of all cases of Legionnaires’ disease was maintained by NHS Lothian Health Protection Team using a password protected spreadsheet on the secure server. This line listing contained basic demographic details of all cases, case status (confirmed, probable, possible), laboratory results, hospitalisation status and ward, some details of symptoms, occupation and whether the case had a history of exposure to south west Edinburgh. The line listing was updated on a daily basis and shared with Health Protection Scotland for the production of epidemic curves throughout the outbreak investigation. Not all data items were initially available for all cases. Prior to data from the trawling questionnaires becoming available an anonymised extract from the line listing was shared with the Microbial Risk Assessment Emergency Response Group at Porton Down for the generation of preliminary spatial models.

2.2.3 Interviews
A member of NHS Lothian Health Protection Team (or other nurses co-opted into the investigation) conducted detailed interviews and completed a trawling questionnaire with each case, or with a family member of any cases who were too ill to be interviewed. The trawling questionnaire had been developed by Health Protection Scotland for use in an earlier outbreak of Legionnaires’ disease. This questionnaire captured information on demographics, onset, symptoms, hospitalisation, underlying medical conditions, occupation, work location(s), usual mode of transport and route to work, exposures to potential sources of infection including spas, showers and fountains. It also included a fourteen day diary of places visited, routes and journeys in the fourteen days before onset, with each day divided into morning, afternoon and evening.
Completed trawling questionnaires were sent electronically by secure email to Health Protection Scotland. The postcodes were added for all locations mentioned in the questionnaires and entered into a password protected database to provide baseline data for spatial analysis. Data validation was conducted on a number of levels:

- **Database design**
  The formats were set to match the nature of the data being recorded (for instance, text, number, date).

- **Data capture**
  Dropdown menus were used to limit input to permitted pre-defined values.

- **Post-capture**
  A compulsory data validation process was incorporated. Errors were displayed on a general validation screen and as part of the individual record maintenance facility. The list of validation checks was designed to strike a balance between identifying obvious errors (for instance date inconsistencies) and the need to record accurately what was on the questionnaire.

Anonymised datasets: demographics, onset, hospitalisation dates and locations recorded in the fourteen day diaries were extracted from the database and shared with the Microbial Risk Assessment Group at the Health Protection Agency, Porton Down.

### 2.2.4 Temporal and Spatial Modelling Group

A modelling group was established as a sub-group of the Incident Management Team. The group was chaired by Health Protection Scotland and comprised NHS Lothian Health Protection Team, Bioterrorism and the Emerging Disease Analysis Microbial Risk Assessment Emergency Response Group, Health Protection Agency, Porton Down and the United Kingdom Meteorological Office.

The group met for the first time on Thursday 7 June 2012, and met on three further occasions with the final meeting on 26 June 2012.

Two data extracts from the line listing and four data extracts from the trawling questionnaire database were sent to the Microbial Risk Assessment Emergency Response Group, Porton Down. The group based in Porton Down has specialist expertise in the statistical modelling techniques used here to help determine the likely release period and location of the source of the outbreak. The analysis included:

- Statistical calculation of the release window based on the epidemic curve
- Cluster analysis
- Attack ratio analysis
The Meteorological Office provided data on meteorological conditions including wind speed and direction for the affected area. Wind roses were generated using numerical weather prediction data for the coordinates of cooling tower locations in the affected area. A wind rose is the usual way of showing the wind, direction and speed, over a period of time at a specific location. Wind direction is given as the direction from which the wind is coming (hence a south-westerly wind will transport airborne substances in a north-easterly direction). These wind roses were provided for cooling tower locations by day and by week for the likely exposure period.

The Meteorological Office used the Lagrangian dispersion model NAME (Numerical Atmospheric-dispersion Modelling Environment), driven by meteorology from the Meteorological Office’s 1.5km resolution limited area Numerical Weather Predication model. They took the Microbial Risk Assessment Emergency Response Group’s modelling work and used the Numerical Atmospheric-dispersion Modelling Environment model to investigate the geographical areas that contributed most significantly to the air that arrived at two separate areas that were identified as potential regions of infection.

2.3 Results of descriptive and analytical epidemiology and modelling

2.3.1 Case numbers
In total, 92 cases were identified in the outbreak; 56 confirmed cases and 36 probable and possible cases. Seven of the confirmed cases and two in the probable and possible category were identified outwith NHS Lothian.

Table 1: Total number of confirmed, probable and possible cases, by location

<table>
<thead>
<tr>
<th></th>
<th>Confirmed</th>
<th>Probable</th>
<th>Possible</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
<td>49</td>
<td>9</td>
<td>25</td>
<td>83</td>
</tr>
<tr>
<td>Out of board</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>10</td>
<td>26</td>
<td>92</td>
</tr>
</tbody>
</table>

Clear and concise case definitions are essential for the categorisation of cases. However, determining the final case status can require additional microbiological typing and epidemiological information, both of which take time to obtain and analyse. Once such data becomes available, this can result in the re-classification of some individuals. These final figures differ, therefore, from some of those reported during the outbreak investigation. This reflects the additional clinical and microbiological information that made available subsequent to the earlier reports.
Over 1000 symptomatic people were tested and treated in Primary Care practices in the affected area between 14 May 2012 and the end of June 2012. It is likely that some of these cases in the community had the less severe, self limiting form of legionellosis but did not go on to develop pneumonia. A post outbreak serosurveillance study has been investigating the whether this is the case.

2.3.2 Deaths
Four deaths have been reported among confirmed cases. The case fatality rate was 7.1% among confirmed cases and 4.3% amongst all cases. The fourth death has been classified as confirmed based on microbiological analysis by expert advisers to the Incident Management Team. The evidence from the specialist investigation (sequence based typing using a nested PCR) is consistent with the patient having been infected with the same strain of Legionella as the other culture confirmed cases.

2.3.3 Dates of onset
The onset dates for the confirmed cases ranged from 17 May 2012 to 23 June 2012 (Figure 1). It was difficult to get an accurate history of the onset of symptoms from the patient with the latest date of onset so this date may not be precise.

2.3.4 Age and sex of cases
Among the 56 confirmed cases 41 (73.2%) were male and 15 (26.8%) female. Their ages ranged from 32 to 85 years, mean 57.1 years, median 58.0 years. The mean age for males was 56.0 years and 60.1 years for females. This difference was not significant (p = 0.269). Probable and possible cases were aged 20 to 88 years, mean 55.2 years, median 54.5 years.

2.3.5 Underlying medical conditions
Among the confirmed cases 70% (39/56) had a serious underlying medical condition, 16% (9/56) were diabetic and 25% (14/56) had a condition or were on treatment that was likely to result in immunosuppression. Forty-four out of the 56 (79%) confirmed cases were reported to be current smokers compared with 19% in the overall Lothian population \(^1\) and 9% (5/56) were reported to have excess alcohol consumption (based on a clinical assessment of alcohol consumption greater than 21 units per week for males and 14 units for females).

\(^1\) Health and Lifestyle survey 2010, Community Health Partnership
Figure 1: Onset date for confirmed cases of Legionnaires’ disease.*

Onset date for confirmed cases of Legionnaires’ disease
(onset dates for 55 confirmed cases, date of onset not known for one case)

* There is no onset date for one further confirmed case (total = 56)
Figure 2: Age band and sex of confirmed cases of Legionnaires’ disease.

Age band and sex of confirmed cases of Legionnaires' disease (n=56)
2.3.6 Temporal and Spatial modelling results

The release end date based on all cases submitted to the modelling group was estimated to be 30 May 2012 (95% confidence intervals -28 May 2012 to 2 June 2012). When the model was repeated using only confirmed cases of Legionnaires’ disease the release end date was estimated to be 28 May 2012 (95% confidence intervals 25 May 2012 to 30 May 2012).

The cluster analysis was conducted using onset date, hospitalisation date, including and excluding unconfirmed cases. All the results suggested a single cluster of cases.

The attack ratio analysis using postcode geography is illustrated in Figure 3. The results suggest a source near or in the EH11 2 postcode sector in the Gorgie area of Edinburgh. The attack ratios appear to drop three orders of magnitude from zone A (which includes the putative source) radiating out to zone E which is further away from the putative source.

The Microbial Risk Assessment Response Group noted that while such ‘radial’ attack analysis had been used elsewhere to consider Legionnaires’ disease outbreaks this technique has not previously been applied to postcode geography.

The denominator populations for these models were taken from the National Population Database created by the Health and Safety Laboratory (NPD) estimation of residential population. This will not reflect the true daytime population of the area, but is indicative for this purpose and a reasonable estimate.

2.3.7 The United Kingdom Meteorological Office modelling data supported the possibility that cooling towers in south west Edinburgh could be the source of Legionella in this outbreak.

2.3.8 Epidemiological evidence obtained through mapping of cases, analysis of travel diaries and complex meteorological analysis of wind speed and direction suggests that a common outdoor airborne exposure occurred over south-west Edinburgh with an estimated release end date of 30 May 2012 (95% confidence intervals - 28 May to 2 June 2012) and is consistent with the putative source of the airborne bacteria being from cooling towers located in south west Edinburgh.
Figure 3: Attack ratio analysis using postcode geography.
2.4 Follow up Analytical Epidemiological investigations
A number of further investigations are ongoing. These include a seroprevalence study and a case control study. This report contains preliminary finding from these studies. The final outcomes of these studies will inform further public health action and our continued improvement of the management of future outbreaks.

2.4.1 Prevalence studies
2.4.1.1 Symptoms and prescribing
Non-pneumonic legionellosis is the less severe, self-limiting form of legionellosis and is often known as Pontiac fever. During the outbreak over 1000 people in south west Edinburgh sought medical attention with a range of symptoms. Where appropriate, they were prescribed the antibiotic clarithromycin by their General Practitioner.

Primary care data on these cases was reviewed. Clarithromycin prescribing was used as a preliminary proxy measure to ascertain the extent of healthcare sought for symptoms of legionellosis. Primary care prescribing data was extracted from the Prescribing Information System for Scotland (PRISMS). It showed that whilst there is normally a seasonal dip in clarithromycin prescribing over the summer months, this was not the case in 2012. Figure 5 shows a peak in clarithromycin prescribing in June 2012. Other areas of Lothian did not experience such peaks (data not shown) indicating that the increase was likely to be a direct result of the Legionnaires’ outbreak.
2.4.1.2 Seroprevalence study

A seroprevalence study was carried out to further determine the extent of non-pneumonic legionellosis (Pontiac fever) amongst those who sought healthcare during the outbreak and the characteristics, symptom profiles and risk factors associated with this group of people.

Invitations to participate in the study were sent to every individual over 18 years old, resident in the exposed area between 14 May and 6 June 2012, registered with one of seven general practices located in the centre of the exposed geographical area who had developed symptoms of non-pneumonic legionellosis and sought healthcare, for legionellosis, between 14 May and 27 June 2012. This group comprised 915 individuals.

The study comprised donating a sample of blood and completing a self-administered questionnaire six to eight weeks after the outbreak was officially declared. The study population was predominantly female (58%) with a mean age of 47 years.
The participation rate was 31.4% (n=282) with 65% of those who participated being female with a mean age of 52 years.

Non pneumatic Legionellosis (Pontiac fever) has no single agreed clinical definition. In this investigation we used one of the stricter clinical definitions “fever and either cough, headache or muscle aches”.

When this clinical definition was applied to the 282 participants, 48% (n=135) fulfilled the clinical case definition. Only a small number (n=6) showed serological evidence of an immune response to Legionella.

These six individuals had an antibody detected at a titre of >16 (range 32 to 128). Subsequent samples taken from these individuals either reverted to negative (three of the six) or remained positive but at a lower titre (range 16 to 32) indicating possible recent infection with the Legionella bacterium.

These preliminary results suggest that only a small percentage of the cohort of patients who attended their General Practitioners with symptoms in May and June 2012 showed recent infection with the Legionella bacterium.

2.4.2 Case-control study
Alongside the seroprevalence study exploring those with non-pneumatic legionellosis, a case control study is being undertaken. The aims of the case control study are to quantify the relationship between wet cooling systems (a potential source of aerosolised Legionella) and cases of Legionnaires’ disease, and secondly, to identify further the characteristics and risk factors associated with Legionnaires’ disease.

Interviews with cases and controls were undertaken by City of Edinburgh Council and NHS Lothian Public Health staff. Analysis of results is on-going and a full report will be made available. Preliminary analysis suggests that most cases experienced confusion and altered mental state; many had limited memory of the period of illness. These symptoms seem more common than has been reported previously and this is being investigated further. If confirmed, this could help explain the discrepancy between recovery from illness as documented using physical measures and patient reports of a longer-lasting illness.

* A fourfold or greater rise in specific serum antibody titre to \textit{L. pneumophila} sg1 is considered to be a confirmatory diagnosis for Legionnaires’ disease. A single high serological titre result is considered to indicate recent \textit{Legionella} infection in the presence of compatible symptoms.
3. Medical Microbiological Investigation of clinical cases

The identification of the outbreak followed the notification to Public Health by Medical Microbiology of four inpatients, admitted over a four day period to Critical Care in NHS Lothian. All had severe community acquired pneumonia and were confirmed as positive for *Legionella pneumophila* Sg 1 urinary antigen.

Following the identification of the outbreak over the weekend of 2 and 3 June 2012, further possible cases were identified by clinical suspicion on presentation to acute care, and through active case finding by clinicians and medical microbiologists.

Advice to clinicians on medical microbiological testing was issued by Medical Microbiology and Public Health on Monday 4 June 2012 and updated by Medical Microbiology on Friday 8 June 2012. Clinicians were advised to submit urine for detection of *L. pneumophila* serogroup 1 urinary antigen, sputum or broncho-alveolar lavage samples for molecular testing and culture, and paired sera for specific antibody detection.

3.1 Methodology for medical laboratory processing of diagnostic samples

Samples for microbiological testing were processed according to the NHS Lothian Department of Laboratory Medicine standard operating procedures. Detection of *L. pneumophila* Sg 1 urinary antigen was performed using a rapid, specific immunochromatographic assay (BinaxNOW Legionella Urinary Antigen Test: Alere).

An in-house multiplex real-time polymerase chain reaction (PCR) assay was used at the Royal Infirmary of Edinburgh, Molecular Microbiology Laboratory to detect *Legionella pneumophila* and *Legionella species* in respiratory samples. Samples positive by PCR were referred to the Scottish Haemophilus, Legionella, Meningococcus and Pneumococcus Reference Laboratory for enrichment culture and identification and typing.

Legionella cultures at the local laboratory were performed on Buffered Charcoal Yeast Extract (BCYE) agar and were incubated for 7-10 days at 35-37 degrees Centigrade.

Post-mortem samples were submitted by NHS Lothian Department of Forensic Pathology. A standardized proforma was used for ‘chain of evidence’ specimen collection and processing. Legionella isolates cultured at the Royal Infirmary of Edinburgh Laboratory from post-mortem samples from the patients who died, were also referred to Scottish Haemophilus, Legionella, Meningococcus and Pneumococcus Reference Laboratory.
Samples from hospital inpatients and cases presenting at NHS Lothian unscheduled care departments were prioritised. There was a low positivity rate in samples from patients presenting to general practitioners. An algorithm was developed to advise General Practitioners on the management of less unwell patients who did not require submission of a sample, and was issued to Lothian Unscheduled Care Services on Friday 8 June 2012, and to General Practitioner practices on Monday 11 June 2012.

3.2 Medical Microbiology Results
Sixty four patients with pneumonia tested positive for *Legionella pneumophila* Sg1 by urinary antigen detection, culture, respiratory Polymerase Chain Reaction (PCR) or serology.

Positive cultures were obtained from 15 of these patients and the causative organism was identified at the Scottish Haemophilus, Legionella, Meningococcus and Pneumococcus Reference Laboratory as *Legionella pneumophila* Sg1, monoclonal subtype Knoxville, sequence based type ST 191 (6,10,19,28,19,4,6).

3.3 Antimicrobial treatment of probable, possible and confirmed cases
Patients with severe pneumonia were treated with intravenous levofloxacin 500 mg twice daily. Intravenous clarithromycin 500 mg twice daily was added at the discretion of the treating clinician, in view of the potential small risk of cardiac electrophysiological abnormalities with quinolone/macrolide combinations (British Thoracic Society Guidelines 2009).

Information on the use of antibiotics in the treatment of Legionnaires’ disease in specific patient groups was prepared by the Lothian Medicines Information Service and circulated to clinical teams. Recommended dose adjustments were made for both levofloxacin and clarithromycin when treating patients with renal impairment. No dosage adjustments were made for patients with hepatic impairment, but hepatic function was monitored closely.
4. Impact of the outbreak on services in NHS Lothian

4.1 Primary Care
Media coverage of the outbreak from Sunday 3 June 2012 led to increased public awareness of the outbreak across Edinburgh. Primary care practices in the affected area and Lothian Unscheduled Care Services reported marked increases in telephone and face to face consultations during the week commencing Monday 4 June 2012. This increased following the initiation of the NHS 24 Helpline on 6 June 2012 and the house to house leaflet drop which started in the middle of that week. Practices did manage to cope with the increased numbers of patients but were under severe pressure. Over 1000 patients were investigated and treated in primary care.

4.2 Acute Care
Forty-five of the confirmed cases were admitted to acute hospitals in NHS Lothian during late May and June 2012. Twenty one of the cases were admitted to the Royal Infirmary and 24 to the Western General Hospital. Twenty-two patients required admission to Critical Care; 19 were admitted to Intensive Care and three to a High Dependency Unit.

An NHS Lothian Bed Management Team met twice daily for the duration of the outbreak. This involved teleconferencing with all three acute sites in NHS Lothian with input from bed managers and senior clinicians in Acute Medicine and Critical Care. Clinical guidance and information was disseminated by this team across NHS Lothian. A situation report on hospital and Critical Care beds and up to date numbers of probable, possible and confirmed cases was produced after each meeting and disseminated to key staff.

Although no elective surgery was cancelled over the first week of the outbreak, five cases booked for elective surgery at the Western General Hospital requiring Critical Care use post operatively were deferred. In addition three elective patients booked for Critical Care at the Royal Infirmary of Edinburgh were held in recovery overnight.

Critical Care surge management plans had been updated following the 2009 influenza A/H1N1 pandemic and these were utilised for planning for possible further increases in cases. Neighbouring Health Board Critical Care teams were consulted and volunteered to provide further capacity if the need arose.

The mean length of stay in the intensive care unit was 11.3 (±7.6) days and mean hospital length of stay for those who were admitted to intensive care unit was 23.0 (±16.9) days. For all hospitalised patients the mean length of stay was 15.7 (±14) days.
4.3 Critical Care
Of those patients admitted to Critical Care in Lothian, 17 (77%) required mechanical ventilation. In those patients who were ventilated, the mean duration of ventilation was 10.3(±6.0) days. Three patients (18%) required prone ventilation for severe Acute Respiratory Distress Syndrome, two (12%) required treatment with inhaled nitric oxide, one (6%) required high frequency oscillatory ventilation and one (6%) required referral for extra-corporeal membrane oxygenation (ECMO). Six patients (29%) required renal replacement therapy for acute kidney injury.

4.4 Resources sub-group
The report of a case of anthrax in Scottish Borders highlighted the importance of establishing a resources sub-group to manage large or complex incidents. In this outbreak, the Director of Finance oversaw the initial phase personally as executive on call and the Joint Management Team of NHS Lothian agreed to ensure that the necessary resources were made available. Two members of finance staff were delegated responsibility for gathering, analysing and costing resource use based on existing guidance. The Director of Finance, Director of Public Health and Health Policy, Director of Strategic Planning, Performance and Information and the Director of Operations for Acute Medical Specialties met once on 3 July 2012 to confirm the principles and processes being followed and to ensure no areas of potential concern had been overlooked.

Estimated costs to NHS Lothian associated with this outbreak

Table 2 below sets out the estimated costs to NHS Lothian associated with this outbreak.
Table 2: Estimated costs to NHS Lothian associated with the outbreak of Legionnaires’ disease June 2012.

<table>
<thead>
<tr>
<th>Expenditure area</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hospital admissions by Legionnaires’ patients</td>
<td></td>
</tr>
<tr>
<td>-general ward</td>
<td>126,000</td>
</tr>
<tr>
<td>-Critical Care</td>
<td>374,000</td>
</tr>
<tr>
<td>Public information</td>
<td></td>
</tr>
<tr>
<td>-leaflet delivery</td>
<td>7,900</td>
</tr>
<tr>
<td>-NHS 24 helpline</td>
<td>29,000</td>
</tr>
<tr>
<td>Enhanced staffing</td>
<td></td>
</tr>
<tr>
<td>-secondary care</td>
<td>50,300</td>
</tr>
<tr>
<td>-primary care</td>
<td>61,800</td>
</tr>
<tr>
<td>Increased prescribing costs</td>
<td></td>
</tr>
<tr>
<td>-secondary care</td>
<td>4,800</td>
</tr>
<tr>
<td>-primary care</td>
<td>2,600</td>
</tr>
<tr>
<td>Laboratory costs</td>
<td></td>
</tr>
<tr>
<td>-staffing</td>
<td>4,500</td>
</tr>
<tr>
<td>-testing kits</td>
<td>26,700</td>
</tr>
<tr>
<td>Public Health – staffing and resources*</td>
<td>8,000</td>
</tr>
<tr>
<td>Further Public Health investigation</td>
<td>38,200</td>
</tr>
<tr>
<td><strong>Total estimated costs</strong></td>
<td><strong>725,800</strong></td>
</tr>
</tbody>
</table>

*This does not take account of all the staff that came in early/stayed late and undertook additional tasks or provided mutual aid
5. **Update on other investigations**

5.1 The environmental investigations have been aimed at establishing the potential source of the Legionella organism causing human illness. Water samples were taken from installations across south west Edinburgh which had the potential to generate plumes of aerosols. These included cooling towers, sprinkler systems and a vehicle washing bay. Maintenance data for these installations were also inspected as part of the investigation.

5.2 Meteorological data were reviewed to determine wind direction and strength in the outbreak area around the estimated exposure period to establish the relationships between the distribution of cases and plume dispersal (also see section 2.2.4). An epidemiological model was used to confirm the relationship between postcode distribution and plume dispersal taking into account wind direction, wind speed, the height of the individual cooling towers and evaporative condensers above ground level.

5.3 Findings from the environmental investigations carried out have not yet been conclusive in identifying the exact source of the outbreak. Viable Legionella bacteria were not isolated from the environmental water samples. Further investigations which use new techniques involving whole genome DNA sequencing are currently being undertaken to generate information that might provide information on the timing and geography of likely acquisition by individual patients. Similar sequencing may be possible on Legionella DNA isolated from environmental water samples. It is hoped that this detailed investigation will establish a relationship between the patient and environmental samples.

5.4 Health and Safety enforcing authorities are investigating the circumstances of the deaths under the direction of the Crown Office and Procurator Fiscal Service Health and Safety Division.

5.5 The Health and Safety Executive issued a safety bulletin to all users of cooling towers and evaporative condensers on 27 July 2012 drawing their attention to the key aspects of the proper management of the risks from Legionella. It was informed by a Health and Safety Executive review of outbreaks in Britain over the past ten years that showed common failings in control, and a potential risk of further Legionella outbreaks, such as that in Edinburgh in June 2012 [http://www.hse.gov.uk/safetybulletins/coolingtowers.htm](http://www.hse.gov.uk/safetybulletins/coolingtowers.htm). As a result of the review, Health and Safety Executive and Local Authorities are currently carrying out a programme of visits to all sites with cooling towers and evaporative condensers across Britain to ensure that duty holders are effectively controlling Legionella risks.
6. Conclusion

In conclusion, this was a large outbreak of Legionnaires’ disease affecting the population of south west Edinburgh and caused considerable impact on NHS services during June 2012. Appropriate control measures were applied quickly and work is continuing to prevent any future similar outbreaks.

The NHS Lothian Incident Management Team has conducted structured debriefs of the incident response. Analysis of these debriefs indicate that the locally co-ordinated Public Health, Environmental Health and clinical response (primary care, and adequate Critical Care, Lothian Unscheduled Care Service, Accident and Emergencies and Laboratory services) helped prevent ongoing exposure of the population and mitigated associated mortality and morbidity. The mutual aid and support of colleagues from across NHS Lothian and Public Health staff from other Health Boards was essential in enabling an effective response to this outbreak, another public health incident that occurred over the same period and in enabling the routine response to be maintained.

7. Recommendations

NHS Lothian and the other agencies involved in managing the response and investigations into the outbreak are now taking forward the following key actions:

7.1 Revise the Health Protection Network guidance to reflect current best practice and organisational arrangements regarding the responsibilities of regulators, other agencies and expert bodies to advise and/or address issues such as sampling (techniques and reporting results) and processes to be followed whether there is a potential for future investigation of the attribution of corporate responsibility, including homicide.

**Lead:** Health Protection Advisory Group to advise Chief Medical Officer and Scottish Directors of Public Health Group on recommendations.

7.2 Develop a common approach for the recording of complex microbiological and environmental information across agencies such as the Health and Safety Executive, local authority Environmental Health and Scientific Services and National Reference Laboratories.

**Lead:** Health Protection Advisory Group to advise Chief Medical Officer and Scottish Directors of Public Health Group on recommendations.

7.3 Review resources and facilities required for emergency planning and resilience to ensure that all agencies involved in the management of a major outbreak can respond formally to a major outbreak in a timely manner and maintain their response as required.

**Lead:** All agencies involved to review against updated Scottish Government and United Kingdom guidance during 2013.
7.4 Rehearse the local multiagency major outbreak plan on an annual basis and regularly review roles and agree tasks within and across agencies. 
**Lead:** NHS Lothian and all partner agencies

7.5 Develop a suite of templates/procedures to support for rapid distribution of information to patients, public and professionals by all appropriate means.
**Lead:** NHS Lothian in line with Health Protection risk communication and Scottish Government guidance

**APPENDICES**

**APPENDIX 1:** INCIDENT MANAGEMENT TEAM MEMBERS
**APPENDIX 2:** DATES OF INCIDENT MANAGEMENT TEAM AND SUB GROUP MEETINGS
## APPENDIX 1
### INCIDENT MANAGEMENT TEAM MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alison McCallum</td>
<td>Director of Public Health and Health Policy</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Sian Tucker</td>
<td>Acting Clinical Director, Lothian Unscheduled Care Service (LUCS)</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Lynn Cree</td>
<td>Environmental Health Adviser</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>Alison Smith-Palmer</td>
<td>Epidemiologist</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>Steve Harvey</td>
<td>Emergency Planning Officer</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Mary Hanson</td>
<td>Consultant Microbiologist</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Andrew Campbell</td>
<td>Environmental Health Officer</td>
<td>City of Edinburgh Council</td>
</tr>
<tr>
<td>Sue Payne</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Michael Gillies</td>
<td>Clinical Director of Critical Care</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Christine Evans</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Steve Harvey</td>
<td>Emergency Planning Officer</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Mary Hanson</td>
<td>Consultant Microbiologist</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Dona Milne</td>
<td>Specialist in Public Health</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Sue Payne</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Michael Gillies</td>
<td>Clinical Director of Critical Care</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Fatim Lakha</td>
<td>Specialist Registrar, Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Alison Potts</td>
<td>Epidemiologist</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>Robbie Beattie</td>
<td>Scientific and Environmental Services Manager</td>
<td>City of Edinburgh Council</td>
</tr>
<tr>
<td>Alistair McNab</td>
<td>Head of Operations, Health and Safety Executive</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Carol Harris</td>
<td>Communications Manager</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Stuart Wilson</td>
<td>Director of Communications</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Giles Edwards</td>
<td>Consultant Microbiologist, Scottish Haemophilus, Legionella, Meningococcus and Pneumococcus Reference Laboratory</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Colin Sibbald</td>
<td>Food Health and Safety Manager</td>
<td>City of Edinburgh Council</td>
</tr>
<tr>
<td>Janet Stevenson</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Duncan McCormick</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Jim McMenamin</td>
<td>Consultant Epidemiologist</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>Garry Stimpson</td>
<td>HM Principal Inspector, Health and Safety Executive</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Louise Wellington</td>
<td>Health Protection Nurse</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Diane Lindsay</td>
<td>Principal Clinical Scientist, Scottish Haemophilus, Legionella, Meningococcus and Pneumococcus Reference Laboratory</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Martin Donaghy</td>
<td>Medical Director</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>Jennifer Irvine</td>
<td>PA in Public Health</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Jonathan Mills</td>
<td>Specialty Registrar, Medical Microbiology</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>John Healy</td>
<td>Team Leader, Occupational Hygiene T</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>Richard Othieno</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Lothian</td>
</tr>
</tbody>
</table>
## APPENDIX 2
### INCIDENT MANAGEMENT TEAM AND SUB GROUPS MEETING DATES

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Chair</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Management Team</td>
<td>Dr Duncan McCormick, NHS Lothian</td>
<td>Sunday 3 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Duncan McCormick, NHS Lothian</td>
<td>Monday 4 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Duncan McCormick, NHS Lothian</td>
<td>Tuesday 5 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Janet Stevenson, NHS Lothian</td>
<td>Wednesday 6 June 2012</td>
</tr>
<tr>
<td>Surveillance Meeting</td>
<td>Dr Janet Stevenson, NHS Lothian</td>
<td>Thursday 7 June 2012</td>
</tr>
<tr>
<td>Spatial Analysis Meeting</td>
<td>Dr Jim McMenamin, Health Protection Scotland</td>
<td>Thursday 7 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Duncan McCormick, NHS Lothian</td>
<td>Friday 8 June 2012</td>
</tr>
<tr>
<td>Clinical Guidance Meeting</td>
<td>Dr Mary Hanson, NHS Lothian</td>
<td>Friday 8 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Sue Payne, NHS Lothian</td>
<td>Saturday 9 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Sue Payne, NHS Lothian</td>
<td>Sunday 10 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Monday 11 June 2012</td>
</tr>
<tr>
<td>Laboratories Meeting</td>
<td>Dr Martin Donaghy, Health Protection Scotland</td>
<td>Tuesday 12 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Wednesday 13 June 2012</td>
</tr>
<tr>
<td>Spatial Analysis Meeting</td>
<td>Dr Jim McMenamin, HPS</td>
<td>Thursday 14 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Friday 15 June 2012</td>
</tr>
<tr>
<td>Surveillance Meeting</td>
<td>Dr Janet Stevenson</td>
<td>Monday 18 June 2012</td>
</tr>
<tr>
<td>Spatial Analysis Meeting</td>
<td>Dr Jim McMenamin</td>
<td>Monday 18 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Wednesday 20 June 2012</td>
</tr>
<tr>
<td>Spatial Analysis Meeting</td>
<td>Dr Alison Smith-Palmer, Health Protection Scotland</td>
<td>Tuesday 26 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Janet Stevenson</td>
<td>Tuesday 26 June 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Tuesday 3 July 2012</td>
</tr>
<tr>
<td>Resources Sub-Group</td>
<td>Dr Alison McCallum, NHS Lothian</td>
<td>Tuesday 3 July 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Tuesday 10 July 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno, NHS Lothian</td>
<td>Tuesday 17 July 2012</td>
</tr>
<tr>
<td>Incident Debrief</td>
<td>Steve Harvey, NHS Lothian</td>
<td>Wednesday 1 August 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Janet Stevenson</td>
<td>Wednesday 22 August 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Richard Othieno/Dr Duncan McCormick, NHS Lothian</td>
<td>Friday 21 September 2012</td>
</tr>
<tr>
<td>Incident Management Team</td>
<td>Dr Duncan McCormick, NHS Lothian</td>
<td>Thursday 20 February 2013</td>
</tr>
</tbody>
</table>
SUMMARY PAPER - QUALITY REPORT

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Para</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Compliance with the evidence-based stroke standard for admission</td>
<td>3.1</td>
</tr>
<tr>
<td>to Stroke Unit within one day of admission and Swallow Screen on</td>
<td></td>
</tr>
<tr>
<td>day of admission also remains an issue (see graphs 22 &amp; 23).</td>
<td></td>
</tr>
<tr>
<td>• Maintaining the HEAT target for Clostridium Difficile infection</td>
<td>3.2</td>
</tr>
<tr>
<td>remains a challenge (see graph 11).</td>
<td></td>
</tr>
<tr>
<td>• The 3-day and 20-day complaints response rate remains a challenge,</td>
<td>3.3</td>
</tr>
<tr>
<td>however, there has been improvement in April for both the 3-day and</td>
<td></td>
</tr>
<tr>
<td>20-day response rates (see graphs 1 and 3).</td>
<td></td>
</tr>
<tr>
<td>• NHS Lothian remains an outlier for medical and surgical</td>
<td>3.4</td>
</tr>
<tr>
<td>readmissions at 7 and 28 days plus average length of stay for</td>
<td></td>
</tr>
<tr>
<td>surgery.</td>
<td></td>
</tr>
<tr>
<td>• NHS Lothian’s total instrumental delivery rate is higher than</td>
<td>3.5</td>
</tr>
<tr>
<td>Scotland overall.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Dr Elizabeth Bream
Consultant in Public Health
11 July 2013
Elizabeth.bream@nhslothian.scot.nhs.uk
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for June 2013, to provide assurance on the quality of care NHS Lothian provides with a particular focus on Child & Maternal Health.

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

2 Recommendations

2.1 Review the quality dashboard and Child & Maternal Health clinical effectiveness measures to inform assurance reporting, (context and technical appendix are set out in Appendix 1).

3 Discussion of Key Issues

Exception Reporting

3.1 Compliance with the evidence-based stroke standard for admission to Stroke Unit within one day of admission and Swallow Screen on day of admission also remains an issue (see graphs 22 & 23). The June 2013 Board Quality Report set out the actions being undertaken by the service to improve compliance with the stroke standards.

3.2 Maintaining the HEAT target for Clostridium Difficile infection remains a challenge (see graph 11). The Committee should note changes to the HAI HEAT targets from 1st April (2013). A more detailed Healthcare Associated Infections (HAI) paper is on this committee’s agenda.

3.3 The 3-day and 20-day complaints response rate remains a challenge, however, there has been improvement in April for both the 3-day and 20-day response rates (see graphs 1 and 3). The June 2013 Complaints paper set out actions being undertaken to improve compliance and learning from complaints.

3.4 NHS Lothian remains an outlier for medical and surgical readmissions at 7 and 28 days plus average length of stay for surgery.

3.5 NHS Lothian’s total instrumental delivery rate is higher than Scotland overall.
3.6 **Clinical Effectiveness Measure – Child & Maternal Health**

3.6.1 The measures are as follows; several of them are influenced by a range of factors outwith the NHS:

1. Pregnancy screening: uptake rates, sensitivity and false positive rates for Down’s Syndrome screening
2. Percentage of babies born with Low Birth Weight at term
3. Caesarean section & other intervention rates
4. Perinatal mortality rates
5. Percentage of babies exclusively breast fed at 6-8 weeks
6. Percentage of children to complete all childhood immunisations at 24 months of age

3.6.2 It should be noted that other sources of assurance are provided to the NHS Board Healthcare Governance Committee, for example when reports such as the Confidential Enquiry into Maternal Deaths are published, these would be reviewed at the NHS Board Healthcare Governance Committee.

1. **Pregnancy screening: uptake rates, sensitivity and false positive rates for Down’s Syndrome screening**

Pregnant women who book before 20 weeks are offered serum screening for Down’s syndrome. Since January 2011 women booking before 14 weeks have been offered first trimester screening which also includes ultrasound measurement of the nuchal translucency space. Pregnant women make the decision whether or not to accept the screening test based on informed consent – as a result there are no targets for the uptake of screening. The introduction of the first trimester screen has coincided with a marked increase in uptake (from 63% between 2005 and 2010, to 81% in 2011). In 2011, 85% of screening tests were from the first trimester, marking the success of maternity services in booking women early enough to arrange the screening tests within a narrow time frame (11-13 weeks gestation).

The sensitivity (detection rate) and false positive rate (% of women without a Down’s syndrome pregnancy with an “increased chance” result) provide a measure of the quality of the screening process. These remained at a similar level between 2006 and 2010 and were at the level expected for a two marker second trimester test. The results shown in Table 1 differ from previous years because they show results for individual years (rather than three year rolling averages) and they give the numbers as well as the percentages. These more detailed figures show the increased number of Down’s syndrome affected pregnancies undergoing screening – from an average of 12.5 per year between 2005 and 2010, to 20 in 2011. As anticipated, the figures also show the increase in sensitivity of the test – a measure of the ability of the test to correctly identify affected cases. Between 2005 and 2010 the overall sensitivity for Down’s syndrome was 70%. In 2011 the sensitivity exceeded the UK National Screening Committee (NSC) standard of 90%, with all 20 cases correctly identified. It should be noted, however, that figures vary from year to year, and there has been one previous year (2009) when a sensitivity of 100% was also achieved.

Figure 1 shows the false positive rate for Down’s syndrome screening in Lothian. False positives are the incorrect identification of an unaffected pregnancy as having
a high chance result. The long term trend has been downwards, but the 2011 figure (false positive 4.4%) shows an improvement that exceeds the long term downward trend. This is expected, because of the introduction of first trimester Down’s syndrome screening in 2011. There is room for improvement, however, as the level exceeds the UK National Screening Committee standard (2%).

Table 1: Uptake and performance of Down’s syndrome screening (Lothian 2008-11)

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>NSC standards (for first trimester screening)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uptake</td>
<td>59.6%</td>
<td>58.7%</td>
<td>63.5%</td>
<td>81%</td>
<td>7.283/12,229 (\text{N/A})</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>61.5%</td>
<td>100%</td>
<td>60%</td>
<td>100%</td>
<td>8/13 (&gt;90%)</td>
</tr>
<tr>
<td>False positive rate</td>
<td>6.3%</td>
<td>8.2%</td>
<td>4.4%</td>
<td>(&lt;2%)</td>
<td>459/7,270 (453/7,184)</td>
</tr>
</tbody>
</table>


Figure 1: False positive rate for Down’s syndrome screening (Lothian 2005-2011)
Bars = standard error, a measure of precision of the estimate.

2. Percentage of babies born with Low Birth Weight
Low birth weight is associated with a number of medical conditions and maternal factors. These include previous obstetric problems, hypertensive disorders, number of previous pregnancies, maternal age, socio-economic status, and smoking. Overall, preterm or low birth weight babies have higher rates of morbidity, infant mortality and disability.

Data at a Scottish and Lothian level are available for comparison up to 2011. There is no significant difference between the proportion of low birth weight babies
between Scotland and Lothian, and the figures have remained stable over time (Table 2).

Figure 2 shows the rates for low and very low birth weight as a percentage of all singleton births (combined data for preterm and full term and babies) by Scottish Index of Multiple Deprivation (SIMD) for financial year ending 31 March 2011. Nationally, a mother living in an area of high deprivation is almost three times as likely to have a low birth weight baby (1500g to 2499g) compared to a mother living in an area of low deprivation. In Lothian there is not such a marked difference between the most and least deprived. The difference in the pattern by SIMD between Scottish and Lothian figures may be explained by the older age of pregnant women in Lothian compared to the national average, as increasing maternal age is a risk factor for both prematurity and low birth weight and is more likely to be associated with relative affluence.

Table 2: Births by birth weight (Scotland and Lothian 2005-11)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Number of births</th>
<th>Under 1500g (%)</th>
<th>1500g - 2499g (%)</th>
<th>2500g+ (%)</th>
<th>Number of births</th>
<th>Under 1500g (%)</th>
<th>1500g - 2499g (%)</th>
<th>2500g+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>53,085</td>
<td>1.2</td>
<td>5.6</td>
<td>90.2</td>
<td>9,560</td>
<td>1.0</td>
<td>5.4</td>
<td>93.6</td>
</tr>
<tr>
<td>2010</td>
<td>53,275</td>
<td>1.2</td>
<td>5.7</td>
<td>92.9</td>
<td>9,264</td>
<td>1.2</td>
<td>6.0</td>
<td>92.8</td>
</tr>
<tr>
<td>2009</td>
<td>53,487</td>
<td>1.3</td>
<td>6.0</td>
<td>92.6</td>
<td>9,560</td>
<td>1.3</td>
<td>6.0</td>
<td>92.7</td>
</tr>
<tr>
<td>2008</td>
<td>53,144</td>
<td>1.4</td>
<td>5.9</td>
<td>92.6</td>
<td>9,511</td>
<td>1.2</td>
<td>5.8</td>
<td>93.0</td>
</tr>
<tr>
<td>2007</td>
<td>53,136</td>
<td>1.2</td>
<td>5.9</td>
<td>92.7</td>
<td>8,933</td>
<td>1.1</td>
<td>6.3</td>
<td>92.6</td>
</tr>
<tr>
<td>2006</td>
<td>53,182</td>
<td>1.4</td>
<td>6.6</td>
<td>92.0</td>
<td>8,480</td>
<td>1.5</td>
<td>6.5</td>
<td>92.0</td>
</tr>
<tr>
<td>2005</td>
<td>53,425</td>
<td>1.3</td>
<td>6.1</td>
<td>92.5</td>
<td>8,315</td>
<td>1.5</td>
<td>6.1</td>
<td>92.5</td>
</tr>
</tbody>
</table>

Figure 2: Low percentage weights in singleton births (Scotland and Lothian 2011)

Source: ISD Scotland November 2012 (SMR02 – Maternity Inpatient and Day Case) P provisional
3. Caesarean section & other intervention rates

There is an increasing move to “normality” in pregnancy, including the Scottish Government/ Health Care Improvement Scotland programme Keeping Childbirth Natural and Dynamic. There is also a place for interventional delivery for the safety of mother and child.

The caesarean section (CS) rates (elective and emergency) in Lothian between 2005/06 to 2008/09 were showing a downward trend and were slightly below the national average; this was not sustained in 2010 and 2011 (Table 3). As explained in the preceding section, however, more recent national data are not available.

The higher usage of forceps in Lothian suggests that the total instrumental delivery rate is higher in Lothian than Scotland overall. These routinely collected data do not allow an assessment of the appropriateness of delivery method overall, nor are there agreed limits for optimal practice around instrumental delivery. Nonetheless, it is reassuring that while the total instrumental delivery rate is higher than Scotland overall, perinatal mortality rates (next section) are lower than the Scottish average, though such information does not provide evidence for a causal link.

Table 3: Percentage of live births by mode of delivery (Scotland and Lothian 2005-11)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Scotland % live births</th>
<th>Lothian % of live births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vacuum</td>
<td>Forceps</td>
</tr>
<tr>
<td>2011p</td>
<td>2.8</td>
<td>9.9</td>
</tr>
<tr>
<td>2010p</td>
<td>2.9</td>
<td>9.7</td>
</tr>
<tr>
<td>2009</td>
<td>3.3</td>
<td>9.7</td>
</tr>
<tr>
<td>2008</td>
<td>3.5</td>
<td>9.3</td>
</tr>
<tr>
<td>2007</td>
<td>3.7</td>
<td>8.4</td>
</tr>
<tr>
<td>2006</td>
<td>4.2</td>
<td>7.6</td>
</tr>
<tr>
<td>2005</td>
<td>4.9</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Source: ISD Scotland November 2012 (SMR02 – Maternity Inpatient and Day Case P provisional)

4. Perinatal mortality

Perinatal mortality (stillbirths and deaths in the first week of life) reflects a variety of factors including antenatal, obstetric and neonatal care and maternal risk factors such as smoking, obesity and substance misuse. There have no new national data released since the 2012 quality report; perinatal mortality rates were lower than the Scottish average in 2011 at 6.5 per 1,000 in NHS Lothian and 6.9 per 1,000 in Scotland (Figure 3).

There is regular multi-disciplinary review of perinatal deaths; with recommendations for improvements to maternity and neonatal care. Developments in pregnancy screening and health improvement (e.g. smoking cessation, maternal nutrition, weight management) would be expected to bring about further improvements in perinatal outcomes.
5. Breastfeeding
The national target for Exclusive Breastfeeding rates at 6-8 weeks\(^1,2\) was 33.3% for 2010/11. The NHS Lothian target was 43.7% for the same period. NHS Lothian continues to exceed the national average\(^3\) and remains the best performing mainland Health Board in Scotland (Figure 4).

It is important to note that as the target is a percentage, it is affected by the change in actual numbers of births. When the HEAT target was set in 2006/2007 the actual number of live births was 9,241 and in 2010/11 it had increased to 9,855 (National Records of Scotland). Breastfeeding rates are affected by a number of key factors, many of which are culturally and socially dependent. NHS Lothian actions and interventions are only one component of achieving the target; while we have in place a range of evidence based interventions to enable, encourage and support women, the choice to breastfeed is an individual one.

---

**Figure 3: Perinatal mortality rates (Lothian and Scotland, 2007-11)**

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Scotland</th>
<th>Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>7.6</td>
<td>7.8</td>
</tr>
<tr>
<td>2008</td>
<td>6.4</td>
<td>7.4</td>
</tr>
<tr>
<td>2009</td>
<td>7.0</td>
<td>7.4</td>
</tr>
<tr>
<td>2010</td>
<td>6.3</td>
<td>6.9</td>
</tr>
<tr>
<td>2011p</td>
<td>6.5</td>
<td>6.9</td>
</tr>
</tbody>
</table>

1. Source: General Register Office for Scotland – Vital Events

**Figure 4: Percentage babies exclusively breastfed at 6-8 weeks (Scotland and Lothian 2006/7-2011/12)**

<table>
<thead>
<tr>
<th>Financial Year ending 31 March</th>
<th>Scotland</th>
<th>Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>35.0</td>
<td>36.2</td>
</tr>
<tr>
<td>2007/08</td>
<td>35.9</td>
<td>36.6</td>
</tr>
<tr>
<td>2008/09</td>
<td>36.7</td>
<td>36.4</td>
</tr>
<tr>
<td>2009/10</td>
<td>36.1</td>
<td>35.1</td>
</tr>
<tr>
<td>2010/11</td>
<td>35.1</td>
<td>33.9</td>
</tr>
<tr>
<td>2011/12</td>
<td>36.2</td>
<td>36.2</td>
</tr>
</tbody>
</table>

Source: Child Health Surveillance Programme - ISD Scotland (Published October 2012)
Definitions
1. Breastfeeding information is recorded at the 6-8 week review by the public health/health visitor.
2. Among participating NHS Boards, there is some variation in the timing of the 6-8 week review, although the majority of 6-8 week reviews in Scotland are carried out before babies are 9 weeks old. The maximum age limit for the 6-8 week review is recommended as 12 weeks, some effect on the reported rates as there is a known drop-off in breastfeeding rates with time.
3. The system for recording the information is the Child Health Surveillance Programme (CHSP) and the number of NHS Boards participating in CHSP has increased since 1991. The most recent Scotland data in financial year 2009/10 accounts for approximately 89% of Scotland’s pre-school population.

6. Childhood Immunisations
In Scotland the target of the national immunisation programme is for 95% of children to complete courses of the following routine childhood immunisations by 24 months of age: Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type B (Hib), Meningitis C (Men C) and Pneumococcal Conjugate Vaccine (PCV). An additional target of 95% uptake of one dose of Measles, Mumps and Rubella (MMR) vaccine by 5 years old (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts to reduce the number of susceptible children entering primary school.

In calendar year ending December 2012, NHS Lothian met or exceeded the 95% target for all primary immunisation at 24 months (97.7% for DTP/Pol/Hib; 96.8% for Men C; 97.8% for PCV; 95.0% for MMR1).\(^1\) NHS Lothian exceeded the 95% target for MMR1 at 5 years (96.9%) but not for MMR 2 (91.6%).\(^1\)

3.7 The June 2013 Quality Report set out the Maternity Care Quality Improvement Collaborative, launched in March 2013, which is a new workstream of the Patient Safety Programme. Its overall aim is to improve outcomes and reduce inequalities in outcomes in maternity settings in Scotland. This includes reducing avoidable harm in women and babies by 30% by December 2015 and increase the percentage of women satisfied with their experience of maternity care to greater than 95% by December 2015.

\(^1\) Data source: Source of Data: Childhood Immunisation Statistics - ISD Scotland (Published March 2013)
Quality Dashboard - June 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.\(^2\) 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

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-day Complaints Response Rate *</td>
<td>Number of complaints *</td>
</tr>
<tr>
<td>3-day Complaints Response Rate *</td>
<td></td>
</tr>
</tbody>
</table>

### Quality Ambition: Safe

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

### Quality Ambition: Effective

<table>
<thead>
<tr>
<th>Process Measures</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: January-December 2012 (Next release due Aug/Sept 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>22.22</td>
<td>20.28</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>43.21</td>
<td>38.82</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>49.19</td>
<td>44.87</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>110.08</td>
<td>100.79</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>0.90</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>1.05</td>
</tr>
<tr>
<td>Lothian</td>
<td>Scotland</td>
</tr>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td></td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td></td>
</tr>
</tbody>
</table>

\(^2\) Note that these arrows have not been assigned following a formal set of rules; they are more of a general indication of the last period’s data. For example HSMR is shown to be remaining stable across Lothian, although the actual ratios for the last quarter 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 (Graph 1)</th>
<th>Title: Number of Complaints (Graph 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Percentage of complaints responses within 20 days</td>
<td>Numerator: Total number of complaints</td>
</tr>
<tr>
<td>Denominator: Percentage of all complaints responses</td>
<td>Goal: Reduction in number of formal complaints</td>
</tr>
<tr>
<td>Goal: 85% of complaints responded to within 20 days</td>
<td></td>
</tr>
</tbody>
</table>

**Process Measure**
20-Day Response Target across NHS Lothian, Monthly (Sept 2012-Apr 2013)

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>20-Day Response %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-12</td>
<td>81.00%</td>
</tr>
<tr>
<td>Oct-12</td>
<td>72.00%</td>
</tr>
<tr>
<td>Nov-12</td>
<td>65.00%</td>
</tr>
<tr>
<td>Dec-12</td>
<td>43.00%</td>
</tr>
<tr>
<td>Jan-13</td>
<td>58.47%</td>
</tr>
<tr>
<td>Feb-13</td>
<td>31.15%</td>
</tr>
<tr>
<td>Mar-13</td>
<td>42.86%</td>
</tr>
<tr>
<td>Apr-13</td>
<td>71.00%</td>
</tr>
</tbody>
</table>

Data Source: Datix

**Outcome Measure**
Formal Complaints monthly across NHS Lothian (Oct 2012-Apr 2013)

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Total Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-12</td>
<td>101</td>
</tr>
<tr>
<td>Nov-12</td>
<td>125</td>
</tr>
<tr>
<td>Dec-12</td>
<td>85</td>
</tr>
<tr>
<td>Jan-13</td>
<td>118</td>
</tr>
<tr>
<td>Feb-13</td>
<td>122</td>
</tr>
<tr>
<td>Mar-13</td>
<td>140</td>
</tr>
<tr>
<td>Apr-13</td>
<td>127</td>
</tr>
</tbody>
</table>

Data Source: Datix

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

**Process Measure**
3-Day Response Target across NHS Lothian, Monthly (Sept 2012-Apr 2013)

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>3-Day Response %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-12</td>
<td>100.00%</td>
</tr>
<tr>
<td>Oct-12</td>
<td>90.00%</td>
</tr>
<tr>
<td>Nov-12</td>
<td>80.00%</td>
</tr>
<tr>
<td>Dec-12</td>
<td>24.00%</td>
</tr>
<tr>
<td>Jan-13</td>
<td>83.05%</td>
</tr>
<tr>
<td>Feb-13</td>
<td>59.84%</td>
</tr>
<tr>
<td>Mar-13</td>
<td>92.86%</td>
</tr>
<tr>
<td>Apr-13</td>
<td>97.64%</td>
</tr>
</tbody>
</table>

Data Source: Datix
Quality Ambition: Safe

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

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

**Data Source:** ISD (Quarterly)
Safe: Reduction in Incidents with Harm and improved Incident Management

Title: Incident Management Key Performance Indicators (KPIs) (Graph 7)

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

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

Goal: Compliance target – 100%

Title: Incidents with harm (Graph 8)

Numerator: Number of incidents associated with serious harm reported per month in NHS Lothian (Mar 2011- Jan 2013)

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

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

Process Measure

Outcome Measure

Data Source: Datix

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

Rate of Adverse Events per 1000 patient days. Nov 2008 to May 2012

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

**Title:** Percent compliance with hand hygiene (NHS Lothian Acute Hospitals)  
(Graph 10)

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

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

**Goal:** 95% Compliance

---

**Title:** C. difficile associated disease rate against HEAT Target 2012-13  
(Graph 11)

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

**Goal:** New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.
**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 2012-13 *(Graph 13)*

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

**Goal:** New SAB HEAT targets were set in April 2013 which will be measured against the actually number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.

---

**Process Measure**

**Outcome Measure**

---

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

**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

---

**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

Outcome Measure

OUTCOME MEASURE TO BE DETERMINED

Source Data: Local Audits (QIDS)
Quality Ambition: Effective

“The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.” Progress on this ambition is measured through clinical quality indicators, stroke care, medicine reconciliation and cost effective prescribing in primary care.

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

**Title:** Patient Falls with Harm **(Graph 18)**

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

Data Source: QiDS
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

Process Measure

Data Source: QiDS

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)

Outcome Measure

Data Source: Datix
Effective: Delivering Better Care - Reduction in Nursing Medication Administration Incidents

Title: Number of Nursing Medication incidents per month  (Graph 21)
Numerator: Number of all medication incidents
Goal: 10% reduction in all nursing and midwifery medication errors by March 2013

Outcome Measure

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

Title: Admission to Stroke Unit within 1 day of admission (Graph 22)
Numerator: Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator: Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal: By March 2013 90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

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
4 Key Risks

4.1 Achieving the national 3-day and 20-day response rate target for complaints, sustaining HAI SABs infection rate, achieving the C.Difficile HEAT target and stroke targets.

4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.

4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

5 Risk Register

5.1 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). Compliance with stroke standards is being considered for inclusion on the Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.

6.2 This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).

6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

7 Involving People

7.1 Not applicable.

8 Resource Implications

8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.
List of Appendices

Appendix 1: Supporting Context and Technical Appendix
Context and Technical Appendix

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

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

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

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

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

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

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

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
SUMMARY PAPER - UNSCHEDULED CARE

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

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

- Performance in June for Unscheduled Care was 94.6% against a target to achieve 95% by the end of August 2014. 3.1
- NHS Lothian’s Local Unscheduled Care Plan has been submitted to the Scottish Government and we are awaiting formal feedback. 3.3
- The primary focus has been on ensuring safe provision of Emergency Services from August in light of national reductions of Emergency Medicine training posts. This has involved the successful appointment of 6 Clinical Development Fellows. 3.4
- The Unscheduled Care Board have initiated an evaluation process of supported projects to assess impact and ensure a balanced financial plan for 2014/15 3.5
- Plans for implementing Step-down capacity in Edinburgh are progressing with a phased opening scheduled from October 2013 which is aimed at reducing delayed discharge. 3.6
- A Festival GP practice, operated by Lothian Unscheduled Care Service, will be in operation during the Festival as part of the response to increased population numbers in Edinburgh during August for the Festival 3.7
- Winter planning has commenced for 2013 with staff recruitment planning to ensure staff are in post to support additional bed capacity 3.8

Chris Stirling
Hospital Director, SJH
9 August 2013
Chris.stirling@luht.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note performance against the Emergency Care standard and progress of the Unscheduled Care Group.

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

2 Recommendations

2.1 To note the performance against the Emergency Care Standard and the progress of the Unscheduled Care Group.

3 Discussion of Key Issues

3.1 The NHS Lothian unscheduled care performance for the month of June was 94.6%. The Scottish Government target is to achieve 95% by the end of August 2014 and then to achieve 98% as soon as possible thereafter. There were two twelve hour breaches during the month. The weekly performance is shown below along with the individual site performance.
3.2 Performance across Lothian has improved, notably at St John’s Hospital which recorded its highest performance for since August 2011. Performance challenges still remain and boarding levels remain an issue.
3.3 The Local Unscheduled Care Action Plan (LUCAP) agreed by the Board on 26 June was submitted to the Scottish Government. Formal feedback is still awaited however initial feedback has been positive.

3.4 The principle focus of attention has been on ensuring continued safe delivery of Emergency Medicine services at RIE, SJH and RHSC in light of the reducing number of trainees. This work is outlined in the Medical Workforce Risk Assessment Update and involves the successful recruitment of six Clinical Development Fellows who will support the overnight staffing of the Emergency Department at St John’s while also undertaking other clinical duties and development opportunities.

3.5 The Unscheduled Care Board has initiated an evaluation process for the funding allocations made in 2012/13 and 2013/14 to assess impact with a view to ensuring that the available funding supports projects which make the most significant contribution to sustainably achieving the emergency care standard while ensuring patient safety. This process will conclude by October 2013.

3.6 A key development that is progressing is the introduction of Step-down bed capacity from October 2013 in Edinburgh. This is aimed at supporting a reduction in the number of patients whose discharge from an acute hospital bed is delayed who may be able to safely transferred to alternative facilities in the community.

3.7 In anticipation of the additional numbers of patients who attend during the Edinburgh Festival in August, an additional resource is in place to support activity. This includes a Festival GP practice, awareness raising about the use of the WGH Minor Injuries Unit and additional resources deployed at the RIE.

3.8 Winter planning for 2013 is now underway with plans for recruitment of additional staff being confirmed to ensure early appointment of the additional staff required to cope with the increase in winter flexible beds during this period.

4 Key Risks

4.1 The availability of appropriate numbers and grades of workforce required to deliver the additional capacity identified.

4.2 The performance against delayed discharges and the impact this has on patient flow.

5 Risk Register

5.1 Risks are noted within the NHS Lothian corporate risk register for unscheduled care.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was carried out on 13 June. The main findings were improving access to the general population and those elements of the population most likely to access unscheduled care services (elderly, experiencing long-term conditions, vulnerable adults and those from lower socio-economic areas).
6.2 The membership of the Unscheduled Care Group is drawn from councils, Primary Care, CHPs and Acute sector.

7 Resource Implications

7.1 The resource implications are detailed in the LUCAP and represent a projected spend for 2013/14 of £13.4m. This figure is regularly being reviewed due to the nature of implementation of the unscheduled care schemes.

Chris Stirling
Site Director, St Johns Hospital
10 July 2013
Chris.stirling@luht.scot.nhs.uk
### SUMMARY PAPER - PERFORMANCE MANAGEMENT

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1</td>
<td>CAMHS: 176 people started treatment in May of which 129 (73%) were treated within 18 weeks (compared to our current target trajectory of 75%).</td>
</tr>
<tr>
<td>4.1.2</td>
<td>There are currently 1296* patients waiting for treatment of which, at the end of May, 204 (16%) had been waiting over 18 weeks.</td>
</tr>
<tr>
<td>4.1.2</td>
<td>Psychological Therapies: 98 people had a first treatment for a formal psychological therapy in May, of which 48 (49%) were seen within 18 weeks.</td>
</tr>
<tr>
<td>4.1.2</td>
<td>858 people were still waiting for treatment for a psychological therapy at the end of May of which 189 (22%) had been waiting over 18 weeks.</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Cancer: performance on cancer waiting times was 62 days – 99.3%, and 31 days – 99.7%.</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Delayed Discharges: In June there were 161 patients whose hospital discharge was delayed, including 60 &gt; 2 weeks.</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Stroke: performance has improved to 78.9% but still not as would wish. Work continues to get back towards the national 90% standard.</td>
</tr>
</tbody>
</table>

---

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

Alex McMahon  
Director of Strategic Planning  
10 July 2013  
alex.mcmahon@nhslothian.scot.nhs.uk
PERFORMANCE MANAGEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the 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 the HEAT 2012-13 Performance Management System was updated on Friday 5 July 2013 with data for the last quarter of 2012-13 for a number of items. This data is shown in Appendix 1, unless more up-to-date data from local management systems is available.

2.3 To note that the Annual Review, which will take place on 30 August 2013, is the formal process by which NHS Lothian is held to account for delivery of the HEAT targets and standards during 2012-13.

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)

The key points are:

- 176 people started treatment in May of which 129 (73%) were treated within 18 weeks (compared to our current target trajectory of 75%).
There are currently 1296 patients waiting for treatment of which, at the end of May, 204 (16%) had been waiting over 18 weeks.

The total number of people waiting for treatment has increased by 44 patients from 1252 to 1296 in May.

The CAMHS waiting times data are adjusted for non-attendance in line with national guidance. In order to reduce the number of patients with long waits we are now undertaking a process of reviewing all those over 26 weeks and referring cases via the nominated executive lead to the responsible clinician.

### 4.1.2 Faster Access to Psychological Therapies (PT’s) (Responsible Director: Director Health & Social Care West Lothian)

April performance:
- 98 people had a first treatment for a formal psychological therapy in May, of which 48 (49%) were seen within 18 weeks.
- 858 people were still waiting for treatment for a psychological therapy at the end of May of which 189 (22%) had been waiting over 18 weeks.

The above data includes the following services:
- East Mid Psychological Therapies
- Rivers Centre
- Cullen Centre
- Psychodynamic Psychotherapy
- Veteran’s 1st Point
- West Lothian Older People’s Psychology Service

The A12 team has been working with the adult service in Edinburgh and the Older Peoples services in Edinburgh, East & Mid and West Lothian to make the required changes in order to provide accurate A12 data from these services.

We will also be implementing next month a system to review those with the longest waits in relation to psychological therapies.

The psychological therapies waiting time data has not been adjusted to take account of non-attendance, patient unavailability or reasonable offer. It seems appropriate that we now look at adjusting this data in line with national guidance for non-attendance.

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

Following the delivery of a detailed programme of work undertaken over the last few months led by ISD, the latest information available from clinical audit data on stage distribution for cases of lung, breast and colorectal cancer diagnosed in 2010 and 2011 was published by ISD Scotland at the end of May 2013. This publication triggered the adoption of a baseline upon which the DCE HEAT Target achievement will be measured. NHS Boards were duly requested to submit their revised LDP trajectory to the Scottish Government by the end of June 2013. The trajectory for NHS Lothian has been submitted, and consequently it is now reflected in the
performance appendix to this paper. NHS Lothian must achieve a minimum of 29% of cancers in breast, lung and colorectal cancer combined to be diagnosed at stage 1 of disease, by the end of 2015. The baseline position for NHS Lothian is 22.6%. Quarterly management information will be made available to NHS Boards by the Scottish Government to assist performance management (the date of commencement for this is currently unspecified).

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

In June performance has been 95%.

4.1.5 Reduce Carbon Emissions & Energy Consumption (Responsible Director: Director of Human Resources and Organisational Development)

NHS Lothian was successful in the achievement of HEAT targets in Phase 1 of the programme, showing the best performance of all territorial Boards. A change in baseline between Phase 1 and Phase 2 of the HEAT programme has been detrimental to the Board and resulted in many early actions now being disregarded. NHS Lothian’s energy strategy includes works on asset rationalisation and tough energy standards for new-build designs, however these elements can be overlooked via the current HEAT target calculation method. NHS Lothian continues to be proactive in the implementation of energy efficiency projects, but the options for low cost-quick win measures is reducing. Major investment and changes to what is deemed to be ‘unaffordable’ are now required in order to meet ongoing targets. Given the importance of HEAT targets, this matter will now be referred to NHS Lothian’s Corporate Risk Register. NHS Lothian performs well across other energy/carbon assessment procedures: it holds the Carbon Trust Standard and was the second best NHSScotland Board in the Carbon Reduction Commitment league table for 2012.

4.1.6 IVF Treatment (Responsible Director: Medical Director)

Work is continuing nationally on the collection and recording of data for IVF waits. Edinburgh Fertility and Reproductive Endocrine Centre (EFREC) staff met with ISD colleagues to explore this in July and arrangements are being made, following clarification from the HFEA on the confidentiality requirements, for the patient waits to be added to Trak over the coming months. Once national data requirements are finalised, it is expected that these records will be submitted into ISD data warehouse for national monitoring and eventually publication.

Local information from the service places waits at under a year. This will be able to be tested more robustly once the information is on TRAK. A small number of patients (suggestions are around 6) are waiting in excess of a year where IVF is dependent on donor sperm. Sperm is being sourced to enable these outlying couple to be treated.

To assist with national position on IVF - patients nationally need to be within 12 months by March 2015 - EFREC is assisting with the treatment of patients from other parts of Scotland. Over 100 patients to date have been redirected to Edinburgh for treatment over the coming year from elsewhere. This activity is being funded nationally from Scottish Government monies.
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 May 2013 for NHS Lothian was:

- 62 days – 99.3%
- 31 days – 99.7%

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 June 2013 census:

<table>
<thead>
<tr>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Total Delays (Exc. x-codes)</th>
<th>Complex (X) Codes</th>
<th>&gt;4Weeks National standard from 4/13 is Zero</th>
<th>&gt;2Weeks National standard due in 4/15 will be Zero</th>
<th>Acute Short Stay Beds &gt;3 days</th>
<th>Average length of stay as a delayed discharge Days (non-x)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June</strong></td>
<td>169</td>
<td>109</td>
<td>60</td>
<td>27</td>
<td>60</td>
<td>11</td>
</tr>
</tbody>
</table>

Indicates an increase or decrease from the previous month

- 109 delays after X codes removed (121 May, 107 April, 120 March)
- 169 overall including X codes (183 May, 160 April, 180 March)
- 27 Patients delayed >4 wks (26 May, 17 April, 24 March.)
- 18 days is the average length of stay (16 April, 18, March, 22 Feb)
- 2 Non-Lothian delays (1 May, 1 April, 0 March)
- 60 complex coded delays (62 May, 53 April, 60 March)
- 361 Overall number of patients held on the delayed discharge data base on census day.

The table below sets out the delay by reason and council area for June 13:

<table>
<thead>
<tr>
<th>Count of CH number</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>City of Edinburgh</td>
<td>East Lothian</td>
<td>Midlothian</td>
<td>West Lothian</td>
<td>Falkirk</td>
<td>Scottish Borders</td>
<td>Grand Total</td>
</tr>
<tr>
<td>11A - Awaiting commencement of post-hospital social care assessment</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11B - Awaiting completion of post hospital social care assessment</td>
<td>13</td>
<td>6</td>
<td>3</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24A - Awaiting place in Local Authority Residential Home</td>
<td>18</td>
<td>1</td>
<td></td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24C - Awaiting place in Nursing Home (not NHS funded)</td>
<td>14</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>34D - Awaiting place in Specialist Residential Facility for under 65 age groups</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24F - Awaiting place availability in care home (Elderly &amp; Children had repaired)</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25D - Awaiting completion of social care arrangements - in order to live in own home</td>
<td>5</td>
<td>13</td>
<td>1</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25D0O - Health assessment POC under 16 lives with parent</td>
<td>2</td>
<td>3</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25E - Living in own home - awaiting procurement/delivery of equipment</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25F - Specialist Housing Provision (including homeless patients)</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>71</td>
<td>29</td>
<td>6</td>
<td></td>
<td></td>
<td>106</td>
<td></td>
</tr>
</tbody>
</table>

Data source EDISON delayed Discharge Data base

- Nursing home availability, both in range of choice and affordability for self-funders, remain the largest reason for delay. Within this, placements for patients/clients
needing care homes capable of managing dementia and challenging behaviour are in short supply.

- Demand is still high for supported accommodation-specialist housing for patients delayed with in the Royal Edinburgh Hospital
- Edinburgh have 71 delays which is better than last month’s 85
- East have 29 delays which is one more than last month 28 delays
- West and Midlothian continue to have their residents discharged from Hospital with the national standard of no patient waiting more than 4 weeks from being declared ready for discharge.
- Over the last two years, there has been a sustained and continuing improvement in the speed at which ‘packages of care’ have been put in place for those patients going back home for the acute Hospitals in Lothian.

The following graph shows the totals for both the number of patients and accumulated beds days waiting, from October 2011 to current. On an average daily basis there are around 25 patients waiting as opposed to the 38 in October 2011. Correspondingly 210 days currently, has come down from 450 days of accumulated bed days lots, across those individuals waiting for packages of care to be arranged, enabling them to return home.

Data source: capacity and site Royal Infirmary of Edinburgh

4.2.3 Stroke (Responsible Director: Nurse Director)

Performance has continued to improve across all sites since March 2013, and May’s performance of 78.9% is the best pan-Lothian performance since May 2012, and has met the revised local trajectory of 75%. Weekly exception reports are produced for each site, and the subsequent discussions with site directors and stroke unit charge nurses will continue. With the overall number of stroke patients increasing each month, these will maintain focus on this standard and bring about continued improvement.
4.2.4 Emergency Bed Day Rate 75+yrs. (Responsible Director: Nurse Director)

Lothian continues to reduce its overall Emergency Bed Day rate for the over 75s with a fall of 1.9% against target from June 2012. HEAT target continues to reduce at 0.3% month-on-month. In actual terms, the reduction in the bed day rate has been 3% during that same period.

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, Joint Management Team and other Committees.

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

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

List of Appendices

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

### Appendix 1

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

### Health Improvement

<table>
<thead>
<tr>
<th>HEAT Target</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Owner</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Healthy Weight - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (add: requirement that least 40% of child healthy weight interventions are delivered to children/families in the two most deprived SIMD quintiles by local SIMD datazone to be reported annually)</td>
<td>Mar-14</td>
<td>2,288</td>
<td>Apr-11 - Mar-12 682</td>
<td>Apr-12 - Dec-12 467</td>
<td>265</td>
<td>↓</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>Suicide Reduction - % of suicides per yr per 100,000 pop</td>
<td>2013</td>
<td>20%</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>↓</td>
<td>AKM</td>
<td>This target is currently being reviewed by the Scottish Government. Consultation closes in June 2013.</td>
</tr>
<tr>
<td>Smoking Cessation - to deliver universal smoking cessation services to achieve at least 11,686 successful quitters at one month post quit including 7,011 in the 40% most-deprived within Board SIMD areas over the period 2011/12 to 2013/14</td>
<td>Mar-14</td>
<td>11,686</td>
<td>Mar-13 10,388</td>
<td>Apr-13 10,048</td>
<td>8,360</td>
<td>↑</td>
<td>JP</td>
<td>This includes 6,578 in the 40% most-deprived within Board SIMD.</td>
</tr>
<tr>
<td>Child Fluoride Varnishing Aged 3 - achieve at least 60 per cent of 3 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td>Mar-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Fluoride Varnishing Aged 4 - achieve at least 60 per cent of 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td>Mar-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 20% aim to be diagnosed while in the first stage of the disease</td>
<td>Mar-15</td>
<td>29%</td>
<td>Baseline 22.60</td>
<td></td>
<td>25.60</td>
<td>↓</td>
<td>AKM</td>
<td>Baseline 2010/2011 for NHS Lothian has now been agreed at 22.6% and trajectory for 2012/2013 to 25.60</td>
</tr>
<tr>
<td>Efficiencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Carbon Emissions - % reduction year-on-year (Tonnes of CO2)</td>
<td>Mar-15</td>
<td>-8.73</td>
<td>Qtr 3, 12/13 6.07</td>
<td>Qtr 4, 12/13 6.59</td>
<td>5.91</td>
<td>↑</td>
<td>AB</td>
<td></td>
</tr>
<tr>
<td>Reduce Energy Consumption - % reduction year-on-year (Energy GJ)</td>
<td>Mar-15</td>
<td>-2.07</td>
<td>Qtr 3, 12/13 1.49</td>
<td>Qtr 4, 12/13 1.34</td>
<td>1.89</td>
<td>↓</td>
<td>AB</td>
<td></td>
</tr>
<tr>
<td>Access to Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster access to CARHIS - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td>0</td>
<td>Apr-13 4%</td>
<td>May-13 7%</td>
<td>75%</td>
<td>↓</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td>0</td>
<td>Apr-13 4%</td>
<td>May-13 4%</td>
<td>60%</td>
<td>↓</td>
<td>JF</td>
<td></td>
</tr>
<tr>
<td>Treatment Appropriately for Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Attendances - rate of A&amp;E attendances per 100,000 population</td>
<td>Mar-14</td>
<td>1,911</td>
<td>Apr-13 2,051</td>
<td>May-13 2,105</td>
<td>1,942</td>
<td>↑</td>
<td>AKM</td>
<td></td>
</tr>
<tr>
<td>MRSA / MSSA Reductions - achieve a reduction in the infection rate of methicillin-resistant Staphylococcus aureus bacteraemia (including MRSA) cases to 0.24 or less per 1,000 acute occupied bed days</td>
<td>Mar-15</td>
<td>0.24</td>
<td>Apr-13 0.28</td>
<td>May-13 0.28</td>
<td>0.31</td>
<td>↔</td>
<td>NH</td>
<td>Represented under Nurse-Director's report on Healthcare Associated Infection Initiatives, which will be considered alongside LUCAP and outcome is expected towards end of July.</td>
</tr>
<tr>
<td>C.diff Infections - 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</td>
<td>Mar-15</td>
<td>0.25</td>
<td>Apr-13 0.51</td>
<td>May-13 0.41</td>
<td>0.37</td>
<td>↔</td>
<td>NH</td>
<td>Represented under Nurse-Director's report on Healthcare Associated Infection Initiatives</td>
</tr>
</tbody>
</table>
Note that Lothian emergency bed day rate for 2012 was previously amended accordingly, based on rolling year-on-year SMR01 return, previous months’ totals subject to change as long as patients are discharged.

Lothian continues a downward trajectory month-on-month, distance to Scot Gov milestone remains at 5.7% for second month. Reduction in rates City of Edinburgh and Midlothian offset by small rise in those of East and West Lothian. West continues to be the only council area below target.

### HIAT Standards & Other Measures

<table>
<thead>
<tr>
<th>Drug and Alcohol waiting times</th>
<th>Target Date</th>
<th>Target Patients</th>
<th>Lothian Performance Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Drvr.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</td>
<td>Standard</td>
<td>90%</td>
<td>90.00%</td>
<td>↑</td>
<td>↑</td>
<td>AM/WM</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer Waiting Times - 62 day referral to treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 62 days if urgently referred with a suspicion of cancer, referred through A&amp;E, or referred from one of the national cancer screening programmes</td>
<td>Standard</td>
<td>95%</td>
<td>99.30%</td>
<td>↑</td>
<td>↑</td>
<td>DF</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer Waiting Times - 31 day decision to treat to first treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat, irrespective of the source or urgency of the referral</td>
<td>Standard</td>
<td>95%</td>
<td>99.70%</td>
<td>↑</td>
<td>↑</td>
<td>DF</td>
<td>↑</td>
</tr>
<tr>
<td>Stroke Unit - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Ongoing</td>
<td>90%</td>
<td>79%</td>
<td>↑</td>
<td>↑</td>
<td>MH</td>
<td>↑</td>
</tr>
</tbody>
</table>

### Note

- Local recovery trajectory agreed at: February 80%, March 80%, April 70%, May 75%.
- June 80%, July 90%.

### Lothian Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and Alcohol waiting times</td>
<td>90%</td>
<td>93.90%</td>
<td>94.70%</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer Waiting Times</td>
<td>95%</td>
<td>99.30%</td>
<td>99.70%</td>
<td>↑</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>90%</td>
<td>79%</td>
<td>70%</td>
<td>↑</td>
</tr>
</tbody>
</table>

### Table of Figures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Previous Period</th>
<th>Current Period</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and Alcohol waiting times</td>
<td>90%</td>
<td>93.90%</td>
<td>94.70%</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer Waiting Times</td>
<td>95%</td>
<td>99.30%</td>
<td>99.70%</td>
<td>↑</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>90%</td>
<td>79%</td>
<td>70%</td>
<td>↑</td>
</tr>
</tbody>
</table>
## SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong></td>
<td>Hand Hygiene National Audits for NHS Lothian reported a compliance of 98% compared to the national compliance rate of 96%</td>
</tr>
<tr>
<td><strong>3.2</strong></td>
<td><em>Staphylococcus aureus</em> Bacteraemia (SAB): there were 17 episodes of SAB in June 2013 comparable with the 19 reported in May 2013. In order to achieve the target, NHS Lothian has to average no more than 15 episodes per month for the 24 month period, with a current average of 18 episodes per month.</td>
</tr>
<tr>
<td><strong>3.3</strong></td>
<td><em>Clostridium difficile</em> Infection (CDI): there were 37 episodes of CDI in patients aged 15 or over in June 2013, compared with 25 reported in May 2013. In order to achieve the target, NHS Lothian has to average no more than 21 episodes per month for the 24 month period, with a current average of 34 episodes per month.</td>
</tr>
<tr>
<td><strong>3.4</strong></td>
<td>Norovirus outbreaks: Since 1/1/2013 there have been 481 patients identified as norovirus positive in acute sites, with 19 patients identified as norovirus positive within community hospitals.</td>
</tr>
<tr>
<td><strong>3.5</strong></td>
<td>The Meticillin Resistant <em>Staphylococcus aureus</em> Screening Programme: First quarter's data will be reported to Health Protection Scotland during July 2013.</td>
</tr>
<tr>
<td><strong>3.6</strong></td>
<td>Mandatory Surgical Site Infection Surveillance: NHS Lothian continues to monitor and report mandatory Surgical Site Infection Surveillance and are currently investigating a cluster of superficial wound infections following caesarean sections at the Royal Infirmary in May 2013.</td>
</tr>
<tr>
<td><strong>3.7</strong></td>
<td>Healthcare Environmental Inspectorate (HEI): The Healthcare Environmental Inspectorate report for Royal Infirmary was published on the 24 June 2013 identifying 5 requirements for which an action plan has been developed.</td>
</tr>
<tr>
<td><strong>3.8</strong></td>
<td>Antimicrobial Management Team: a 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.</td>
</tr>
</tbody>
</table>

Fiona Cameron  
Head of Infection Prevention and Control Services  
10 July 2013  
fiona.cameron@nhslothian.scot.nhs.uk
HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection 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 Progress against Health Efficiency Access Treatment (HEAT) Targets
### 3.2 *Staphylococcus aureus* Bacteraemia

In June 2013, there were 17 episodes of *Staphylococcus aureus* Bacteraemia, compared to 19 in May 2013. 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 0.25 (updated to June 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 18 episodes per month.

Collaborative working with Health Protection Scotland, Infection Prevention and Control Services continues. There is a focus of resources with support from Practice Education and Patient Safety Programme on activities for a sustained reduction which includes:

- Promote engagement of the clinical team with investigation of all *Staphylococcus aureus* bacteraemias and review of associated clinical practice
- Promotion of related care bundles such as Peripheral Catheter Insertion and Maintenance
- Associated Clinical Skills Education

### 3.3 *Clostridium difficile* Infection

In June 2013, there were 37 episodes of *Clostridium difficile* Infection in patients aged 15 or over, compared to 25 in May 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 0.45 (updated to June 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 of April. The previous year with extended denominator averaged 30 episodes per month.
3.4 Norovirus outbreaks: Since 1/1/2013 there have been 481 patients identified as norovirus positive in acute sites, with 19 patients identified as norovirus positive within community hospitals. Sporadic incidences continue.

3.5 The Meticillin Resistant *Staphylococcus aureus* Screening Programme: NHS Lothian is currently embedding the process outlined in the Chief Nursing and Medical Officer Letter which was distributed to NHS Boards on 1 May 2013 and will be reporting the first quarter’s data during July 2013 to Health Protection Scotland.

3.6 Mandatory Surgical Site Infection Surveillance: NHS Lothian continues to monitor and report mandatory Surgical Site Infection Surveillance on caesarean sections, hip arthroplasty and repair fracture neck of femur. An Incident Management Team are currently investigating a cluster of 4 cases of superficial wound infection following caesarean section at the Royal Infirmary in May 2013.

3.7 Healthcare Environmental Inspectorate: The Healthcare Environmental Inspectorate report for Royal Infirmary was published on the 24 June 2013 identifying 5 requirements for which an action plan has been developed. The Healthcare Environment Inspectorate requested an 16 week action plan update for the unannounced Inspection at the Western General Hospital on 27-28 February 2013. This was returned to Inspectorate on 3 July 2013. The NHS Lothian Healthcare Associate Infection Self Assessment update along with associated evidence date, was also returned to the Healthcare Environment Inspectorate on 3 July 2013.

3.8 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.

Fiona Cameron  
Head of Infection Prevention and Control Services  
11 July 2013  
fiona.cameron@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
**Royal Infirmary of Edinburgh**

**Staphylococcus aureus** Bacteraemia (SAB)
There were 2 SAB recorded during June 2013.

**Clostridium difficile** Infection (CDI)
There were 12 CDI recorded during June 2013.

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

---

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<th>Year</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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96%</td>
<td>97%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
<td>97%</td>
<td>na</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<th>Year</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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<th>Year</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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
</tr>
</tbody>
</table>

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

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

---

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

**MRSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th>Year</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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th>Year</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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during June 2013.

**Clostridium difficile Infection (CDI)**
There were 9 CDI recorded during June 2013.

---

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

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>na</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**Staphylococcus aureus Bacteraemia (SAB)**
There were 2 SAB recorded during June 2013.

**Clostridium difficile Infection (CDI)**
There were 3 CDI recorded during June 2013.

---

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

### Hand Hygiene Monitoring Compliance
<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>99%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>na</td>
</tr>
</tbody>
</table>

### Cleaning Compliance
<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### Estates Monitoring Compliance
<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>93%</td>
<td>93%</td>
<td>95%</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
<td>93%</td>
</tr>
</tbody>
</table>

---

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

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

**MRSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
**Liberton Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during June 2013.

**Clostridium difficile Infection (CDI)**
There were no CDI recorded during June 2013.

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

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
<td>na</td>
</tr>
</tbody>
</table>

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>98%</td>
<td>94%</td>
<td>81%</td>
<td>97%</td>
<td>98%</td>
<td>95%</td>
<td>97%</td>
<td>94%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>69%</td>
<td>96%</td>
<td>87%</td>
<td>94%</td>
<td>94%</td>
<td>91%</td>
<td>85%</td>
<td>90%</td>
<td>94%</td>
<td>95%</td>
<td>93%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**MRSA Bacteraemia Cases**

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
**Royal Hospital for Sick Children**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during June 2013.

**Clostridium difficile Infection (CDI)**
There were no CDI recorded during June 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

### Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>97%</td>
<td>95%</td>
<td>97%</td>
<td>97%</td>
<td>94%</td>
<td>98%</td>
<td>85%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>na</td>
</tr>
</tbody>
</table>

### Cleaning Compliance

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>97%</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>94%</td>
<td></td>
</tr>
</tbody>
</table>

### Estates Monitoring Compliance

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>99%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
</tbody>
</table>

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Staphylococcus aureus Bacteraemia (SAB)
There were no SAB recorded during June 2013.

Clostridium difficile Infection (CDI)
There were no CDI recorded during June 2013.

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

Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97%</td>
<td>97%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>na</td>
<td></td>
</tr>
</tbody>
</table>

Cleaning Compliance

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>97%</td>
<td>96%</td>
<td></td>
</tr>
</tbody>
</table>

Estates Monitoring Compliance

<table>
<thead>
<tr>
<th></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>
<th>M-13</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

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

MRSA Bacteraemia Cases

MSSA Bacteraemia Cases

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

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during June 2013.

**Clostridium difficile Infection (CDI)**
There were 2 CDI recorded during June 2013.

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

**Staphylococcus aureus** Bacteraemia (SAB)
Patients who are identified with a SAB within 48 hours of admission to Hospital are included in this report card.
There were 12 SAB recorded during June 2013.

**Clostridium difficile** Infection (CDI)
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice's.
There were 11 CDI recorded during June 2013.

This is the new Report Card Format introduced by Scottish Government July 2011
**SUMMARY PAPER - FINANCIAL POSITION TO 30 JUNE 2013**

This paper aims to summarise the key points in the full paper available to Board members at the meeting.

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The Board has overspent by £1.16m in June bringing the year to date position to £1.92m overspent.</td>
</tr>
<tr>
<td>3.2</td>
<td>The key unanticipated issue impacting on the financial position in June is price increases within GP Prescribing. It is however too early to predict whether this will be an ongoing issue and it will be kept under close review.</td>
</tr>
<tr>
<td>3.3</td>
<td>The clinical supplies overspend is a further key issue but is supported by provision in the financial plan. Funding will be released following detailed work on this.</td>
</tr>
<tr>
<td>3.8</td>
<td>Efficiencies of £4.5m have been delivered against the annual plan of £27.8m. However of the savings delivered year to date; only £3.2m is recurring. The efficiency &amp; productivity group will determine what further recurring plans can be implemented to maximise the recurrency of overall delivery by the year-end.</td>
</tr>
<tr>
<td>3.11</td>
<td>The cost of providing elective capacity to meet waiting times targets in the first three months is higher than expected. However no variance is reported as part of the year to date position pending the finalisation of a robust year-end forecast.</td>
</tr>
<tr>
<td>3.15, 4.1</td>
<td>Across all Services, a detailed Quarter 1 year end forecast is currently being prepared which will consider all financial risks and available resources.</td>
</tr>
</tbody>
</table>

Susan Goldsmith  
Director of Finance  
15 July 2013  
susan.goldsmith@nhslothian.scot.nhs.uk
FINANCIAL POSITION TO 30 JUNE 2013

1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the financial position to the end of June 2013.

1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendation

- To note an overspend of £1.16m in June bringing the financial position for the first three months to £1.92m overspent.
- To note the quarter one review forecasting process is currently underway which will consider underlying recurring emerging issues as well as the overall year end position.

3 Discussion of Key Issues

3.1 NHS Lothian is reporting an overspend in the month of £1.16m bringing the overall position for the first quarter to £1.92m overspent. Table 1 below provides a summary of the position; a detailed analysis by expenditure type is attached as Appendix 1 and by operational unit in Appendix 2.

Table 1: Financial Position to 30 June 2013

<table>
<thead>
<tr>
<th></th>
<th>In month £k</th>
<th>Year to date £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline position</td>
<td>(1,282)</td>
<td>(666)</td>
</tr>
<tr>
<td>Efficiency savings</td>
<td>120</td>
<td>(1,250)</td>
</tr>
<tr>
<td><strong>Operational position</strong></td>
<td>(1,162)</td>
<td>(1,916)</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total under/(over) Spend</strong></td>
<td>(1,162)</td>
<td>(1,916)</td>
</tr>
</tbody>
</table>
3.2 The £1.28m overspend in the month within the baseline position is largely driven by GP Prescribing where an increase in average prices within the first months data has given rise to an overspend of £0.6m. It is too early to predict whether this represents an underlying pressure and the position will be monitored closely.

3.3 Within non-pay, excluding prescribing an overspend of £1.5m is recorded in the month largely driven by clinical supplies overspends (reported as Medical Supplies and Ancillary/Admin costs). Work is underway to ensure that the £4m financial plan investment for clinical supplies pressure is allocated appropriately against underlying pressures and this funding has yet to be fed in to the position at this stage.

3.4 A £0.7m over-recovery in the month on income is spread across business units and is largely offset by non-pay overspends with budgets being appropriately realigned for future months.

3.5 Overall for the year to date, the key issues impacting on the £0.67m baseline overspend are the anticipated pressure on clinical supplies for which financial plan funding is yet to be allocated; the unanticipated overspend on GP Prescribing; a net pressure within nursing (after financial plan support for incremental drift and enhancements) largely driven by constant observation costs across Older People, Mental Health and Learning Disabilities and finally with support services pay, an emerging incremental drift pressure across Estates (Logistics and Catering) for which further work is underway to quantify more fully.

3.6 To assess movements in cost, compared with movements in activity, Appendix 3 provides a summary of acute activity by speciality for the first three months compared to activity for the same period last year.

3.7 The PMS allocation for 2013/14 has now been made to NHS Lothian by the Scottish Government. The PMS allocation is based on the list sizes of all the Lothian practices and in addition to a 1.3% uplift provides a further 0.6% towards the issue of demographical change within the Lothian population. The overall allocation has been increased by £1.9m. The allocation is in line with the financial planning assumptions for this year.

**Efficiency & Productivity**

3.8 For the 3 month period to June, efficiencies (or Local Reinvestment Plans – LRP) of £4.5m have been delivered against the annual plan of £27.8m. This reflects an under delivery of £1.25m against the target for the period, comprising £0.79m against workstreams and £0.47m against local LRP targets. Table 2 provides a summary. Appendix 5 provides a break down of delivery against local and workstream targets.
Table 2: Efficiency and Productivity 2013/14

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target</th>
<th>Target £k</th>
<th>Actuals £k</th>
<th>Slippage £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Workstreams</td>
<td>(7,376)</td>
<td>(1,565)</td>
<td>(1,095)</td>
<td>(470)</td>
</tr>
<tr>
<td>Centrally Held</td>
<td>(13,296)</td>
<td>(2,165)</td>
<td>(1,378)</td>
<td>(787)</td>
</tr>
<tr>
<td></td>
<td>(7,160)</td>
<td>(1,974)</td>
<td>(1,982)</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>(27,832)</td>
<td>(5,704)</td>
<td>(4,455)</td>
<td>(1,249)</td>
</tr>
</tbody>
</table>

3.9 There was a slight overachievement of LRP during month 3, resulting in a decrease to the level of slippage year-to-date.

3.10 Of the £4.5m delivered in the first quarter only £3.2m has been delivered on a recurring basis. The level of non recurring delivery combined with the level of slippage in the first quarter has been noted as a concern by the efficiency & productivity group and additional plans are now being identified to maximise recurrency of delivery achieved in 2013/14.

3.11 Across workstreams, whilst Prescribing, Procurement and Labs are reporting slippage in the first quarter against plan, this is considered to be a timing issue only with catch up in the coming months.

3.12 For Outpatients and Review of Interventions of Limited Clinical Value, work to measure efficiency gain and potential to avoid future investment in additional capacity is complex and challenging and this is impacting on planned timescales for delivery.

3.13 The slippage on delivery of Local LRP across University Hospital Services continues to be a key issue. Whilst there has been an improvement in the level of delivery within a number of areas, much of this has been delivered non-recurrently.

Waiting times

3.14 The total cost of delivering additional elective capacity to meet waiting times to the end of June is £7.48m. Expenditure remains higher than projected, in particular in relation to Other Contractors (primarily Medinet) where support to outpatient See & Treat programmes is likely to continue beyond the period identified in the initial forecast. No variance is reported against this position pending Q1 review. Table 3 provides a summary of expenditure to date.
Table 3: Expenditure on Elective Capacity

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outturn</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Internal</td>
<td>7,905</td>
<td>659</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>12,081</td>
<td>1,007</td>
</tr>
<tr>
<td>Other Contractors</td>
<td>4,921</td>
<td>410</td>
</tr>
<tr>
<td>Other NHS</td>
<td>2,642</td>
<td>220</td>
</tr>
<tr>
<td>Total</td>
<td>27,549</td>
<td>2,296</td>
</tr>
</tbody>
</table>

3.15 Progress against recovery trajectories, for outpatients in particular, has been slower than forecast and this presents a significant risk to the forecast. Planned expenditure with independent sector and other contracts has been based on initial forecasts prepared against recovery plans identified in April; these projections included an expected reduction in the use of external capacity from October, with a significant step change in internal capacity on these timescales. The use of other contractors (primarily Medinet) is now expected to be higher than projected. A revised forecast is being prepared in advance of Q1 review.

Property & Asset Management

3.16 A property & asset management investment programme of £71.4m has been agreed for 2013/14, of which £3.1m has been incurred to the end of June 2013. The plan and expenditure to date on individual schemes is set out at Appendix 4. The planned over-commitment of £6.7m will be reviewed as part of the Q1 forecast.

Non recurring position

3.17 A number of investments, including nursing incremental drift and enhancements, were funded in the approved 2013/14 Financial Plan on a non recurring basis. The funding source for these was the expected carry forward from financial year 2012/13, with the recurring implications to be reflected in the Financial Plan for 2014/15. In addition to these specific areas, further anticipated non recurring resources assumed in the Financial Plan were also targeted at the balance of investment required to support the elective and unscheduled care capacity plans, which was beyond the recurring NRAC funding available.

3.18 As part of the initial work on the formal Quarter 1 financial review, a high level analysis of the non recurring position has been undertaken. This indicates that the emerging waiting times pressures (beyond the approved investment) will potentially absorb forecast non-recurring resources likely to be available.

3.19 Investment in capacity to deliver waiting times is the first call on any unplanned additional in year funding (whether this is financial plan slippage, other reserves or any other non recurring benefits). However, it is also recognised that there are
other system-wide issues, particularly in relation to unscheduled care, which potentially impact on service delivery and which may require further investment beyond the approved Financial Plan.

3.20 These issues are being explored, and it is anticipated that the detail will be presented as part of the Quarter 1 review which will be available in mid August.

3.21 As well as considering the likely financial impact, the Quarter 1 review will also take cognisance of discussions already underway between the finance team and operational managers, to develop processes and methodologies to support in year financial planning. This concept was introduced at the recent Budget Seminars, and seeks to address the dichotomy of maintaining tight financial discipline whilst also devolving non recurring funds appropriately (when available), to help budget holders target specific priorities based on patient need.

4 Key Risks

4.1 As in 2012/13, ongoing risks will continue to be managed as trends influencing the financial position become clearer. Examples include:

- Identification of further recurring LRP schemes to mitigate potential shortfall in recurring delivery.
- Development and implementation of a process to identify and reinvest non-recurring resources.
- A robust formal Quarter 1 Review forecast is being prepared in conjunction with budget holders which will encapsulate all potential financial risks and opportunities.
- Continued management of the financial exposure on delivery of elective and unscheduled care capacity;
- The delivery of a significant backlog maintenance programme to address areas of high and significant risk.
- Robust monitoring of the GP Prescribing position, particularly in respect of movement in price.

5 Risk Register

5.1 There is nothing to add to the Risk Register at this stage.

6 Health and Other Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Involving People

7.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local
partnership forums and makes its monthly monitoring returns available under non-routine FOI requests from other stakeholders.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith  
Director of Finance  
15 July 2013  
susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Income and Expenditure Summary June 2013  
Appendix 2: NHS Lothian Summary by Operational Unit June 2013  
Appendix 3: NHS Lothian Summary of Acute Activity June 2013  
Appendix 4: NHS Lothian Property and Asset Management Investment Programme Summary June 2013  
Appendix 5: Efficiency and Productivity Summary June 2013
### NHS LOTHIAN CORE POSITION

#### INCOME

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from other health systems</td>
<td>(145,401)</td>
<td>(38,039)</td>
<td>(37,956)</td>
<td>(82)</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(55,637)</td>
<td>(14,207)</td>
<td>(14,180)</td>
<td>(27)</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,433)</td>
<td>(608)</td>
<td>(554)</td>
<td>(54)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(1,918)</td>
<td>(479)</td>
<td>(479)</td>
<td>0</td>
</tr>
<tr>
<td>Other income</td>
<td>(37,796)</td>
<td>(17,274)</td>
<td>(18,073)</td>
<td>799</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td><strong>(243,184)</strong></td>
<td><strong>(70,608)</strong></td>
<td><strong>(71,243)</strong></td>
<td><strong>636</strong></td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,288,029)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>(1,531,213)</strong></td>
<td><strong>(70,608)</strong></td>
<td><strong>(71,243)</strong></td>
<td><strong>636</strong></td>
</tr>
</tbody>
</table>

#### EXPENDITURE

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Dental Staff</td>
<td>205,596</td>
<td>49,767</td>
<td>48,475</td>
<td>1,292</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>335,558</td>
<td>83,017</td>
<td>83,678</td>
<td>(661)</td>
</tr>
<tr>
<td>Allied Healthcare Professional</td>
<td>56,116</td>
<td>13,738</td>
<td>13,738</td>
<td>0</td>
</tr>
<tr>
<td>Support Services / Other</td>
<td>52,673</td>
<td>12,661</td>
<td>13,121</td>
<td>(460)</td>
</tr>
<tr>
<td>Health Science Services</td>
<td>35,534</td>
<td>8,463</td>
<td>8,107</td>
<td>356</td>
</tr>
<tr>
<td>Personal &amp; Social / Therapeutic</td>
<td>24,337</td>
<td>6,029</td>
<td>5,778</td>
<td>252</td>
</tr>
<tr>
<td>Management/Admin Staff</td>
<td>84,596</td>
<td>20,016</td>
<td>19,883</td>
<td>133</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td><strong>794,409</strong></td>
<td><strong>193,691</strong></td>
<td><strong>192,780</strong></td>
<td><strong>911</strong></td>
</tr>
<tr>
<td>Non-Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>98,338</td>
<td>24,321</td>
<td>24,582</td>
<td>(261)</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>68,980</td>
<td>18,033</td>
<td>17,717</td>
<td>316</td>
</tr>
<tr>
<td>Equipment</td>
<td>16,169</td>
<td>2,815</td>
<td>3,041</td>
<td>(227)</td>
</tr>
<tr>
<td>Other Non Pays</td>
<td>4,162</td>
<td>65</td>
<td>(336)</td>
<td>401</td>
</tr>
<tr>
<td>Prescribing</td>
<td>126,742</td>
<td>30,045</td>
<td>30,659</td>
<td>(615)</td>
</tr>
<tr>
<td>GMS</td>
<td>114,305</td>
<td>27,097</td>
<td>27,031</td>
<td>67</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4,557</td>
<td>1,058</td>
<td>1,320</td>
<td>(262)</td>
</tr>
<tr>
<td>Property/Transport</td>
<td>49,508</td>
<td>10,290</td>
<td>10,675</td>
<td>(385)</td>
</tr>
<tr>
<td>Ancillary / Admin Costs</td>
<td>227,694</td>
<td>24,461</td>
<td>25,709</td>
<td>(1,248)</td>
</tr>
<tr>
<td><strong>Total Non-Pay</strong></td>
<td><strong>710,454</strong></td>
<td><strong>138,186</strong></td>
<td><strong>140,398</strong></td>
<td><strong>(2,212)</strong></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>1,504,863</strong></td>
<td><strong>331,877</strong></td>
<td><strong>333,178</strong></td>
<td><strong>(1,302)</strong></td>
</tr>
</tbody>
</table>

### NHS LOTHIAN CORE/BASELINE POSITION

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRP</td>
<td>(11,417)</td>
<td>(1,250)</td>
<td>0</td>
<td>(1,250)</td>
</tr>
</tbody>
</table>

### NHS LOTHIAN NON CORE POSITION

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>YTD Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation &amp; Capital Grants</td>
<td>37,310</td>
<td>8,785</td>
<td>7,285</td>
<td>1,500</td>
</tr>
<tr>
<td>Revenue Funded Capital Schemes</td>
<td>0</td>
<td>0</td>
<td>1,500</td>
<td></td>
</tr>
<tr>
<td>Impairments, Provisions &amp; Donated Depreciation</td>
<td>457</td>
<td>457</td>
<td>457</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL NHS LOTHIAN CORE/Non Core Position</strong></td>
<td>37,766</td>
<td>9,242</td>
<td>9,242</td>
<td>0</td>
</tr>
</tbody>
</table>

### APPENDIX 1

**NHS Lothian Income and Expenditure Summary June 2013**
<table>
<thead>
<tr>
<th>Operational Unit</th>
<th>Annual Budget</th>
<th>YTD</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITALS SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Services</td>
<td>150,136</td>
<td>36,590</td>
<td>36,990</td>
<td>(401)</td>
<td>(269)</td>
<td>(132)</td>
</tr>
<tr>
<td>Corporate - Divisional</td>
<td>(22,914)</td>
<td>(8,547)</td>
<td>(8,547)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>LUHS AHP Services</td>
<td>14,201</td>
<td>3,561</td>
<td>3,634</td>
<td>(73)</td>
<td>(63)</td>
<td>(11)</td>
</tr>
<tr>
<td>Corporate Services UHS</td>
<td>4,641</td>
<td>764</td>
<td>777</td>
<td>(11)</td>
<td>7</td>
<td>(18)</td>
</tr>
<tr>
<td>Royal Infirmary Edinburgh Site</td>
<td>65,172</td>
<td>16,683</td>
<td>17,055</td>
<td>(371)</td>
<td>(275)</td>
<td>(96)</td>
</tr>
<tr>
<td>St Johns Hospital Site</td>
<td>15,701</td>
<td>4,096</td>
<td>4,329</td>
<td>(234)</td>
<td>(227)</td>
<td>(7)</td>
</tr>
<tr>
<td>Surgical Services Directorate</td>
<td>160,480</td>
<td>41,214</td>
<td>41,684</td>
<td>(470)</td>
<td>(238)</td>
<td>(232)</td>
</tr>
<tr>
<td>Western General Hospital Site</td>
<td>54,320</td>
<td>13,763</td>
<td>13,944</td>
<td>(180)</td>
<td>(137)</td>
<td>(43)</td>
</tr>
<tr>
<td>Women Children &amp; Neuroscience</td>
<td>95,469</td>
<td>22,986</td>
<td>22,817</td>
<td>169</td>
<td>268</td>
<td>(100)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>537,205</strong></td>
<td><strong>131,110</strong></td>
<td><strong>132,681</strong></td>
<td>(1,571)</td>
<td>(932)</td>
<td>(639)</td>
</tr>
<tr>
<td>CHPs/CHCP/PCCO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>297,320</td>
<td>70,818</td>
<td>71,648</td>
<td>(829)</td>
<td>(829)</td>
<td>0</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>72,230</td>
<td>33,693</td>
<td>33,973</td>
<td>(280)</td>
<td>(277)</td>
<td>(4)</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>46,929</td>
<td>11,183</td>
<td>11,202</td>
<td>(19)</td>
<td>(13)</td>
<td>(7)</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>103,545</td>
<td>24,006</td>
<td>24,112</td>
<td>(105)</td>
<td>(98)</td>
<td>(8)</td>
</tr>
<tr>
<td>Primary Care Other</td>
<td>(7,595)</td>
<td>(6,495)</td>
<td>(6,497)</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>512,429</strong></td>
<td><strong>133,205</strong></td>
<td><strong>134,437</strong></td>
<td>(1,233)</td>
<td>(1,215)</td>
<td>(18)</td>
</tr>
<tr>
<td>CORPORATE BUDGETS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive</td>
<td>510</td>
<td>124</td>
<td>126</td>
<td>(2)</td>
<td>0</td>
<td>(2)</td>
</tr>
<tr>
<td>Consortium</td>
<td>46,466</td>
<td>11,332</td>
<td>11,294</td>
<td>37</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Communications</td>
<td>1,138</td>
<td>253</td>
<td>244</td>
<td>9</td>
<td>10</td>
<td>(2)</td>
</tr>
<tr>
<td>Ehealth</td>
<td>20,189</td>
<td>3,794</td>
<td>3,792</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>81,913</td>
<td>17,830</td>
<td>18,213</td>
<td>(383)</td>
<td>(358)</td>
<td>(25)</td>
</tr>
<tr>
<td>Finance &amp; Capital Planning</td>
<td>10,103</td>
<td>2,477</td>
<td>2,504</td>
<td>(27)</td>
<td>(22)</td>
<td>(5)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>10,287</td>
<td>1,236</td>
<td>1,104</td>
<td>132</td>
<td>136</td>
<td>(4)</td>
</tr>
<tr>
<td>Medical Director</td>
<td>1,677</td>
<td>88</td>
<td>97</td>
<td>(9)</td>
<td>(9)</td>
<td>0</td>
</tr>
<tr>
<td>Nursing</td>
<td>6,975</td>
<td>(1,032)</td>
<td>(1,124)</td>
<td>92</td>
<td>94</td>
<td>(3)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12,635</td>
<td>2,840</td>
<td>2,772</td>
<td>68</td>
<td>78</td>
<td>(10)</td>
</tr>
<tr>
<td>Planning</td>
<td>3,615</td>
<td>(2,308)</td>
<td>(2,339)</td>
<td>32</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>Public Health</td>
<td>7,120</td>
<td>929</td>
<td>858</td>
<td>71</td>
<td>98</td>
<td>(28)</td>
</tr>
<tr>
<td>Other</td>
<td>114</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>202,745</strong></td>
<td><strong>37,562</strong></td>
<td><strong>37,542</strong></td>
<td>20</td>
<td>98</td>
<td>(78)</td>
</tr>
<tr>
<td>STRATEGIC BUDGETS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLAs/UNPACs/NCA</td>
<td>12,865</td>
<td>3,197</td>
<td>3,192</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Income from other health systems</td>
<td>(1,240,647)</td>
<td>(30,939)</td>
<td>(30,574)</td>
<td>(366)</td>
<td>(366)</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation, Capital Grants &amp; Asset Impairment</td>
<td>34,406</td>
<td>8,879</td>
<td>8,879</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Provisions for Pension Costs &amp; Claims</td>
<td>9,096</td>
<td>959</td>
<td>643</td>
<td>317</td>
<td>317</td>
<td>0</td>
</tr>
<tr>
<td>Commissioning from 3rd Sector</td>
<td>13,914</td>
<td>3,559</td>
<td>3,815</td>
<td>(256)</td>
<td>(232)</td>
<td>(25)</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>7,679</td>
<td>1,559</td>
<td>1,559</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reserves &amp; Uncommitted Allocations</td>
<td>(93,030)</td>
<td>1,297</td>
<td>1,708</td>
<td>(411)</td>
<td>80</td>
<td>(491)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,255,717</strong></td>
<td><strong>11,490</strong></td>
<td><strong>10,779</strong></td>
<td><strong>711</strong></td>
<td><strong>195</strong></td>
<td><strong>516</strong></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>(3,337)</strong></td>
<td><strong>290,388</strong></td>
<td><strong>293,883</strong></td>
<td><strong>(3,495)</strong></td>
<td><strong>(2,245)</strong></td>
<td><strong>(1,250)</strong></td>
</tr>
<tr>
<td>Waiting Times</td>
<td>3,337</td>
<td>53</td>
<td>53</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Offset by release of provisions and reserves</td>
<td>0</td>
<td>1,581</td>
<td>0</td>
<td>1,581</td>
<td>1,581</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>0</strong></td>
<td><strong>292,022</strong></td>
<td><strong>293,935</strong></td>
<td><strong>(1,916)</strong></td>
<td><strong>(666)</strong></td>
<td><strong>(1,250)</strong></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>------------</td>
<td>------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td><strong>CLINICAL SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Radiology</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>44</td>
<td>39</td>
<td>12</td>
<td>13</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>1,010</td>
<td>1,235</td>
<td>337</td>
<td>416</td>
<td>335</td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td>3,196</td>
<td>2,876</td>
<td>1,004</td>
<td>950</td>
<td>1,065</td>
<td></td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>2,432</td>
<td>2,404</td>
<td>756</td>
<td>776</td>
<td>811</td>
<td></td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>1,546</td>
<td>1,481</td>
<td>459</td>
<td>488</td>
<td>515</td>
<td></td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>31</td>
<td>14</td>
<td>10</td>
<td>4</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1,621</td>
<td>1,472</td>
<td>510</td>
<td>466</td>
<td>541</td>
<td></td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>287</td>
<td>279</td>
<td>74</td>
<td>87</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>158</td>
<td>169</td>
<td>51</td>
<td>53</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>1,580</td>
<td>1,532</td>
<td>499</td>
<td>587</td>
<td>527</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>65</td>
<td>80</td>
<td>18</td>
<td>34</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td><strong>ROYAL INFIRMARY EDINBURGH SITE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>270</td>
<td>234</td>
<td>89</td>
<td>76</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>1,772</td>
<td>1,852</td>
<td>554</td>
<td>608</td>
<td>591</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>5,049</td>
<td>4,865</td>
<td>1,684</td>
<td>1,607</td>
<td>1,683</td>
<td></td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>956</td>
<td>909</td>
<td>309</td>
<td>323</td>
<td>319</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>97</td>
<td>27</td>
<td>14</td>
<td>11</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>1,173</td>
<td>1,171</td>
<td>380</td>
<td>400</td>
<td>391</td>
<td></td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>293</td>
<td>271</td>
<td>106</td>
<td>90</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td><strong>ST JOHNS HOSPITAL SITE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>998</td>
<td>1,007</td>
<td>343</td>
<td>359</td>
<td>333</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>2,226</td>
<td>2,204</td>
<td>682</td>
<td>747</td>
<td>742</td>
<td></td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>141</td>
<td>134</td>
<td>49</td>
<td>44</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>57</td>
<td>40</td>
<td>15</td>
<td>17</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td><strong>SURGICAL SERVICES DIRECTORATE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>924</td>
<td>941</td>
<td>293</td>
<td>314</td>
<td>308</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1,001</td>
<td>908</td>
<td>298</td>
<td>301</td>
<td>333</td>
<td></td>
</tr>
<tr>
<td>General Surgery (excl vascular)</td>
<td>5,732</td>
<td>5,891</td>
<td>1,935</td>
<td>2,044</td>
<td>1,909</td>
<td></td>
</tr>
<tr>
<td>Renal Medicine</td>
<td>267</td>
<td>289</td>
<td>81</td>
<td>104</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Trauma and Orthopaedic Surgery</td>
<td>2,716</td>
<td>2,689</td>
<td>905</td>
<td>948</td>
<td>905</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>2,048</td>
<td>1,792</td>
<td>665</td>
<td>539</td>
<td>683</td>
<td></td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>566</td>
<td>655</td>
<td>198</td>
<td>219</td>
<td>188</td>
<td></td>
</tr>
<tr>
<td><strong>WESTERN GENERAL HOSPITAL SITE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>71</td>
<td>85</td>
<td>31</td>
<td>26</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Endocrinology</td>
<td>41</td>
<td>48</td>
<td>10</td>
<td>16</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>2,077</td>
<td>1,974</td>
<td>656</td>
<td>644</td>
<td>692</td>
<td></td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>542</td>
<td>663</td>
<td>178</td>
<td>273</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>294</td>
<td>353</td>
<td>90</td>
<td>111</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>2</td>
<td>44</td>
<td>2</td>
<td>24</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>371</td>
<td>411</td>
<td>121</td>
<td>133</td>
<td>123</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>13,254</td>
<td>13,165</td>
<td>4,375</td>
<td>4,469</td>
<td>4,415</td>
<td></td>
</tr>
</tbody>
</table>
**WOMEN CHILDREN & NEUROSCIENCE**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>2,177</td>
<td>2,186</td>
<td>693</td>
<td>731</td>
<td>725</td>
</tr>
<tr>
<td>Midwifery</td>
<td>461</td>
<td>453</td>
<td>162</td>
<td>171</td>
<td>153</td>
</tr>
<tr>
<td>Neurology</td>
<td>402</td>
<td>383</td>
<td>128</td>
<td>119</td>
<td>134</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>618</td>
<td>647</td>
<td>218</td>
<td>203</td>
<td>205</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>3,135</td>
<td>2,975</td>
<td>1,111</td>
<td>1,013</td>
<td>1,046</td>
</tr>
<tr>
<td>Childrens Services (RHSC)</td>
<td>5,347</td>
<td>5,107</td>
<td>1,747</td>
<td>1,664</td>
<td>1,783</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12,140</td>
<td>11,751</td>
<td>4,059</td>
<td>3,901</td>
<td>4,046</td>
</tr>
</tbody>
</table>

*this includes independent sector activity

**Please direct queries on this report to Finance in the first instance.
## APPENDIX 4

**NHS Lothian Property and Asset Management Investment Programme Summary June 2013**

### Agreed Programme

<table>
<thead>
<tr>
<th>INCOME</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>SGHD Specific Funding</td>
<td>£41,621</td>
<td>£0</td>
</tr>
<tr>
<td>SGHD Formula Allocation</td>
<td>£22,121</td>
<td>£0</td>
</tr>
<tr>
<td>Other Sources of Funding</td>
<td>£928</td>
<td>£0</td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
<td><strong>64,670</strong></td>
<td><strong>£363</strong></td>
</tr>
</tbody>
</table>

### EXPENDITURE

#### Capacity & Unscheduled Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>£2,813</td>
<td>£0</td>
<td>£2,813</td>
</tr>
<tr>
<td>Radiotherapy Phase 9</td>
<td>£2,812</td>
<td>£0</td>
<td>£2,812</td>
</tr>
<tr>
<td>RIE Bed Capacity - 109/209</td>
<td>£2,200</td>
<td>£114</td>
<td>£2,086</td>
</tr>
<tr>
<td>Continuing Care (Balfour Pavilion)</td>
<td>£2,155</td>
<td>£0</td>
<td>£2,155</td>
</tr>
<tr>
<td>Day Surgery Redesign</td>
<td>£500</td>
<td>£0</td>
<td>£500</td>
</tr>
<tr>
<td>St John's Hospital MRI</td>
<td>£1,567</td>
<td>£28</td>
<td>£1,539</td>
</tr>
<tr>
<td>Labour Ward/ Maternity Unit (SJH)</td>
<td>£1,495</td>
<td>£221</td>
<td>£1,273</td>
</tr>
<tr>
<td>Burns Unit (SJH)</td>
<td>£228</td>
<td>£0</td>
<td>£228</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,769</strong></td>
<td><strong>£363</strong></td>
<td><strong>13,406</strong></td>
</tr>
</tbody>
</table>

#### Investment in Primary Care Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>£2,991</td>
<td>£391</td>
<td>£2,600</td>
</tr>
<tr>
<td>Gullane Medical Centre</td>
<td>£1,449</td>
<td>£0</td>
<td>£1,449</td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>£3,235</td>
<td>£180</td>
<td>£3,055</td>
</tr>
<tr>
<td>Ratho Health Centre Satellite</td>
<td>£811</td>
<td>£0</td>
<td>£811</td>
</tr>
<tr>
<td>Tranent</td>
<td>£1,282</td>
<td>£7</td>
<td>£1,275</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,768</strong></td>
<td><strong>£578</strong></td>
<td><strong>9,189</strong></td>
</tr>
</tbody>
</table>

#### Major Service Redesign/Redevelopment

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Hospital for Sick Children and DCN (Enabling)</td>
<td>£21,560</td>
<td>£307</td>
<td>£21,253</td>
</tr>
<tr>
<td>Lothian Asset Management Strategy</td>
<td>£0</td>
<td>£9</td>
<td>£9</td>
</tr>
<tr>
<td>Royal Edinburgh Hospital (Master Planning)</td>
<td>£353</td>
<td>£0</td>
<td>£353</td>
</tr>
<tr>
<td>Reconfiguration of Greenbank Unit</td>
<td>£338</td>
<td>£5</td>
<td>£333</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,251</strong></td>
<td><strong>£303</strong></td>
<td><strong>21,948</strong></td>
</tr>
</tbody>
</table>

#### Invest to Save

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Equipment</td>
<td>£748</td>
<td>£3</td>
<td>£745</td>
</tr>
<tr>
<td>Microbiology Automation</td>
<td>£1,000</td>
<td>£0</td>
<td>£1,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,748</strong></td>
<td><strong>£3</strong></td>
<td><strong>1,745</strong></td>
</tr>
</tbody>
</table>

#### Compliance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP dental premises</td>
<td>£2,000</td>
<td>£13</td>
<td>£1,987</td>
</tr>
<tr>
<td>Endoscopy RIE</td>
<td>£1,300</td>
<td>£28</td>
<td>£1,273</td>
</tr>
<tr>
<td>Endoscopy WGH</td>
<td>£1,030</td>
<td>£0</td>
<td>£1,030</td>
</tr>
<tr>
<td>Community Dentistry Decontamination</td>
<td>£484</td>
<td>£96</td>
<td>£388</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,814</strong></td>
<td><strong>£136</strong></td>
<td><strong>4,678</strong></td>
</tr>
</tbody>
</table>

#### Rolling Programmes

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIE Lifecycle Costs</td>
<td>£4,721</td>
<td>£1,130</td>
<td>£3,591</td>
</tr>
<tr>
<td>Projects under £250k</td>
<td>£1,500</td>
<td>£99</td>
<td>£1,401</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>£4,000</td>
<td>£11</td>
<td>£3,989</td>
</tr>
<tr>
<td>E-Health Strategic Priorities</td>
<td>£2,000</td>
<td>£0</td>
<td>£2,000</td>
</tr>
<tr>
<td>Backlog maintenance</td>
<td>£5,000</td>
<td>£229</td>
<td>£4,771</td>
</tr>
<tr>
<td>CEEF</td>
<td>£446</td>
<td>£26</td>
<td>£420</td>
</tr>
<tr>
<td>National PACS Refresh 2007-17</td>
<td>£129</td>
<td>£0</td>
<td>£129</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17,796</strong></td>
<td><strong>£1,495</strong></td>
<td><strong>16,301</strong></td>
</tr>
</tbody>
</table>

#### Donations

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agreed Programme</th>
<th>Expenditure to month 3</th>
<th>Remaining Anticipated Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macmillan Centre SJH</td>
<td>£448</td>
<td>£56</td>
<td>£392</td>
</tr>
<tr>
<td>Teenage Cancer Trust, WGH</td>
<td>£480</td>
<td>£285</td>
<td>£195</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>928</strong></td>
<td><strong>£341</strong></td>
<td><strong>587</strong></td>
</tr>
<tr>
<td>Completing Schemes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>40</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>HEI</td>
<td>228</td>
<td>28</td>
<td>201</td>
</tr>
<tr>
<td>NSD Projects</td>
<td>16</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>(177)</td>
<td>177</td>
</tr>
<tr>
<td></td>
<td>284</td>
<td>(149)</td>
<td>434</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td>71,358</td>
<td>3,072</td>
<td>68,287</td>
</tr>
<tr>
<td><strong>Total (over)/ under commitment</strong></td>
<td>(6,688)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 5

### NHS Lothian Efficiency and Productivity Summary June 2013

<table>
<thead>
<tr>
<th>WORKSTREAM</th>
<th>Current Year Target</th>
<th>Target £k</th>
<th>Actuals £k</th>
<th>Slippage £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities &amp; Infrastructure</td>
<td>(1,613)</td>
<td>(40)</td>
<td>(40)</td>
<td>-</td>
</tr>
<tr>
<td>Labs Review</td>
<td>(1,327)</td>
<td>(294)</td>
<td>(216)</td>
<td>(78)</td>
</tr>
<tr>
<td>Management &amp; Administration</td>
<td>(748)</td>
<td>(153)</td>
<td>(170)</td>
<td>(17)</td>
</tr>
<tr>
<td>Pharmacy Redesign</td>
<td>(285)</td>
<td>(71)</td>
<td>(63)</td>
<td>(8)</td>
</tr>
<tr>
<td>WCN</td>
<td>(675)</td>
<td>(169)</td>
<td>(42)</td>
<td>(127)</td>
</tr>
<tr>
<td>Flow &amp; Capacity Management</td>
<td>(142)</td>
<td>(17)</td>
<td>-</td>
<td>(17)</td>
</tr>
<tr>
<td>Edinburgh Rehabilitation Bed Redesign</td>
<td>(300)</td>
<td>(34)</td>
<td>-</td>
<td>(34)</td>
</tr>
<tr>
<td>Enhanced Recovery</td>
<td>(300)</td>
<td>(75)</td>
<td>-</td>
<td>(75)</td>
</tr>
<tr>
<td>Review in Interventions of Limited Clinical Value</td>
<td>(500)</td>
<td>(70)</td>
<td>-</td>
<td>(70)</td>
</tr>
<tr>
<td>Outpatients</td>
<td>(1,537)</td>
<td>(143)</td>
<td>-</td>
<td>(143)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(4,621)</td>
<td>(787)</td>
<td>(686)</td>
<td>(101)</td>
</tr>
<tr>
<td>Procurement</td>
<td>(1,248)</td>
<td>(312)</td>
<td>(161)</td>
<td>(151)</td>
</tr>
<tr>
<td></td>
<td>(13,296)</td>
<td>(2,165)</td>
<td>(1,378)</td>
<td>(787)</td>
</tr>
</tbody>
</table>

### LOCAL

<table>
<thead>
<tr>
<th></th>
<th>Current Year Target</th>
<th>Target £k</th>
<th>Actuals £k</th>
<th>Slippage £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh CHP</td>
<td>(811)</td>
<td>(244)</td>
<td>(282)</td>
<td>38</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>(406)</td>
<td>(63)</td>
<td>(60)</td>
<td>(3)</td>
</tr>
<tr>
<td>Mid Lothian CHP</td>
<td>(54)</td>
<td>(13)</td>
<td>(8)</td>
<td>(5)</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>(186)</td>
<td>(39)</td>
<td>(31)</td>
<td>(8)</td>
</tr>
<tr>
<td>Primary Care Other</td>
<td>(28)</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>(343)</td>
<td>(25)</td>
<td>-</td>
<td>(25)</td>
</tr>
<tr>
<td>Corporate Areas</td>
<td>(601)</td>
<td>(121)</td>
<td>(52)</td>
<td>(69)</td>
</tr>
<tr>
<td>University Hospital Services</td>
<td>(4,476)</td>
<td>(1,001)</td>
<td>(660)</td>
<td>(341)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(471)</td>
<td>(59)</td>
<td>(2)</td>
<td>(57)</td>
</tr>
<tr>
<td></td>
<td>(7,376)</td>
<td>(1,565)</td>
<td>(1,095)</td>
<td>(470)</td>
</tr>
<tr>
<td>Centrally held</td>
<td>(7,160)</td>
<td>(1,974)</td>
<td>(1,982)</td>
<td>8</td>
</tr>
</tbody>
</table>

### TOTAL

|                                          | (27,832)            | (5,704)   | (4,455)     | (1,249)     |
SUMMARY PAPER - CORPORATE OBJECTIVES 2013-14

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

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

- Proposed new objectives included within the 2013-14 Corporate Objectives.
  3.2.1
- Proposed objectives recommended for removal from the 2013-14 Corporate Objectives as they are duplicated and appear more than once
  3.2.2
- Update on the current progress towards the 2013-14 Corporate Objectives
  Appendix 1

Moray Paterson  Alex McMahon
Business Manager  Director of Strategic Planning
10 July 2013
moray.paterson@nhslothian.scot.nhs.uk  alex.mcmahon@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board on progress towards the 2013-14 Corporate Objectives. 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 progress towards the 2013-14 Corporate Objectives.

2.2 Note that the Corporate Objectives for 2013-14 are aligned to the six key aims of the Clinical Strategy Framework.

2.3 Approve the revised corporate objectives which have been reviewed to reduce duplication and improve alignment to national policy.

3 Discussion of Key Issues

3.1 Updates have been provided where possible against each of the Corporate Objectives at the end of June 2013.

3.2 Since the objectives were approved at the Board in May 2013, revisions have been made to a number of corporate objectives to reduce duplication and improve alignment to national policy. These are described below.

3.2.1 New objectives included within the 2013-14 Corporate Objectives:
- Objective 6 - Business Continuity Management programme
- Objective 6 - Corporate ROSPA QSA Audit
- Objective 6 - Review the NHS Lothian Health and Safety Manual
- Objective 7 - Person Centred Care
- Objective 7 – Improve patient experience

3.2.2 Objectives recommended for removal from the 2013-14 Corporate Objectives as they are duplicated and appear more than once:
- Objective 6 - Achieve a 30% reduction in adverse events
- Objective 6 - Achieve a 20% reduction in HMSR against 2006/2007 baseline
- Objective 6 - Ensure NHS Lothian’s staphylococcus aureus bacteraemia cares are 0.2%
- Objective 10 - Operate within their agreed revenue resource limit
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 13/14 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  Alex McMahon
Business Manager  Director of Strategic Planning
10 July 2013  
moray.paterson@nhslothian.scot.nhs.uk  alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Corporate Objectives 2013-14 Update Q1 July 2013
# NHS Lothian – Corporate Objectives 2013/14

## Objective 1

**To Transform the Management Culture of the Organisation**

<table>
<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing, by March 14</td>
<td>All</td>
<td>Waiting times challenges continue to be addressed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tranche 2 investments in elective and unscheduled care are being made. Specific areas of challenge in elective care are in urology, ophthalmology, orthopaedics as well as residual challenges around specialist spinal work.</td>
<td></td>
</tr>
<tr>
<td>March 14</td>
<td>AB</td>
<td>A Board workshop was held in early June. Small group now looking at the delivery and implementation of the agreed values.</td>
<td></td>
</tr>
<tr>
<td>March 14</td>
<td>All</td>
<td>Team development sessions have taken place and a further session is planned for the 23rd Sept for Corporate Objectives. Values work, as well as corporate and individual objectives now set and agreed.</td>
<td></td>
</tr>
<tr>
<td>June 13</td>
<td>AMcM/AB</td>
<td>Senior leaders’ workshop held 6 June. Final version of values to be linked to NHS Scotland values, for Board approval July 2013</td>
<td></td>
</tr>
</tbody>
</table>
**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>RELATES TO AIMS 2 AND 4 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OBJECTIVE 2:</strong> To plan and deliver the waiting times recovery plan to clear the backlog of patients and develop recurring demand/capacity equilibrium</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
<td>STATUS</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

| 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. | JUNE 13 | DF/AMCM | SOP revised November 2012. Training to identified staff undertaken by April 2013. Further sessions being conducted. SOPs will require revision in light of revised access policy. Single system Waiting Times staffing remains on plan for May 2015 |
| Ensure comprehensive monthly performance monitoring to the NHS Board on performance against targets, recovery plan and waiting times management compliance | MARCH 14 | AMCM | Monthly performance monitoring and reporting system in place. Monthly waiting times performance and reporting system in place. |
| Ensure the delivery of a sustainable financial framework to support recovery and maintain performance thereafter. | ONGOING | SG | Recurring investment plans agreed in principle at Jun-13 board subject to F&R&C review and agreement of business cases for areas of major service development. Provision made for investment decisions not yet approved. Initial resource requirements for non-recurring support to recovery trajectory agreed at June board, with further work required to confirm independent sector requirements for Q3/Q4. |
| Ensure delivery of the comprehensive system of compliance monitoring of waiting times systems including real-time scrutiny of changes made on TRAK. | JUNE 13 | AMCM | Forensic Dashboard in place for unusual changes affecting waiting time clock. SOP dashboard to assess other aspects of compliance with guidance in development (no timescale). |
### 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>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<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/AM cM</td>
<td>LUCAP describes additional capacity plans, step-down beds jointly commissioned and coming on stream from October 2013. 7 day working event held with action plan</td>
<td>🟢</td>
</tr>
</tbody>
</table>
## NHS Lothian – Corporate Objectives 2013/14

### Objective 3: To Improve Unscheduled Care Performance

<table>
<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 13</td>
<td>PG/MH/ALL</td>
<td>Developed and incorporated into Lothian Unscheduled Care Action Plan. Work is underway to improve flow through preventing admissions, service redesign and increases in capacity. Examples include: <strong>Prevention</strong>: Edinburgh CHP’s Long Term Conditions Programme. Change Fund investments of £8.6m in 2013/14, including £1.2m in building community capacity. <strong>Acute Service redesign</strong>: Creation of a mobile medicine of the elderly service at the Western General. <strong>Acute Staffing capacity</strong>: Additional investment in consultants, specialty doctors and Advanced Nurse Practitioners. <strong>Acute increases in physical capacity</strong>: Additional beds have been opened. <strong>Increases in Social Care Capacity</strong>: In the last 12 months the Council capacity for Care at Home and Home Care has increased by 14% at an additional cost of c. £2.5m.</td>
<td>Target is 95% by Sept 2014 “and that Boards should pursue further improvement towards 98%”. May performance 95% with reduced boarding and</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

### OBJECTIVE 3:
**To improve unscheduled care performance**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>12 hour trolley waits. LUCAP describes planned actions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delayed discharge targets in place – maintain total delays below 78, achieve 0 over 4 weeks, reduce average delay to 20 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change Fund investments in community services have helped to reduce delayed discharges</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Step Down – 47 step down beds will be developed within independent care homes in Edinburgh by October 2013.</td>
<td></td>
</tr>
</tbody>
</table>

### OBJECTIVE 4:
**To develop a cohesive strategic plan for NHS**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lothian, supported by revised organisational arrangements.</strong></td>
<td><strong>MEMBER</strong></td>
<td><strong>Initial list of work-streams developed; proposals for programme office and resourcing requirements developed. Strategic Planning Group now established and overseeing process. JMT development session on 5th August in advance of bring next steps update to Board seminar on 26th August.</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<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 AMcM</td>
<td></td>
<td><strong>Pan Lothian master planning group to commence early September.</strong> REH – Initial report on master plan with final revision due in August. Phase one will focus on the provision of acute services at this site. LD will feature in phase 2. WGH - existing plans being revisited. Site master planning commencing and strategic thinking re cancer centre commenced. SJH site master planning and engagement work due to start in August. SJH/ RIE Looking to procure technical support to produce and develop site master-plans by the end of this year. Steering teams for each site will also be established. Estate and property strategy reads across to Strategic Clinical framework and Strategic Planning Group.</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 AMcM/SG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure implementation of innovative plans with our 4 Council partners to secure the integration of primary,</td>
<td>March 14 JF, PG, DS and AMcM</td>
<td>Strategic clinical framework for primary care will developed during 2013 with local authority</td>
<td></td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>Objective</th>
<th>Start Date</th>
<th>Responsible Parties</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary and social care to drive performance improvement across health and social care.</td>
<td></td>
<td></td>
<td></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>
<td>Scoping review of diabetic pathway undertaken and recommendations on next steps presented to the Efficiency and Productivity Group June 2013</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>
<td>Duplicate - Delete</td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

| Review and refresh the maternity strategy and capacity plan | March `14 | AMcM | Agreed that Maternity should be incorporated within Children and Young People Strategy. The Chief Midwife is currently drafting capacity plan taking into account complexity of pregnancies. Refreshed Maternity Action Plan currently being updated in light of emerging Children’s Strategy, Maternity Collaborative and Early Years Collaborative. Contingency plan for managing the refresh of the SJH maternity unit. |

| RELATES TO AIM 1, 5 AND 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK |
|------------------------|-----------------|-----------------|-----------------|-----------------|
| **OBJECTIVE 5: EFFECTIVE INTERNAL AND EXTERNAL COMMUNICATIONS** | **TIMING** | **LEAD CMT MEMBER** | **COMMENTS** | **STATUS** |
| Implement NHS Lothian’s Communications Strategy. | June 2013 | SRW and AB | A draft Communications Strategy has been prepared and is currently out for consultation with a range of stakeholders. It will be subject to peer review before coming before the NHS Lothian Board. | ✔️ |
| Develop and Implement Communications Plan for Strategic Clinical Framework. | May 2013 | SRW and AB | Under development. Communications Sub group of the strategic planning group is established with non-executive input. | ✔️ |
| Supporting the communication is relation to ‘Our Values Into Action’ | On-going | SRW and AB | A Communications plan has been agreed around supporting the Values work and will be | ✔️ |
## NHS Lothian – Corporate Objectives 2013/14

### Objective 5: Effective Internal and External Communications

<table>
<thead>
<tr>
<th>RELATES TO</th>
<th>AIM 1, 5 AND 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELATES TO</td>
<td>AIM 1, 2, 3, 4 AND 5 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
<td>STATUS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RELATES TO AIM 1, 5 AND 6 WITHIN THE STRATEGIC CLINICAL FRAMEWORK</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>implemented in line with the action plan associated with it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</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>
</tr>
</thead>
<tbody>
<tr>
<td>baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 14</td>
<td>DF/MH/All</td>
<td>June 2013 Board received SPSP update on existing and new programmes set out below. HSMR plan approved by the January 2013 Board and is the focus for patient safety on three acute sites. Board development session in June focused on patient safety and patient experience. A need to review Board meetings and structure to better support focus on both.</td>
</tr>
</tbody>
</table>
| March 14     | DF/All          | Venous thromboembolic prevention in testing phase. Sepsis prevention programme in testing phase. Consultant and midwifery leads have been appointed as Maternity Champions to lead the safety and improvement work over the next two years in NHS Lothian. The NHS Lothian Consultant Lead has also been appointed as the national Maternity Clinical Lead for Obstetrics for this collaborative. The aim this year for the programme is to:   
  - Test the elective induction care bundle | ![Green Icon] |

Ensure the current Safe Care Patient Safety Programme measures are met and reported

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
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

### 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>
</tr>
</thead>
<tbody>
<tr>
<td>March 14</td>
<td>MH</td>
<td></td>
</tr>
</tbody>
</table>

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.

- Develop the Scottish Perinatal Trigger Tool
- Develop measures and operational definitions

Mental Health – working group set up and initial data submitted to extranet. Safety Culture Survey completed. Focus 2013/14:
- Improving Pass Plan procedures
- To initiate patient culture survey
- Medicines Management including Med Rec, PRN medication including the Forensic Unit
- Introduce Walkrounds which include patients
- Development of Rapid Tranquilisation Bundle
- Safety briefs and debriefs post restraint in place

See below for Scottish Patient Safety Programme (SPSP) in General Practice.

<table>
<thead>
<tr>
<th>STATUS</th>
<th>Duplicate – delete</th>
</tr>
</thead>
</table>

Duplicate – delete
<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>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure participation and benefit from involvement in the new Maternity Safety programme.</td>
<td>March 14</td>
<td>AMcM/DF</td>
<td>Please see above.</td>
<td>Green</td>
</tr>
<tr>
<td>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</td>
<td>March 14</td>
<td>DF/DS</td>
<td>Patient safety programme in primary care was launched in March 2013. 11 QOF points to fund practice engagement in the key features of the programme. NHS Lothian continues to fund patient safety (£300,000) through the Patient Safety Scottish Enhanced Services Programme contract (70% of practices participating)</td>
<td>Green</td>
</tr>
</tbody>
</table>

Warfarin: 2012/2013 – 72% of practices signed up to the Local Enhanced Service

Compliance for sites 2012/13:
- 93% completed clinical surveys
- 92% completed monthly data collection with 24% now fully compliant
- 87% completed Global Trigger Tool
- 38% undertaken patient involvement

Learning Set taken place for 2013/14 and compliance monitored through Quality Improvement Database.

91% of practices have signed up to the 2013/14 Scottish Enhanced Service Programme (SESP) on medicines reconciliation. Continued work is
## 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>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>being encouraged on warfarin.</td>
</tr>
</tbody>
</table>

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
  - Public Health has been asked to become involved in the action plan work using international equity standards.

Work towards a reduction in the number of staff assaults

- **March 14**
  - All

Ensure robust arrangements are in place within NHS Lothian’s Business Continuity Management programme to support business resilience of the organisation.

- **On-going**
  - All
  - Formal reassurance has been received from NHS Lothian Executive Directors and General Managers, as part of NHS Lothian’s Business Continuity Management Programme (BCM) compliance reporting.

  Key elements of focus have been:

  **January - March 2013**
  - Cascading of the key document *Generic Principles, Guidelines and Control Documents for NHSL Business Continuity Programme, Plans & Arrangements*, within local Business Continuity fora and communication channels

  **April – June 2013**
  - Annual confirmation that business areas Empower Essential Workers Module records have
### 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>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Business areas who participated in NHS Lothian’s Strategic Business Continuity Management annual *Exercise 2013* took part and contributed to the cold debrief process.
- That Business Continuity 6 monthly communication tests have been conducted.
- Complete the Corporate ROSPA Quality Safety Audit of NHS Lothian’s Health and Safety management system.
  - March 2014
  - AB
  - RoSPA QSA is now complete. A key action is the development of a Strategic Health and Safety Plan, with KPI’s in place along with Performance Management System and relative performance standards.

  - March 2014
  - AB
  - H+S Manual is currently under review with a new document targeted for delivery in April 2014.

### Objective 7: Corporate Team Objective
**Implementation of Patient / Person Centred Care**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# NHS Lothian – Corporate Objectives 2013/14

<table>
<thead>
<tr>
<th>Objective 7: Corporate Team Objective</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of Patient / Person Centred Care</td>
<td>March 14</td>
<td>MH</td>
<td>Two events have been held with partners to outline this agenda and to seek engagement for joint working on specific activity</td>
<td>green tick</td>
</tr>
<tr>
<td>Ensure that NHS Lothian using the recommended methodology progresses work that will demonstrate the robust implementation of person centred care</td>
<td>December 15</td>
<td>DF/MH</td>
<td>Scottish Government in June tabled the initial draft of outcome measures and work is ongoing to consider how these can be used through test of change within local initiatives</td>
<td>green tick</td>
</tr>
</tbody>
</table>

**Improve patient experience:**
- Ensure the targets for the implementation for the Liverpool care pathway are implemented as are our targets on end of life care and place of death.
- Ensure through the direction of the nursing Delivering Better Care Hub that the quality ambitions around falls, food & nutrition, pressure ulcer care, medicines management and clinical documentation are implemented/monitored and improvement noted.
- Ensure through the implementation of Care Rounding that care delivered is person centred.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 14</td>
<td>MH/All</td>
<td>The LCP has now been implemented within the 4 CHCPs, 9 community hospitals and 81 acute hospital wards in Lothian. To support sustainability going forward, work is underway with the SPSP to develop a supportive care intervention, aligned to the rescue arm of the deteriorating patient pathway in the SPSP. We envisage that this approach will replace the use of the LCP. Additionally, a whole-system palliative care redesign programme has been launched, co-sponsored by NHS Lothian and Marie Curie UK, focussing on further improvement to support the achievement of Palliative Care Strategy targets, including preferred place of death.</td>
<td>green tick</td>
</tr>
</tbody>
</table>

May 2013 information on this year’s ambitions.
<table>
<thead>
<tr>
<th><strong>OBJECTIVE 7:</strong> CORPORATE TEAM OBJECTIVE</th>
<th><strong>TIMING</strong></th>
<th><strong>LEAD CMT MEMBER</strong></th>
<th><strong>COMMENTS</strong></th>
<th><strong>STATUS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of Patient / Person Centred Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>were launched at the annual Nursing &amp; Midwifery conference</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Implementation of Care Rounding continues with tests of change around person centred qualitative questions being asked as part of the process “What matters to you”</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>Monthly reports to the Board through the Quality Report. The healthcare governance committee also regularly scrutinises wider aspects of clinical quality and patient care.</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>Board development session on this at the 26th June Board. Outputs from that session will now be considered for Board and other committee functions. Workshops commenced in February targeting Band 3 and upwards in relation to delivering better care, specifically focusing on improvement and continual monitoring, reflecting on Francis. This remains a rolling programme.</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>NHS Lothian actively leading, contributing to and monitoring progress of the 4 local EYCs in Lothian.</td>
<td></td>
</tr>
</tbody>
</table>
**OBJECTIVE 7: CORPORATE TEAM OBJECTIVE**
Implementation of Patient / Person Centred Care

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
</table>
### OBJECTIVE 7:
**CORPORATE TEAM OBJECTIVE**
Implementation of Patient / Person Centred Care

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
</table>

### 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>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 14</td>
<td>SG/All</td>
<td>Month 2 position shows a small overspend against the RRL; comprising an underspend on baseline budgets, but with slippage against efficiency plans</td>
<td>📈</td>
</tr>
<tr>
<td>March 14</td>
<td>SG/All</td>
<td>There has been slippage in the delivery of local LRP savings particularly within Acute Services in the first two months of the financial year. This is now being urgently addressed.</td>
<td>📈</td>
</tr>
<tr>
<td>March 14</td>
<td>SG/All</td>
<td>Initial review shows a potential over commitment which is believed to be manageable at this stage. This will be closely monitored as the year progresses.</td>
<td>📈</td>
</tr>
<tr>
<td>March 14</td>
<td>SG/DF</td>
<td>Procurement for the new RHSC/DCN progressing in line with programme</td>
<td>📈</td>
</tr>
<tr>
<td>March 14</td>
<td>DS/SG</td>
<td>Agreement has been reached on the first phase of the redevelopment. This will comprise 185 beds for acute mental health, rehab and old age</td>
<td>📈</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>RELATES TO AIMS 1, 2, 3, 4, 5 AND 6</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBJECTIVE 7: CORPORATE TEAM OBJECTIVE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of Patient / Person Centred Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychiatry. Work on the detailed design has been progressing with all the key stakeholders with a “design freeze” is scheduled for mid June. The master-planning is progressing well with the interim report agreed by NHSL. The final report is due in August 2013.</td>
<td></td>
<td></td>
<td></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</td>
<td>The redesign of workforce and patient flow pathways continues in ED &amp; AMU. The additional beds on the infirmary are unlikely to be delivered within the agreed timeframe due to contract discussions with Consort, Provisional date of opening has slipped to January 2014.</td>
</tr>
<tr>
<td>Improve performance management of the Consort RIE contract</td>
<td>Ongoing</td>
<td>SG</td>
<td>PFI Contract manager has been appointed and will take forward the performance of the RHSC/DCN and RIE Contracts performance</td>
</tr>
<tr>
<td>To develop a savings programme for implementation in 2014/15 and beyond.</td>
<td>Ongoing</td>
<td>SG/All</td>
<td>Longer terms plans are in development.</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>
<td>Comments</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<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>
<td>Health Inequalities: All areas are developing SOA indicators to monitor progress on tackling health inequalities: Edinburgh working with Poverty and Inequalities Group to identify interventions to reduce poverty and inequalities, which are the key determinants of health inequalities; West Lothian working on ways to broaden consideration of health in other partnerships; Midlothian delivered workshop on health inequalities for elected members and; East Lothian reviewing partnership structure for health improvement. Tobacco: We continue to target cessation services at areas of inequalities while also working closely with Local Authorities and voluntary sector to deliver a range of cessation, prevention and protection activities in support of SG Tobacco Strategy. Alcohol: Work continues with Alcohol Licensing boards in Lothian in preparation for new licensing policies to be adopted in November 2013. The Alcohol Brief Intervention action plan for 2013 is agreed and underway. Keep Well: Latest verified figures from ISD confirm that we delivered 5,717 initial health checks in 2012/13; exceeding the Scottish</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>
<td>COMMENTS</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</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>
<td>Government annual target of 4,800 checks for Lothian. The target for this year is the same as last year and we are on trajectory. MCNs supporting work of Health Promoting Health Service CE: 01 (2012) and Physical Activity Sub Group</td>
</tr>
</tbody>
</table>
**NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14**

<table>
<thead>
<tr>
<th>OBJECTIVE 9: TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>commenced to consider a redesign of screening and symptomatic breast pathways but discussions have now been caught up in the wider cancer reprovision discussions. Peter M leading on this with support from Sue P. No obvious impact to date on screening numbers &amp; uptake as a consequence of DCE social marketing efforts during Autumn 2012. Bowel screening uptake is at 52.4% and is slowly increasing with prospects for an acceleration with DCE programme. The expanded immunisation programme is being rolled out across Lothian during 2013-14 progressing according to a NSD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| STATUS |</p>
<table>
<thead>
<tr>
<th>RELATES TO AIMS 1, 2, 4 AND 5 OF THE STRATEGIC CLINICAL FRAMEWORK</th>
<th>OBJECTIVE 9: TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TIMING</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>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

#### OBJECTIVE 9:
**TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer 13</td>
<td>AMcM</td>
<td>Ensure the review of our children and young people’s strategy is commenced and consulted on during 2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategy in development – aligned to early years and change fund work as well as the RHSC and integration agendas</td>
<td></td>
</tr>
<tr>
<td>Summer 13</td>
<td>AMcM</td>
<td>Commence the review of the learning disabilities strategy, in line with the review milestones and the REAS redevelopment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Underway. Working assumptions are part of phase 2 of the REAS redevelopment and wider developments around community, out of areas and specialist needs were discussed at July JMT.</td>
<td></td>
</tr>
<tr>
<td>March 14</td>
<td>MH</td>
<td>Continue to strengthen Public Protection arrangements by delivery of the 2013/14 action plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work is ongoing to strengthen the Public Protection Team. Progress is being made in relation to the development and recruitment of operational posts for MAPPA and Adult Support and Protection.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The retrial of the Designated Doctor for Child Protection has left a gap as we have been unable to recruit to the Designated Doctor Post to date. Paediatric Consultant cover for Child Protection has been reviewed across Lothian and a lead paediatrician has been identified for Edinburgh and West Lothian.</td>
<td></td>
</tr>
<tr>
<td>RELATES TO AIMS 1, 2, 3, 5 AND 6 OF THE STRATEGIC CLINICAL FRAMEWORK</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<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>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>
<td>The national target was released in May 2013. It is anticipated that we will reach the Lothian Target of an additional 113 Stage 1 cancers per annum.</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>
<td>Currently exceeding target – Central Booking Call System had significant positive impact and created efficiencies in pathway</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>
<td>Latest verified figures from ISD are due 3rd July 2013. Uptake is increasing, highest in deprived areas to reflect need. Some realignment of resources to reflect changes in population.</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>
<td>For the period Apr 2011 – Jun 2013 there have been 1,563 completed interventions (provisional data). This puts us behind the trajectory of 1,740 for Jun 2013. We have recruited additional schools for the 2013/14 school year accordingly. While the decision by Scottish Government to remove height and weight measurements in May 2013 is welcome, there is now concern about</td>
</tr>
</tbody>
</table>
### OBJECTIVE 10: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS

<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>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottish Government funding for the current financial year. This means that there has been uncertainty around this work for almost a year. Despite this, the programme has had some major achievements. For example, at the Edinburgh Children’s Services Inspection (Nov 2012) the inspectors selected our work as an example of good practice, and local authority colleagues selected it as an example of good partnership work for the Midlothian Inspection (Jun 2013).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RELATES TO AIMS 1, 2, 3, 5 AND 6 OF THE STRATEGIC CLINICAL FRAMEWORK</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
<td>COMMENTS</td>
<td>STATUS</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------</td>
<td>-----------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<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>
<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>NHS Lothian and partners have contributed to the SG’ draft document on Preventing Suicide and Selfharm. We now await publication of the document which will set out future priorities. In the meantime we continue to implement local actions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></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>Duplicate - Delete</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>Whilst progress is being made in respect of reducing carbon emissions, current indicators suggest that the HEAT Target will not be met for technical reasons.</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>We are on target in relation to delivering the CAMHS 18 week Referral to Treatment. Backlog of circa 1300 cases. Additional capacity being put in place to support. Psychological therapies – Incremental approach being taken to the inclusion of all therapies within the 18 week target. Based on current performance and those services included we are on target, but further work is required in relation to the backlog of those waiting longer than 18 weeks. Backlog is currently circa 900.</td>
<td></td>
</tr>
</tbody>
</table>
### NHS Lothian – Corporate Objectives 2013/14

<table>
<thead>
<tr>
<th>Objective 10: To have a robust system of performance management and reporting aligned to delivery of government targets</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete by April 2015.</td>
<td>March 14</td>
<td>All</td>
<td>NHS Lothian and partners are currently not meeting this target.</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/DS/JF</td>
<td>We are still not meeting the target. We are close to the trajectory (April 2013 – 2,051 against a target of 1,943).</td>
<td>📡</td>
</tr>
</tbody>
</table>
| To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan. | March 14 | JF | The Lothian Dementia Implementation Group has wide stakeholder involvement and is focused on learning and sharing practice across Lothian, and across agencies. This includes:  
- Defining the role of link worker and ensuring that people understand that it is a role that staff and workers from a wide of professions and agencies can take on  
- Learning from data models in place which ensure that all sectors’ activities can be collated e.g. the A11 target  
- Use learning from pilots and evidence base to inform new service models  
- Recognise and plan service provision accordingly – i.e. not all people will require or want the same degree and intensity of support  
- Ensure there is understanding across all service of how all staff members can contribute to post diagnostic support | 📦 |
### NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 10: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible patients will commence IVF treatment within 12 months by 31 March 2015.</td>
<td>March 14</td>
<td>DF</td>
<td>Waiting time systems are currently being implemented. Local monitoring suggests waits are under a year currently, down from 2 years.</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 of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.</td>
<td>March 14</td>
<td>MH/All</td>
<td>Report of issues associated with increased number of cases between Sept 2012 to March 2013 identified and being implemented. Current SAB rate (Apr-May 2013) – 0.28 Current CDI rate (Apr-May 2013) – 0.41 SAB target by 2014 – 0.28 CDI target by 2014 – 0.30</td>
<td></td>
</tr>
<tr>
<td>95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.</td>
<td>Monthly</td>
<td>MH/PG/All</td>
<td>May performance 95%. Scot Gov target is 95% by Sept 2014.</td>
<td></td>
</tr>
</tbody>
</table>

**HEAT STANDARDS**

95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of...
<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>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBJECTIVE 10: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% of planned / elective patients to commence treatment within 18 weeks of referral.</td>
<td>Monthly</td>
<td>DF</td>
<td>Currently being addressed through corporate objective 2.</td>
<td>🟥</td>
</tr>
<tr>
<td>No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census)</td>
<td>Monthly</td>
<td>DF</td>
<td>Currently being addressed through corporate objective 2.</td>
<td>🟥</td>
</tr>
<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
<td>Annual</td>
<td>DS</td>
<td>no national information available at point of reporting</td>
<td></td>
</tr>
<tr>
<td>90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>March 14</td>
<td>AMcM/PG</td>
<td>Sustained performance above 90%</td>
<td>🟢</td>
</tr>
<tr>
<td>To achieve a sickness absence rate of 4% across NHS Lothian.</td>
<td>March 14</td>
<td>AB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Lothian and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td>March 14</td>
<td>JF/PG/DS and AMcM</td>
<td>The ABI programme delivered 18,275 ABIs in 2013/14, almost twice the HEAT Standard target for NHS Lothian and ADPs. The LES for ABIs and the ABI training team will be funded in 2013/14 from the Scottish Government allocation for Alcohol Prevention, Treatment and Support. This financial commitment will ensure that the ABI programme continues to be delivered above the NHS Lothian</td>
<td>🟢</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>
<td>COMMENTS</td>
<td>STATUS</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>To continue to strive to achieve the target of 90% of stroke patients being admitted to a stroke bed within 24 hours from initial diagnosis</td>
<td>March 14</td>
<td>MH</td>
<td>Stroke exception monitoring now more reliably in place. Performance improving. Further work required on ensuring access and Swallow assessment as priority.</td>
<td>🟥</td>
</tr>
</tbody>
</table>

HEAT Standard.
**SUMMARY PAPER - KEEP WELL ANNUAL REPORT 2012/13**

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>Edinburgh Community Health Partnership host Keep Well on behalf of NHS Lothian, providing operational governance. Strategic oversight is provided by the Director of Public Health and Health Policy.</td>
</tr>
<tr>
<td>3.5</td>
<td>Keep Well in Lothian exceeded the nationally agreed target number of cardiovascular health checks in 2012/13.</td>
</tr>
<tr>
<td>3.5</td>
<td>The programme expanded in 2012/13 in line with government guidance, including a wider geographical area and new eligible patient groups. The programme provides additional clinical results for patients living in the most deprived areas. Local evaluation has been positive but the research study on which it is based used twenty-five year follow up data to demonstrate benefit compared with a control area. The programme has engaged successfully with population groups that find traditional services hard to use. The lessons from the successful methods of engagement should be adopted more widely in the provision of planned and anticipatory care.</td>
</tr>
<tr>
<td>4.1</td>
<td>Scottish Government has indicated dedicated funding will remain in place until 2015.</td>
</tr>
</tbody>
</table>

**Dr Joy Tomlinson**  
Consultant in Public Health Medicine  
11 July 2013  
Joy.tomlinson@nhslothian.scot.nhs.uk
Purpose of the Report

1.1 The purpose of this report is to recommend that the Board review and approve the Keep Well Annual report for 2012/13. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

Recommendations

2.1 Scrutinise and approve the Keep Well annual report for 2012/13.

2.2 Provide ongoing support for delivery of Keep Well in line with Scottish Government plans.

2.3 Encourage all Community Health Partnerships/Community Health (Care) Partnerships to promote General Practice engagement with Keep Well.

Discussion of Key Issues

3.1 Keep Well is a Scottish Government initiative set up in 2006/7. The overall aim of the programme is to reduce cardiovascular disease and associated risk factors among people most affected by socio-economic disadvantage. The programme is modelled on a Welsh programme that demonstrated reduced levels of cardiovascular risk and premature death after twenty-five years. Patients aged 40-64 are invited to attend a forty minute health check to assess cardiovascular risk factors and provided with appropriate onward referral to address these and wider health issues. Keep Well began in Lothian in 2007, initially within fourteen General Practices in Edinburgh. Practices were invited to take part because high numbers of their Practice population were affected by deprivation.

3.2 Keep Well in Lothian is delivered by a small team of anticipatory care nurses, employed by Edinburgh Community Health Partnership. Most of the health checks are delivered within General Practice, although the programme has used a variety of different methods of engagement since it began. Edinburgh Community Health Partnership host delivery of Keep Well on behalf of the other Community Health Partnership/Community Health (Care) Partnership areas. The Keep Well Implementation group, chaired by the clinical director for Edinburgh Community Health Partnership provides operational oversight. An overarching Project Board is chaired by the Director of Public Health and Health Policy. Funding for the initiative comes from Scottish Government and remains ring-fenced until 2015. Funding is subject to ongoing discussion between Scottish Government and Health Boards.

3.3 Significant changes were made to the way Keep Well was delivered in 2011/12, with implementation of these changes in 2012/13. The eligible population resident in the 15% most deprived datazones aged 40-64 are the core group targeted for
inclusion. Keep Well in Lothian previously took a ‘whole practice’ approach to delivery in areas of greatest deprivation. There is now much more active selection of participants. In addition, populations with particular vulnerability are eligible for inclusion across the whole of Lothian. These include offenders, people of South Asian, Black or African-Caribbean ethnicity, Gypsy/Travellers, people who are homeless and people affected by substance misuse. For these groups with additional vulnerability, people aged 35-64 are eligible to take part.

3.4 Scottish Government previously monitored individual Board programme performance through a national Health Efficiency Access Treatment (HEAT) target and quarterly financial reports. In 2012/13 monitoring changed. The Health Efficiency Access Treatment target has been replaced by an annual report submitted to Scottish Government following scrutiny and formal review by each Board.

3.5 Keep Well in Lothian agreed to deliver 4,800 health checks in 2012/13. The programme exceeded this target, with 5,717 checks delivered. This success was achieved on a background of significant changes introduced by Scottish Government to the eligible population groups. The programme has successfully extended engagement to work with a much larger number of General Practices, including at least one in each Lothian Community Health Partnership/Community Health (Care) Partnership area. A tiered model of delivery within General Practices and locality clinics has been rolled out. The programme has also developed strong links within local prisons and with services providing care for people affected by substance misuse.

3.6 The first few years of delivery of Keep Well varied across Scotland. Evaluation of the programme has proved complex and difficult to interpret. All of the interventions used (promoting smoking cessation, physical activity, weight management, identification of hypertension, completion of a formal cardiovascular risk assessment) have a strong evidence base. However, similar anticipatory care approaches used in research studies have not shown significant benefit. There are differences between Keep Well and these earlier research studies. The Keep Well focus is delivery for people most affected by health inequalities, those living in areas of greatest socio-economic disadvantage. In addition, the Keep Well approach is based within ‘normal’ General Practices, not research settings. Risk factors identified are stored directly within the patient’s own health record and follow up takes place within Practices. Scottish Government’s aim with this policy initiative was to support a ‘step-change’ in the reduction of health inequalities which significantly impact on some disadvantaged groups.

3.7 Work continues at national level to collate information on morbidity and mortality from cardiovascular disease among Practice populations who have been in receipt of Keep Well. The Lothian Keep Well programme contributes to this national analysis. Local evaluations have examined self-reported behaviour change among participants, contrasted methods of engagement with the target groups, staff perceptions of the impact of Keep Well and reviews of sub-group populations including people who are homeless and Gypsy/Travellers.

3.8 Last year, review health checks were introduced by Scottish Government for patients five years after the initial health check. Lothian managed to deliver 1,694 review checks in 2012/13. Over time, it is hoped that information from these review
assessments will provide additional information about changes patients may have been able to make to their cardiovascular risk profile.

3.9 In Lothian, the local programme went one step further last year by introducing annual checks for those at greatest risk of developing cardiovascular disease. Data is available for 275 patients who were reviewed in 2012/13. The information available is less complete than had been hoped so it is not possible to report on physical activity or harmful alcohol intake. Small numbers of smokers have successfully stopped over the course of the year and there is some evidence of blood pressure being better controlled. However, there were no improvements in the numbers of people affected by overweight and obesity among this group, in fact several of those seen gained weight over the year. This is disappointing, though perhaps unsurprising given the wider trend of weight gain across the whole population.

3.10 The Keep Well programme has agreed to deliver a further 4,800 health checks in 2013/14. Additional plans include the possible introduction of a risk score for Diabetes into the health check. General Practices have expressed some concerns about this and further discussion will take place before a final decision is made. Keep Well is also participating in an initiative led by Health Scotland, to assess whether provision of more structured brief advice about physical activity results in positive behaviour changes among patients.

4 Key Risks

4.1 Keep Well currently relies on a ring-fenced allocation from Scottish Government. There is uncertainty about whether this will continue after 2015. Although the preparatory work necessary to develop a locally enhanced service was undertaken previously, this would need to be updated.

4.2 Keep Well is delivered by a small team of highly skilled nursing staff on short term contracts. Any loss of staff, taking up permanent posts elsewhere, puts a strain on ability to deliver health checks.

4.3 Most General Practices have been receptive to participation in Keep Well; however, not all we wish to include are currently taking part. There is a risk that the health checks may not be accessible to all eligible patients if Practices do not eventually agree to participate.

5 Risk Register

5.1 There are no entries relating to Keep Well on the risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 No recent impact assessments have been carried out for Keep Well, although these were completed during its development and expansion. The programme is designed to reduce health inequalities by working with some of the most disadvantaged groups in Lothian and as such would be expected to have a positive impact on health.
7 Involving People

7.1 The Keep Well Project Board, chaired by the Director of Public Health and Health Policy, includes a lay member who has contributed to oversight of the initiative since it began. New initiatives, such as the health and wellbeing groups in prison and the weight management groups have collected patient feedback as part of the development process.

8 Resource Implications

8.1 The Keep Well programme receives an annual allocation from Scottish Government of £1,199 000, of which 90% is disbursed and 10% retained centrally for strategic finance purposes. The Directorate of Public Health and Health Policy allocates Director, Consultant, Scientist and support staff time from its core funding. Any change to the allocation will impact on delivery.

Dr Joy Tomlinson
Consultant in Public Health Medicine
11 July 2013
Joy.tomlinson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Keep Well in NHS Lothian: Annual Report 2012/13
Summary

Keep Well is a Scottish Government led initiative launched in 2006/7. It was introduced with the aim of reducing cardiovascular disease and associated risk factors across high risk groups, particularly in areas affected by socio-economic deprivation. Significant changes were introduced by Scottish Government to the eligibility criteria for Keep Well last year. The programme was expanded to all areas across Lothian with particular inclusion of those who have offended and people affected by substance misuse.

Achievements in 2012/13

NHS Lothian promised to deliver health checks to 4,800 people over the course of 2012/13. We exceeded this target, delivering 5,717 initial or five year review health checks. An additional 275 annual reviews were completed for individuals at high risk of cardiovascular disease.

Keep Well established three new locality clinics in Edinburgh and the programme expanded. Back in 2007, 14 Practices were involved; by the end of March 2013, 42 Practices were working with Keep Well across Lothian. All of the data collected is stored in the patient’s own electronic record and held by their registered Practice. This was made possible through innovative work carried out by eHealth colleagues.

The programme also successfully established delivery in both Her Majesty’s Prison (HMP) Edinburgh and Her Majesty’s Prison Addiewell over 2012/13. This is very encouraging, given the transition of prison health services to NHS Lothian.

Weight management groups were developed to ensure that patients who were overweight or obese were able to receive support to address diet and physical activity.

Conclusions

Keep Well exceeded the target number of health checks in 2012/13. The programme is now engaging with a higher number of General Practices. Practice involvement is voluntary, therefore it is particularly encouraging to have high levels of participation. It remains difficult to assess whether Keep Well has brought about significant positive changes to cardiovascular risk factors among the Keep Well population. There are some encouraging findings from the first small dataset for patients receiving an annual review. All of the interventions used within Keep Well are evidence based. A series of local evaluations have proved valuable in developing wider understanding about engagement, behaviour modification and impact of the programme on particularly high risk sub-groups. Work continues nationally to monitor impact on morbidity and mortality.
1 Rationale

The Keep Well programme consists of a forty minute health check, delivered by trained nursing staff. It is delivered to patients aged 40-64 who are identified as being at high risk of cardiovascular disease. The eligible age range is lowered to 35 years for individuals from groups with additional vulnerability, such as those from ethnic groups at highest risk of heart disease. The policy aim of Keep Well is to bring about a step change in addressing health inequalities by targeting intervention in the areas most affected by disadvantage. Appropriate interventions are offered during the appointment, including referral on for specific interventions with the aim of reducing the risk of future ill-health. Follow up is arranged where needed.

Table 1: Total population in NHS Lothian (aged 40-64) split by residence in 15% most deprived datazones (Scottish Index of Multiple Deprivation 2009) and by Community Health Partnership/Community Health (Care) Partnership

<table>
<thead>
<tr>
<th>Community Health Partnership/Community Health (Care) Partnership</th>
<th>15% Most Deprived</th>
<th>Other Deprivation Categories</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>17,329</td>
<td>139,006</td>
<td>156,335</td>
</tr>
<tr>
<td>West Lothian</td>
<td>5,167</td>
<td>59,035</td>
<td>64,202</td>
</tr>
<tr>
<td>East Lothian</td>
<td>743</td>
<td>36,706</td>
<td>37,449</td>
</tr>
<tr>
<td>Midlothian</td>
<td>914</td>
<td>30,242</td>
<td>31,156</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>24,153</td>
<td>264,989</td>
<td>289,142</td>
</tr>
</tbody>
</table>

Source: NHS Lothian CHI Extract (September 2012)

The majority of patients eligible for Keep Well in Lothian live in the Edinburgh Community Health Partnership area. West Lothian also has a sizable number of residents aged 40-64 who are eligible to receive a Keep Well check. Smaller numbers are eligible in East and Midlothian.

Five year review Keep Well health checks were introduced in 2012/13. Locally we agreed that to ensure we were fully compliant with Scottish Intercollegiate Guidelines Network (SIGN) guidelines, there should also be an annual review of any patients identified as being at particularly high risk of cardiovascular disease.

Table 2: Total number Keep Well checks completed grouped by financial year 2007/08 to 2012/13

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>3,485</td>
<td>3,503</td>
<td>2,458</td>
<td>2,125</td>
<td>3,434</td>
<td>4,623</td>
</tr>
<tr>
<td>Annual</td>
<td>261</td>
<td>5</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Review</td>
<td>1,694</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>5,440</td>
<td>3,508</td>
<td>2,470</td>
<td>2,125</td>
<td>3,434</td>
<td>4,623</td>
</tr>
</tbody>
</table>

Source: NHS Lothian Keep Well Data Extract (March 2013)

Please note that the number of health checks completed in the above during 2012-13 will not match the number reported in the summary section on page 1. The data in the above table is based purely on the Keep Well Data Extract and so if patients are incorrectly coded their data is not captured. The figure contained within the summary section is supplemented by information gathered from the Nurse Case Managers, providing a more comprehensive picture of the number of health checks carried out.
2 Use of resources
The report detailing breakdown of spend to support delivery of Keep Well in 2012/13 can be found in Appendix 1. The single largest area of spend was employment of staff to enable delivery (£435,529). Practices are paid according to the number of completed checks, so those where higher numbers of checks are carried out receive the highest payments.

Keep Well indirectly benefits from other NHS funded resources such as smoking cessation or alcohol services, onto which patients may be referred. Keep Well similarly supports other important work, for example working with the Willow service for women who have offended. This is described in more detail in section 3.3.1.

3 Activities and Outputs
3.1 Model of delivery
A tiered delivery model was implemented this year across Lothian. The model is based firmly around the patient’s registered General Practice. These include both the Edinburgh Access Practice, which supports people who are homeless, and the Challenging Behaviour Practice.

- Tier 1 - Practices where 45% or more of the population aged 40 to 64 live in the 15% most deprived areas of Lothian. All registered patients in these Practices are invited to participate in Keep Well.
- Tier 2 - Practices where 100 to 500 people aged 40 to 64 live in the 15% most deprived areas of Lothian. Patients meeting current eligibility criteria are selected and invited to participate in Keep Well.
- Tier 3 - Practices where relatively small numbers (less than 100) of people aged 40 to 64 live in the 15% most deprived areas of Lothian. Health checks are delivered in locality clinics by a Keep Well nurse.

Our experience of delivery using this tiered approach has been positive (see Appendix 2). A full list of Practices who have participated in Keep Well can be found in Appendix 3.

3.2 Coding and IT Challenges:
Remote IT access ensures timely and consistent recording of Keep Well assessments via Bluebay. Achieving secure remote IT access has proved to be one of the main challenges of delivering Keep Well using the locality model. The past year has seen a number of improvements in the recording of health information which has been underpinned by the ongoing development of a codeset for Keep Well.

3.3 Vulnerable groups
3.3.1 Those who have offended
We have significantly expanded our work with Her Majesty’s Prison Edinburgh and Her Majesty’s Prison Addiewell over the last year. Discussion is ongoing at national level to ensure that data is extracted in a consistent fashion across Scotland.

Her Majesty’s Prison Edinburgh
Prisoners can refer themselves to Keep Well, can be referred by Primary Care nurse practitioners or invited directly by Keep Well. Health check information
is recorded on paper and relevant information entered manually into the patient’s records. A letter is sent to the individual’s General Practitioner on release requesting clinical follow up as required. Future plans for both prisons (see also Her Majesty’s Prison Addiewell below) include identification of a prison nurse practitioner to deliver health checks. A Keep Well nurse case manager would continue to oversee delivery, as with other General Practices.

A Healthy Living Skills Course was delivered in Her Majesty’s Prison Edinburgh to two male and two female groups, with four to eight attendees in groups. Positive health behaviour changes were made. Outcomes included referrals to smoking cessation (but only very limited services are provided for this at present), an increase in physical activity and a reduction in salt and sugar consumption. Feedback from participants taking the Healthy Living Skills course has been positive:

- “I was unaware that you have no symptoms of high blood pressure.”
- “Useful course, important info for anyone looking to get out of prison and live differently health-wise.”
- “I really, really enjoyed this course. I learned more about healthy diets, to learn how to cook better and it’s helped me gain more confidence.”

**Her Majesty’s Prison Addiewell**
Keep Well health checks are delivered in the health centre and there is access to a General Practitioner during the clinic if required. Prisoners are sent an invitation by Keep Well. A letter is sent to the individual’s General Practitioner on release requesting clinical follow up as required.

**Willow (women who have offended group)**
The Willow project involves partnership between NHS Lothian, the City of Edinburgh Council and Safeguarding Communities Reducing Offending (SACRO) to address the social, health and welfare needs of women in the criminal justice system. A Keep Well health check is one of the interventions offered to women. The group’s manager, Kirsty Pate, has been very positive about Keep Well’s contribution to Willow.

A link is being established with the Criminal Justice Management Group to establish a pathway for referrals and engagement with the population on a community service order eligible for Keep Well (aged 35 to 64).

**3.3.2 Substance misuse**
See also Willow summary (women who have offended group) above.

Keep Well has liaised with the Recovery Hub, Craigmillar to provide health checks for those with substance misuse problems using the Recovery Hub. The plan is to base a Keep Well nurse at the hub on a specific day, providing scheduled appointments and a drop in facility (starting from April 2013).

**3.3.3 People with severe and enduring mental health issues**
People with severe and enduring mental health issues resident in the 15% most deprived datazones in Lothian have been identified and encouraged to attend through Community mental health teams and General Practitioner surgeries. The North East Community mental health team was already
carrying out some physical health checks. Work has begun to carry out a joint health check collaboratively. A number of home visits have been carried out for people who are unable to attend clinics.

3.3.4 Gypsy/Travellers
Gypsy/Travellers aged 35 to 64 are eligible for a health check. Visits have been made to the Edinburgh Gypsy/Traveller site in partnership with the Shelter Gypsy/Traveller Development/Support worker to encourage eligible residents to attend Keep Well Health checks at their own General Practice. We continue to work closely with the key General Practices caring for significant numbers of Gypsy Travellers including the Edinburgh Access Practice.

3.3.5 People from minority ethnic groups at high risk
Individuals aged 35 to 64 and resident in 15% most deprived datazones are eligible for Keep Well. We have used a variety of methods to engage with people from high risk ethnic minorities in the past. A recent review of statistics found that the majority of patients from a high risk ethnic background were now accessing their own General Practice directly for a Keep Well assessment. We have therefore focussed on seeing these patients in their own Practices.

3.3.6 People who are homeless
Keep Well health checks are offered at the Edinburgh Access Practice to people who are homeless who fit the Keep Well criteria. This tends to be on an opportunistic basis.

4 New developments
4.1 Keep Well Weight Management and Exercise Groups
Prior to 2011/12, Keep Well in Lothian provided support for people who were overweight or obese through a programme called Counterweight. This was difficult to sustain as it relied on one to one support from practitioners. In addition, very few men engaged with this model of weight management (25% of those attending were male). Building on the experience of using Counterweight, the Keep Well team developed Keep Well Weight Management and Exercise Groups in 2012/13. There are three Keep Well Weight Management and Exercise Groups (Gilmerton, Sighthill and Pilton area). Group attendance is approximately ten to fifteen people per group in Sighthill and Pilton, with numbers less at Gilmerton. At this early stage men are attending these groups in slightly higher numbers than took part in Counterweight. Reviews were offered to participants who completed more than twelve weeks in the group. Information from seventeen people is presented below. No information is available from people who dropped out and therefore findings must be interpreted cautiously.
Health review results:

Table 3: Health profile of patients attending the Weight Management and Exercise Group, before stating and after 12 weeks of attendance (n=17)

<table>
<thead>
<tr>
<th>Type of health information</th>
<th>Health profile of the group: Before starting</th>
<th>After 12 weeks of attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>Average 132/74</td>
<td>Average 118/70</td>
</tr>
<tr>
<td>Pulse rate</td>
<td>Average 82</td>
<td>Average 63</td>
</tr>
<tr>
<td>Smoking status</td>
<td>14 non smokers</td>
<td>14 non smokers</td>
</tr>
<tr>
<td></td>
<td>3 smokers</td>
<td>2 smokers (1 ex-smoker)</td>
</tr>
<tr>
<td>Exercise</td>
<td>7 light exercise</td>
<td>Group exercise 3,</td>
</tr>
<tr>
<td></td>
<td>10 no exercise</td>
<td>&gt;3/wk = 8, &gt;2/wk = 7</td>
</tr>
</tbody>
</table>

Source: NHS Lothian Keep Well Nurse Case Manager

Initial feedback from participants in the weight management group has been positive with people making changes to both their diet and activity levels:

- “Started having breakfast regularly, and eating more fruit. Cut out processed meat.”
- “Reduced portion sizes, increased fruit and veg intake.”
- “I have been walking more, awaiting information from gym and have been carrying out exercise from Keep Well clinic.”

4.2 Physical activity pilot

Keep Well is involved in NHS Health Scotland’s physical activity pilot (which started in March 2013) and will focus on how brief advice and intervention can best be delivered at a Keep Well health check.

5 Reach

5.1 Eligible groups in Lothian

Most people are identified as being eligible for Keep Well on the basis of their deprivation status, which is measured according to the datazone they live in. Other groups eligible for Keep Well are those who have offended, people from ethnic groups at high risk of cardiovascular disease, people who are homeless and people affected by substance misuse. The figure overleaf illustrates the proportions of people eligible for Keep Well by different identified risk factors.
People aged 40-64 who are resident in one of the 15% most deprived datazones in Scotland form the majority of those eligible for Keep Well. With the introduction of new criteria, the number eligible for the programme in 2012/13 was 25,044. People will be added to this target as they reach their 40th birthday and will leave at their 65th birthday. Our target was to deliver 4,800 checks over the course of the year, so we see approximately 20% of those who are eligible every year. Keep Well has a rolling programme of delivery, with five yearly recall. Over the course of five years we will aim to invite all of those potentially eligible in Lothian. The target agreed with Scottish Government is for the total number of health checks. The split between initial and review checks is left to the Lothian Keep Well team to determine.

5.2 Delivery across Lothian
The map below shows uptake in 2012/13 across Lothian. Locality clinics are marked with red dots.
Figure 2: Keep Well patient health checks delivered in 2012/13, by patient postcode, in NHS Lothian area.

6 Outcomes and Results
6.1 Identification of people at high risk of cardiovascular disease
Overall, 11% of people seen in 2012/13 were identified as being at high risk of developing cardiovascular disease within the next ten years. Age is associated with an increase in cardiovascular risk so the pattern below is unsurprising.

Table 4: Patients identified as being at high risk of cardiovascular disease following their first Keep Well check.

<table>
<thead>
<tr>
<th>Population</th>
<th>Number of people with completed first health checks</th>
<th>Number of people with ASSIGN risk score ≥20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total eligible population: (a) aged ≥40 and &lt;50</td>
<td>1,614</td>
<td>39</td>
</tr>
<tr>
<td>(b) aged ≥50 and &lt;65</td>
<td>1,643</td>
<td>316</td>
</tr>
<tr>
<td>Total eligible population:</td>
<td>3,257</td>
<td>355</td>
</tr>
</tbody>
</table>

Source: NHS Lothian Keep Well Data Extract (March 2013)

Please note that patients under the age of 40 are excluded from this table.
6.2 Follow up of people at high risk of cardiovascular disease

Numbers seen for annual review: this was the first year that Keep Well in Lothian began recalling patients identified as being at high risk of cardiovascular disease. In total, 275 patients were reviewed. We were particularly interested in finding out whether patients had been able to make positive changes to their risk factors. More than one year may have elapsed for some of these patients. Those identified as being at high risk anytime since the start of the initiative will be eligible for recall.

Smoking: encouragingly, some smokers were able to stop smoking between their initial check and review check (9 quit smoking out of 34). Three patients started smoking (previously reported as non-smokers).

Overweight and Obesity: overall, there were small increases in the numbers of patients who were overweight or obese (7 patients increased their weight category out of 158 with weight measurements available). This was perhaps not surprising given the steady rise in levels of overweight and obesity among the general population. It is not possible to compare these small increases with a similar population group. This means it is impossible to assess whether inclusion in Keep Well has any separate impact on weight.

Blood pressure: there was an increase in the number of patients diagnosed with hypertension between the initial and review checks (increase from 30 patients to 58 patients). Associated with this, more patients had blood pressure measurements within the target range (from 79 patients with good control to 91 patients).

Data in future: changes were made during the year to the way physical activity is recorded. It was not possible to compare self-reported activity levels this year, but the programme hopes to be able to do this in future. Keep Well will also include information on the numbers of patients reporting possible harmful alcohol intake in future years.

6.3 What cardiovascular risk factors do people have?

Just under a third of people attending for a health check in 2012/13 were obese. High proportions of the Keep Well population are current smokers, with around 39% of those living in most deprived circumstances currently smoking. Approximately 13% of people were found to have potentially harmful alcohol intake. At a Keep Well check, patients who need ongoing support to make positive changes are offered referral to particular services. It is encouraging to see that those in the most deprived portion of our communities have relatively high levels of referral onward for weight management (most deprived 10% versus 7% for all checks 2012/13), and smoking cessation advice (most deprived 12% versus 9% for all checks 2012/13).

There are some differences in risk factor profiles in different parts of Lothian. In 2012/13 only one Practice from East Lothian and one Practice from Midlothian participated, so some of the differences seen may be partly due to smaller numbers from these areas. A complete breakdown of risk factors by
Community Health Partnership/Community Health (Care) Partnership can be found in Appendix 5.

6.4 **Is there any difference in uptake across different age groups or gender?**

The group least likely to attend are men under the age of forty. Only small numbers are eligible in this age group, either because they come from a high risk ethnic group, are affected by substance misuse, homelessness or are involved in the criminal justice system.

All of the interventions delivered by Keep Well, including how we enable patients to access services, are evidence based. It is well known that identifying and controlling hypertension, stopping smoking, maintaining a healthy weight and taking part in regular physical activity all reduce cardiovascular risk. Interventions to reduce these individual risk factors are central to the Keep Well health check.

The table below summarises the numbers of people referred onto specific services following a health check. Overall 442 referrals to different services were made for Keep Well patients.

**Table 5:** Patients referred onto other services during their initial Keep Well health check, 2012/13. Data from health checks in quarters 1-3 only- see note below.

<table>
<thead>
<tr>
<th>Services</th>
<th>Number of first health checks</th>
<th>Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Management</td>
<td>2,527</td>
<td>129</td>
</tr>
<tr>
<td>Alcohol Interventions</td>
<td>2,527</td>
<td>9</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>2,527</td>
<td>173</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,527</td>
<td>These data are not yet available</td>
</tr>
<tr>
<td>Wellbeing/Health Coaching</td>
<td>2,527</td>
<td>291</td>
</tr>
<tr>
<td>Literacy</td>
<td>2,527</td>
<td>These data are not yet available</td>
</tr>
<tr>
<td>Employability</td>
<td>2,527</td>
<td>These data are not yet available</td>
</tr>
<tr>
<td>Exercise Programme</td>
<td>2,527</td>
<td>131</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,527</strong></td>
<td><strong>733</strong></td>
</tr>
</tbody>
</table>

Source: NHS Lothian Keep Well Data Extract (March 2013)

Note this is a summary table of National Indicator 5, which requires Boards to collect data about onward referrals in the three months following a health check. As a result only data from Quarters 1-3 of health checks are included.

Health coaching sessions are provided within Keep Well for patients who require more individual support. After assessment with Keep Well coaches, patients may be referred on to receive literacy or employability support. These onward referrals are not captured at present. There are no systems currently within Lothian that would allow us to report on attendance after referral. This is a matter of interest for both NHS Lothian and Health Scotland. We have attempted to match up Keep Well referrals to the smoking cessation database but insufficient information was available to allow us to match up patients.
It is difficult to capture changes in health as a consequence of Keep Well because the programme is only one of a range of interventions being delivered to the eligible population.

7 Contextual factors
Over time, there have been substantial changes to the allocation received by NHS Lothian to support delivery of Keep Well. We were fortunate to have carried out substantial reorganisation of the staff team in 2010/11 and this helped to ensure we were ‘ready to go’ at the start of 2012/13.

Keep Well relies on a very small, able group of staff, who remain on short term contracts. When staff take up new posts it can cause difficulties. Any delays in the recruitment process can result in pressures on the wider team.

8 Implications and Learning
The new delivery model has been embedded and is working well with Practices recruited to the programme. We have not been able to convince all Practices we would like to take part. A small number of Practices remain unconvinced of the need for our involvement. We hope to continue to work closely with each of the Lothian Community Health Partnership/Community Health (Care) Partnerships in order to find a way to resolve this issue to ensure all of those potentially eligible for Keep Well are able to access a health check.

We have experienced very positive interactions with mental health staff and prison staff, who are keen to embrace delivery of Keep Well. There is a role for the team supporting and training other staff to enable more people to be reached in different settings.

We continue to contribute to wider NHS learning to support behavioural change, developing our own weight management group and now taking part in the Health Scotland physical activity pilot. The employment of health workers and good relationships with the third sector is enabling Keep Well staff to link attendees into services that help mitigate the underlying social and environmental conditions that increase the risk of cardiovascular disease among people living in areas of deprivation as well as the immediate risks such as smoking, overweight and obesity and alcohol. Together, this provides a welcome opportunity for the organisation to learn how to better support people to modify their cardiovascular risk.
## Appendix 1
### Financial Summary

Keep Well Financial Report
Community Health Partnership: Edinburgh
Quarter End Date: 31/03/13
Financial year: 2012-13

### EXPENDITURE

<table>
<thead>
<tr>
<th>Headline cost</th>
<th>detailed cost</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE PROJECT TEAM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G.P / Clinical Director, 0.02 wte</td>
<td>2,284</td>
<td>2,285</td>
<td>1,523</td>
<td>2,284</td>
<td>8,376</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Bank, 0.02 wte</td>
<td>14</td>
<td>581</td>
<td>0</td>
<td>252</td>
<td>847</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Consultant Band 8B, 0.07 wte</td>
<td>2,288</td>
<td>2,288</td>
<td>1,526</td>
<td>2,288</td>
<td>8,390</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Case Manager Band 6, 3.20 wte</td>
<td>32,232</td>
<td>29,377</td>
<td>29,721</td>
<td>33,439</td>
<td>124,769</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Nurses Band 5, 7.03 wte</td>
<td>54,382</td>
<td>57,772</td>
<td>45,126</td>
<td>48,487</td>
<td>205,767</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach Workers Band 5, 1.17 wte</td>
<td>7,601</td>
<td>7,601</td>
<td>7,601</td>
<td>11,903</td>
<td>34,706</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Administrator Band 3, 0.61 wte</td>
<td>3,396</td>
<td>374</td>
<td>3,678</td>
<td>5,044</td>
<td>12,492</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Manager - Band 7, 0.83 wte</td>
<td>11,823</td>
<td>12,054</td>
<td>12,229</td>
<td>4,076</td>
<td>40,182</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services and supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provide details below</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instruments &amp; Sundries</td>
<td>229</td>
<td>862</td>
<td>1,039</td>
<td>1,345</td>
<td>3,475</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property Maint.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>6,035</td>
<td>5,464</td>
<td>3,455</td>
<td>3,313</td>
<td>18,267</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel &amp; Subsistence</td>
<td>3,851</td>
<td>3,701</td>
<td>2,869</td>
<td>2,868</td>
<td>13,289</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>4,963</td>
<td>510</td>
<td>1,690</td>
<td>2,700</td>
<td>9,863</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,492</td>
<td>31</td>
<td>350</td>
<td>212</td>
<td>2,085</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Printing &amp; Stationery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postages &amp; Telephones</td>
<td>746</td>
<td>488</td>
<td>809</td>
<td>1,032</td>
<td>3,075</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone System</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room Hire</td>
<td>0</td>
<td>2,040</td>
<td>1,128</td>
<td>3,168</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained by finance to meet overheads</td>
<td>29,975</td>
<td>29,975</td>
<td>29,975</td>
<td>29,975</td>
<td>119,900</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total of those with unit cost less than £1000</td>
<td>972</td>
<td>313</td>
<td>254</td>
<td>473</td>
<td>2,012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Analyst, 1.00 wte</td>
<td>10,948</td>
<td>10,948</td>
<td>36,491</td>
<td>5,853</td>
<td>64,240</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT Support (NSS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bluebay Medical Systems - Data Extract</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services and supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total of those with unit cost less than £1000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRACTICE PAYMENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>provide details below</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breich Valley Medical Practice (Stoneyburn)</td>
<td>135</td>
<td>1,395</td>
<td>1,080</td>
<td>705</td>
<td>3,315</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conan Doyle M.C. (Dr. L. Taylor)</td>
<td>1,025</td>
<td>280</td>
<td>625</td>
<td>1,550</td>
<td>3,480</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dalkeith Road M.P. (Drs Paterson, Quinn &amp; Wright)</td>
<td>460</td>
<td>440</td>
<td>20</td>
<td>920</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inchpark Surgery</td>
<td>1,000</td>
<td>920</td>
<td>60</td>
<td>1,980</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Leonard's Medical Centre (Dr. Burns-Brown)</td>
<td>1,000</td>
<td>1,020</td>
<td>260</td>
<td>2,280</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southside Surgery (Dr. A. Paterson)</td>
<td>1,000</td>
<td>640</td>
<td>80</td>
<td>1,720</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leithmount Surgery</td>
<td>2,625</td>
<td>3,210</td>
<td>7,440</td>
<td>13,275</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crewe Medical Centre</td>
<td>10,096</td>
<td>3,466</td>
<td>5,880</td>
<td>19,443</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fermiehill Surgery</td>
<td>1,050</td>
<td>1,350</td>
<td>2,700</td>
<td>5,100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muirhouse Medical Group</td>
<td>6,293</td>
<td>6,458</td>
<td>8,790</td>
<td>21,540</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rose Garden M.C. (Dr. Temple)</td>
<td>2,138</td>
<td>1,850</td>
<td>3,578</td>
<td>7,565</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Name</td>
<td>Males</td>
<td>Females</td>
<td>Total</td>
<td>Total Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>-------</td>
<td>---------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gracemount Medical Practice</td>
<td>4,894</td>
<td>2,779</td>
<td>3,623</td>
<td>11,295</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whinpark M.C. (Dr. N. Wallace)</td>
<td>5,974</td>
<td>2,374</td>
<td>10,215</td>
<td>18,563</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milton Surgery</td>
<td>1,875</td>
<td>1,290</td>
<td>3,165</td>
<td>6,325</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craigmhill M.C. (Dr. C. Bickler)</td>
<td>7,088</td>
<td>26,955</td>
<td>34,043</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashgrove Group Practice</td>
<td>3,083</td>
<td>3,518</td>
<td>1,530</td>
<td>8,130</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craighill Partnership</td>
<td>6,375</td>
<td>2,415</td>
<td>1,455</td>
<td>10,245</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durham Road Medical Group</td>
<td>1,260</td>
<td>1,706</td>
<td>3,533</td>
<td>6,499</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prestonpans H.C. (Dr. J. L. Reeks)</td>
<td>90</td>
<td>3,030</td>
<td>3,120</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sighthill M.C. (Dr. A.M. Watson)</td>
<td>1,920</td>
<td>1,298</td>
<td>4,590</td>
<td>7,808</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sighthill H.C. (Dr. Johnson)</td>
<td>600</td>
<td>278</td>
<td>1,260</td>
<td>2,138</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mackenzie Medical Centre</td>
<td>1,460</td>
<td></td>
<td>300</td>
<td>1,760</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craiglockhart Medical Group</td>
<td>1,660</td>
<td>480</td>
<td>180</td>
<td>2,320</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firhill Medical Centre</td>
<td>1,110</td>
<td>400</td>
<td>80</td>
<td>1,590</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marchmont M.P. (Dr. Raczkowski)</td>
<td>720</td>
<td>40</td>
<td>60</td>
<td>820</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boroughloch M.C. (Dr. L. MacCallum)</td>
<td>2,185</td>
<td></td>
<td>100</td>
<td>2,285</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Westerhailes Medical Centre</td>
<td>6,214</td>
<td>1,789</td>
<td>4,890</td>
<td>12,893</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.M. Prison</td>
<td>1,390</td>
<td></td>
<td></td>
<td>1,390</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bellevue M.C. (Dr. Tolley)</td>
<td>1,000</td>
<td>120</td>
<td>100</td>
<td>1,220</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polwarth Surgery (Dr. A.M. Millar)</td>
<td>940</td>
<td>260</td>
<td>160</td>
<td>1,360</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leith Walk Surgery (Dr. R.J. Scott)</td>
<td>1,000</td>
<td>280</td>
<td>340</td>
<td>1,620</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baronscourt M.P. (Dr. F.O. George)</td>
<td>1,000</td>
<td>160</td>
<td>760</td>
<td>1,920</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Triduanas M.P. (Dr. J.A. Garner)</td>
<td>1,000</td>
<td></td>
<td>640</td>
<td>1,640</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bellevue M.C. (Dr. Gray)</td>
<td>1,000</td>
<td>160</td>
<td>220</td>
<td>1,380</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangholm Loan (Dr. A. Stevenson)</td>
<td>1,000</td>
<td>260</td>
<td></td>
<td>1,260</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brunton Place Surgery</td>
<td>1,000</td>
<td>620</td>
<td></td>
<td>1,620</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangholm M.C. (Drs L. Stobie &amp; F.J. Wood)</td>
<td>1,400</td>
<td>180</td>
<td></td>
<td>1,580</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Springwell Medical Group (Drs I. Dickson &amp; R. Liddle)</td>
<td>1,320</td>
<td>360</td>
<td></td>
<td>1,680</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Calder Medical Practice</td>
<td></td>
<td></td>
<td>1,620</td>
<td>1,620</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southfield Medical Practice</td>
<td></td>
<td></td>
<td>520</td>
<td>520</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newlands Practice</td>
<td></td>
<td></td>
<td>1,000</td>
<td>1,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>Amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carry Forward from 2010/11</td>
<td>£</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish Government (KW)</td>
<td>£</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish Government (Service Enhancement Fund)</td>
<td>£</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish Government (Wave 4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish Government (extension fund)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish Government (Smoking Cessation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FUNDED SERVICES**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sighthill H.C. (Dr. Sharpe &amp; Partners)</td>
<td>1,000</td>
</tr>
<tr>
<td>1,000</td>
<td></td>
</tr>
</tbody>
</table>

**WORKFORCE DEVELOPMENT**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide details below</td>
<td></td>
</tr>
</tbody>
</table>

**EVALUATION**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide details below</td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>198,063</td>
<td></td>
</tr>
<tr>
<td>245,357</td>
<td></td>
</tr>
<tr>
<td>254,295</td>
<td></td>
</tr>
<tr>
<td>328,075</td>
<td></td>
</tr>
<tr>
<td>1,025,789</td>
<td></td>
</tr>
</tbody>
</table>

**INCOME**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry Forward from 2010/11</td>
<td>£</td>
</tr>
<tr>
<td>Scottish Government (KW)</td>
<td>£</td>
</tr>
<tr>
<td>Scottish Government (Service Enhancement Fund)</td>
<td>£</td>
</tr>
<tr>
<td>Scottish Government (Wave 4)</td>
<td></td>
</tr>
<tr>
<td>Scottish Government (extension fund)</td>
<td></td>
</tr>
<tr>
<td>Scottish Government (Smoking Cessation)</td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>Amount</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Scottish Government (IT Monies)</td>
<td></td>
</tr>
<tr>
<td>Other (State)</td>
<td></td>
</tr>
<tr>
<td>Other (State)</td>
<td></td>
</tr>
<tr>
<td>Other (State)</td>
<td></td>
</tr>
<tr>
<td>Other (State)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>£ 1,199,000.00</td>
</tr>
</tbody>
</table>

**BALANCE**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spend</td>
<td>£ 1,025,789</td>
</tr>
<tr>
<td>Total Income</td>
<td>£ 1,199,000.00</td>
</tr>
<tr>
<td>Balance</td>
<td>£ 173,211.46</td>
</tr>
<tr>
<td>Carry Forward to 2013/14</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2
Practice delivery information

Tier 1:
Muirhouse, Crewe, Craigmillar, Westerhailes
Keep Well is running effectively in the Tier I Practices. There needs to be continual IT support and guidance for Practices in order to manage any Bluebay difficulties more quickly and effectively. Follow up for high ASSIGN scores and/or abnormal blood results is carried out in partnership with General Practitioners and is also running smoothly as per guidelines.

Tier 2:
Ferniehill, Newbattle, Durham Road, Gracemount, Milton, Southfield, Liberton, Boroughloch, Prestonpans, Rose Garden, Leith Mount, Blackburn, West Calder, Craigshill, Sighthill Green, Sighthill (Sharpe), Johnson and Whinpark
Most of these Practices have been delivering Keep Well to their Practices without problems. Some Practices found it more difficult to deliver Keep Well and this may be because patients are living further away from their Practices. Practices have invited their eligible population for an initial health check on three or more occasions using letters, telephone calls and NHS 24. By the end of March 2013, twelve Practices were delivering five year health checks.

Tier 3:
Tollcross Locality Clinic/South East Locality Clinic/North East Locality Clinic – Leith Community Treatment Centre
The locality clinic model has worked effectively and all three locality clinics have proved popular with patients and Practices. Follow up for high cardiovascular disease and abnormal blood results have been working smoothly.

The South East locality clinic commenced April 2012 and delivers Keep Well health checks for patients from six General Practices. Approximately half of patients seen in the first quarter were referred for follow up or another service (e.g. smoking cessation, weight management etc).

The North East locality clinic began in November 2012. The booking rate for each Practice after two invitations is 25% and there are clinics every weekday. It has been noted that patients have attended Leith Community Treatment Centre directly to book an appointment when unable to make a phone call to the centralised booking line. The reasons for doing so are because English is not their first language or they have not had the financial resource to make a phone call. Approximately 40% of patients who attended required follow up or were referred to another service. This is a popular venue for health checks and the model is kept under regular review by the Keep Well Implementation Group.
# Appendix 3

A full list of NHS Lothian Practices participating in Keep Well during 2012/13

<table>
<thead>
<tr>
<th>Practice</th>
<th>Practice name</th>
<th>Delivery Model</th>
<th>Locality Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>70126</td>
<td>Southfield Medical Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70164</td>
<td>Ferniehill Surgery</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70215</td>
<td>Craigmillar Medical Group</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70253</td>
<td>Whinpark Medical Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70376</td>
<td>Liberton Medical Group</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70427</td>
<td>Milton Surgery</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70499</td>
<td>Dr Gray &amp; Partners (Bangholm)</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70516</td>
<td>Gracemount Medical Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70521</td>
<td>Dr Martin Tolley &amp; Partners</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70573</td>
<td>Crewe Medical Centre</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70605</td>
<td>Durham Road Medical Group</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70662</td>
<td>Muirhouse Medical Group</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70696</td>
<td>Rose Garden Medical Centre</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70911</td>
<td>Watson</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70959</td>
<td>Dr Guy Johnson and Dr Helga Rhein</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70963</td>
<td>Edinburgh Access Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70978</td>
<td>Wester Hailes Health Centre</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>71114</td>
<td>Leith Mount Surgery</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>76122</td>
<td>Prestonpans Group Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>77106</td>
<td>Newbattle Medical Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>78043</td>
<td>Breich Valley Medical Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>78147</td>
<td>West Calder Medical Practice</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>78311</td>
<td>The Craighill Partnership</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>78330</td>
<td>Ashgrove Group Practice (Blackburn)</td>
<td>Practice</td>
<td>-</td>
</tr>
<tr>
<td>70610</td>
<td>Craiglockhart Medical Group</td>
<td>Locality</td>
<td>Tollcross</td>
</tr>
<tr>
<td>70766</td>
<td>Marchmont Medical Practice</td>
<td>Locality</td>
<td>Tollcross</td>
</tr>
<tr>
<td>71011</td>
<td>Polwarth Surgery</td>
<td>Locality</td>
<td>Tollcross</td>
</tr>
<tr>
<td>71082</td>
<td>Springwell Medical Group</td>
<td>Locality</td>
<td>Tollcross</td>
</tr>
<tr>
<td>71097</td>
<td>The Firrhill Medical Centre</td>
<td>Locality</td>
<td>Tollcross</td>
</tr>
<tr>
<td>70022</td>
<td>Bangholm Medical Centre (White Practice)</td>
<td>Locality</td>
<td>Leith CTC</td>
</tr>
<tr>
<td>70179</td>
<td>Leith Walk</td>
<td>Locality</td>
<td>Leith CTC</td>
</tr>
<tr>
<td>70268</td>
<td>Brunton Place Surgery</td>
<td>Locality</td>
<td>Leith CTC</td>
</tr>
<tr>
<td>70272</td>
<td>Dr Anne Stevenson &amp; Partners (Bellevue)</td>
<td>Locality</td>
<td>Leith CTC</td>
</tr>
<tr>
<td>70658</td>
<td>The Baronscourt Medical Partnership</td>
<td>Locality</td>
<td>Leith CTC</td>
</tr>
<tr>
<td>70785</td>
<td>St Triduana's Medical Practice</td>
<td>Locality</td>
<td>Leith CTC</td>
</tr>
<tr>
<td>70291</td>
<td>Inchpark Surgery</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
<tr>
<td>70381</td>
<td>Mackenzie Medical Centre</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
<tr>
<td>70470</td>
<td>Dalkeith Road Medical Practice</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
<tr>
<td>70639</td>
<td>Dr L Taylor &amp; Partners (Bellevue)</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
<tr>
<td>70732</td>
<td>Boroughloch Medical Practice</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
<tr>
<td>70841</td>
<td>St Leonard's Medical Centre</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
<tr>
<td>70893</td>
<td>Southside Surgery</td>
<td>Locality</td>
<td>Conan Doyle</td>
</tr>
</tbody>
</table>
Appendix 4

Percentage of Keep Well population who have one of the risk factors associated with cardiovascular disease or have received an intervention as a result of Keep Well check, presented for different patient groups

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>All Eligible (n=42,451)</th>
<th>Check 12-13 (n=3,470)</th>
<th>Check 11-12 (n=3,501)</th>
<th>Most Deprived (n=7,948)</th>
<th>Carers (n=967)</th>
<th>High Risk Ethnicity (n=607)</th>
<th>Substance Misuser (n=390)</th>
<th>Homeless (n=57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI over 30</td>
<td>34.6%</td>
<td>32.7%</td>
<td>33.3%</td>
<td>35.9%</td>
<td>38.3%</td>
<td>26.2%</td>
<td>21.2%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Current smoker</td>
<td>36.5%</td>
<td>38.1%</td>
<td>34.5%</td>
<td>39.0%</td>
<td>34.2%</td>
<td>14.6%</td>
<td>69.7%</td>
<td>67.3%</td>
</tr>
<tr>
<td>High FAST score</td>
<td>13.4%</td>
<td>11.7%</td>
<td>13.2%</td>
<td>12.0%</td>
<td>7.7%</td>
<td>2.3%</td>
<td>55.7%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Positive mental health screening</td>
<td>13.7%</td>
<td>24.0%</td>
<td>22.4%</td>
<td>18.4%</td>
<td>24.9%</td>
<td>13.2%</td>
<td>36.7%</td>
<td>28.1%</td>
</tr>
<tr>
<td>Interventions 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed statin ²</td>
<td>11.6%</td>
<td>13.0%</td>
<td>14.5%</td>
<td>21.0%</td>
<td>21.1%</td>
<td>12.7%</td>
<td>19.5%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Referred for weight management</td>
<td>4.3%</td>
<td>6.6%</td>
<td>5.4%</td>
<td>9.9%</td>
<td>11.3%</td>
<td>6.9%</td>
<td>6.7%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Referred to smoking cessation</td>
<td>4.9%</td>
<td>9.0%</td>
<td>6.7%</td>
<td>12.4%</td>
<td>10.9%</td>
<td>5.9%</td>
<td>14.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Referred to alcohol services</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>1.3%</td>
<td>0.2%</td>
<td>0.5%</td>
<td>13.1%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Referred to physical activity services</td>
<td>4.8%</td>
<td>11.4%</td>
<td>7.8%</td>
<td>12.5%</td>
<td>13.3%</td>
<td>12.0%</td>
<td>15.6%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>

Note ¹: Please note that with the exception of weight management referrals, a patient who is sign-posted to another service will likely be recorded as a referral in the data. The number of patients who then refer on as a direct result of the health check is currently unknown but will be lower.

Note ²: Statin last prescribed within 1 year of having health check. This is a measure of prior risk combined with ongoing need for medication.
### Appendix 5

Percentage of Keep Well population who have one of the risk factors associated with cardiovascular disease or have received an intervention as a result of Keep Well check, presented for NHS Lothian and CHPs

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>NHS Lothian (n=42,451)</th>
<th>Edinburgh (n=36,558)</th>
<th>East Lothian (n=563)</th>
<th>Midlothian (n=660)</th>
<th>West Lothian (n=4,670)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI over 30</td>
<td>34.6%</td>
<td>33.5%</td>
<td>46.9%</td>
<td>32.2%</td>
<td>42.1%</td>
</tr>
<tr>
<td>Current smoker</td>
<td>36.5%</td>
<td>36.9%</td>
<td>48.6%</td>
<td>52.2%</td>
<td>28.5%</td>
</tr>
<tr>
<td>High FAST score</td>
<td>13.4%</td>
<td>14.2%</td>
<td>4.7%</td>
<td>15.7%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Positive mental health screening²</td>
<td>13.7%</td>
<td>12.4%</td>
<td>11.0%</td>
<td>24.4%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Interventions¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed statin³</td>
<td>11.6%</td>
<td>11.4%</td>
<td>12.8%</td>
<td>11.4%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Referred for weight management</td>
<td>4.3%</td>
<td>4.8%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Referred to smoking cessation</td>
<td>4.9%</td>
<td>5.3%</td>
<td>5.0%</td>
<td>3.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Referred to alcohol services</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Referred to physical activity services</td>
<td>4.8%</td>
<td>5.1%</td>
<td>4.8%</td>
<td>3.0%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Note ¹: Please note that with the exception of weight management referrals, a patient who is sign-posted to another service will likely be recorded as a referral in the data. The number of patients who then refer on as a direct result of the health check is currently unknown but will be lower.

Note ²: Mental health screening was only introduced in 2009 and this table presents data on all patients ever receiving a health check. Therefore the apparently higher levels of positive screening in Mid and East Lothian are misleading. Comparing all Lothian screened patients from 2011/12 and 2012/13, in Appendix 4, reveals very similar proportions screened positive.

Note ³: Statin last prescribed within 1 year of having health check. This is a measure of prior risk combined with ongoing need for medication.
SUMMARY PAPER - ANTI-BRIBERY STATEMENT

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

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

- The UK Ministry of Justice’s statutory guidance on the Bribery Act 2010 advises that all organisations should agree communicate their anti-bribery stance. This sets the “tone at the top”.
  
  3.1, 3.4

- An anti-bribery statement for the Board has been drafted, and the Audit & Risk Committee has reviewed it and agreed it should be recommended to the Board.
  
  2.1, 3.8

- The agreed statement should be demonstrably communicated as the position of the Board.
  
  2.2, 3.3

- As a body that “carries on a business”, the Board could potentially be exposed to the corporate offence of failing to prevent a bribe being made to the Board’s advantage. The only available defence to that charge is the Board being able to prove that it had put in place “adequate procedures” designed to prevent such conduct.
  
  4.1-4.4

- The statement will complement measures that are either in place (e.g. Code of Conduct for Board members, standards of business conduct for employees, procurement practices), or are being developed, which are pertinent to having adequate and proportionate procedures to manage the risk of bribery.
  
  3.3-3.7

Alan Payne
Corporate Governance Manager
5 July 2013
alan.payne@luht.scot.nhs.uk
ANTIBRIBERY STATEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an anti-bribery statement for its approval.

Any member wishing additional information should contact the Director of Finance in advance of the meeting.

2 Recommendations

2.1 Approve the anti-bribery statement.

2.2 Agree that the full statement is incorporated into the minutes of this Board meeting, and that the Statement is published in a prominent position on the NHS Lothian website.

3 Discussion of Key Issues

3.1 Principle 2 of the Ministry of Justice’s statutory guidance (for the Bribery Act 2010) for commercial organisations (March 2011) is about “Top Level commitment”. One of the suggested steps is that the organisation should agree and communicate its anti-bribery stance. Many organisations have already done this and published their position on their website.

3.2 On 30 August 2012 a small group of people (including communications and partnership) met to draft an anti-bribery statement for the Board. The approach taken was to review a sample of statements from a variety of organisations, to identify good practice and select something appropriate. The Group liked the concise approach taken by Brodies LLP, and the attached statement is an adaptation of that. (Brodies have subsequently confirmed that they are content for the Board to make use of their statement.)

3.3 The statement is a communication of the Board’s fundamental position, and will just be one piece of the general arrangements to establish an anti-bribery culture. The existence of such a Statement sets the “tone at the top” with regard to preventing bribes being made in the Board’s name. It is important that the Statement is undeniably the position of the Board, and is demonstrably communicated as such.

3.4 A detailed action plan has been prepared to build up the “adequate procedures” that the Board should have in place in order to reduce the risk of bribery. The aim is to build upon what the Board has in place at the moment, and put in place “adequate
“procedures” that are proportionate to the risk that the Board actually faces. In order to do this, a better understanding of the risk is required.

3.5 The action plan at the moment is therefore concerned with building up a picture. The Board’s “associated persons” will be defined, which in turn will inform an organisational risk assessment that will inform the areas that should be prioritised for further action. The goal of all of this work is for the Board to have a clear understanding of its risks with regard to bribery, the key systems of control that are in place to manage them, and assurance that those systems are effective.

3.6 The application of good standards of business conduct (gifts, hospitality, interests etc) is a key element of culture that does not tolerate bribery. Progress has already been made to communicate and implement the Board’s procedure on “Applying the Principles of Good Business Conduct”. The Executive Summary of the procedure is in Mandatory Policy Pack 1 which should be given to all employees. (This relates to the actions to improve general compliance with policies and procedures, which the Committee was briefed on at its meeting of 15 November 2012). The Procedure has been presented to several management teams. The Area Drugs & Therapeutics Committee has re-drafted its local procedure on the declaration of interests in order to adopt the Procedure in practice. The Board’s website has the Board members’ Register of Interests as at April 2013.

3.7 The Corporate Management Team (as was) reviewed a draft of this statement on 3 October 2012 and confirmed that they were happy with the content, and that it should go on the Board’s website. Since then the Statement has been updated to reflect the revised whistle-blowing policy (which has just been approved), the national confidential alert line (launched on 1 April 2013), and the contact details for CFS, Fraud Liaison Officer, and links to the websites of CFS and the Public Standards Commissioner.

3.8 The Audit & Risk Committee reviewed the draft statement on 24 June 2013 and agreed that it should be recommended to the Board. Further to feedback at that meeting, the supporting definition of bribery and corruption has been revised. The definition is not part of the Statement as such, but will be available to readers to via a pop-up.

3.8 The draft Anti-Bribery Statement is presented below:

An Anti-Bribery Statement from the Board
Lothian NHS Board conducts its business with integrity, transparency and fairness.

We are committed to the prevention of bribery and corruption as we recognise the importance of maintaining our reputation and the confidence of our stakeholders, particularly patients, the general public, those with whom we conduct business, and our employees.

We do not accept bribery and corruption in the conduct of our activities and functions, either within the organisation or in our relationships with any external parties. We will not work with others who do not share our commitment to preventing bribery and corruption.
If you have any concerns with regard to bribery and corruption in relation to the Board’s activities, there are several ways in which you can raise this:

1. Reporting any concerns to the Board’s Fraud Liaison Officer (David Woods – telephone 0131 465 7765, internal 47765) or Counter Fraud Services (CFS Fraud Hotline – 08000 15 16 28)

2. If the issue relates to the behaviour of a member of the Board, and compliance with the Board Member’s Code of Conduct, reporting the matter to the Public Standards Commissioner.

3. As a Board employee, making use of the Whistleblowing Policy. You can call the National Confidential Alert Line – telephone 0800 008 6112.

Brian Houston Tim Davison
Board Chairman Chief Executive

1. Link to a pop-up with this definition.

It is a criminal offence to either make a bribe or to receive a bribe. The Bribery Act 2010 sets out technical definitions for both, however in simple terms a bribe has the following elements:

- to give/ promise/ offer an advantage (financial or otherwise) to someone, OR
- to request/ agree to receive/ accept an advantage (financial or otherwise) from someone

AND, with the intention (by either the giver or receiver) to:

a) Encourage the recipient to improperly perform a function or an activity, OR
b) Reward the recipient who has already improperly performed a function or an activity.

It is also an offence when it is known by the giver or receiver that acceptance of the advantage would itself constitute improper performance of a relevant function or activity. An example of this would be the offer or acceptance of hospitality & entertainment that goes beyond the limits of what is considered modest, normal and reasonable in the circumstances, as defined by the relevant code of conduct.

When bribery happens it leads to corruption. This is where people abuse their position for their personal benefit/ reasons, rather than properly performing their role for the benefit of the Board and the stakeholders it serves.

4 Key Risks

4.1 There is a risk that decision-making or the conduct of the Board's business is influenced by bribery. The Bribery Act 2010 commenced in July 2011, and clarifies the offences of bribery, and creates a new corporate offence for "commercial organisations" for failing to prevent bribery.

4.2 On 25 November 2011 Peter Gray QC gave a presentation to NHS Scotland colleagues on the Bribery Act 2010. He highlighted that a NHS Board can be a “commercial organisation” under the Act depending on the circumstances of the particular item of business. What is key to being a “commercial organisation” is whether or not the Board “carries on a business”
This means that the Board must have "adequate procedures" to prevent bribery, and those procedures must be consistently implemented and monitored. If the Board does not have adequate procedures, then it does not have an effective defence against the corporate offence of failing to prevent bribery being conducted to the Board’s advantage. A successful prosecution against the Board for the corporate offence could lead to an unlimited fine.

The work associated with this supports embedding good procurement practice, having a solid understanding of the third parties the Board does business with, and having a robust framework for engaging with those parties. Therefore regardless of how unlikely it is that someone would offer a bribe in order to obtain business or an advantage for the Board, there are governance and internal control benefits from pursuing this work.

5 Risk Register

5.1 The Risk of Bribery is on the “corporate governance” specialty risk register (risk ID 2839).

6 Impact on Health Inequalities

6.1 An impact assessment has not been performed. This statement is an expression of the Board’s stance against bribery, and does not represent a change of policy, strategy, or the provision of services.

7 Involving People

7.1 A range of employees were invited to take part in the working group that developed the statement. The group did include representation from finance, communications and partnership. The draft statement has been circulated amongst members of the Corporate Management Team, and also reviewed by staff from Counter Fraud Services (who sit on the Counter Fraud Action Group) and the Audit & Risk Committee.

8 Resource Implications

8.1 The agreement and publication of this Statement will not have any resource implications.

Alan Payne
Corporate Governance Manager
4 July 2013
alan.payne@luht.scot.nhs.uk
HEALTHCARE GOVERNANCE COMMITTEE TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the amended Terms of Reference of the Healthcare Governance Committee.

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

2 Recommendations

2.1 Agree the amended Terms of Reference of the Healthcare Governance Committee.

3 Discussion of Key Issues

3.1 The Healthcare Governance Committee has updated their Terms of Reference bringing them into line with the Corporate Governance Code.

4 Risk Register

4.1 There are no implications for NHS Lothian’s Risk Register.

5 Impact on Inequality, Including Health Inequalities

5.1 This is an administrative matter and has no impact on Inequalities.

6 Involving People

6.1 The amended Terms of Reference have been agreed by the Healthcare Governance Committee.

7 Resource Implications

7.1 There are no resource implications arising from these recommendations.

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

List of Appendices

Appendix 1: Amended Terms of Reference for the Healthcare Governance Committee
HEALTHCARE GOVERNANCE COMMITTEE

Remit:

The Healthcare Governance Committee is to provide assurance to the Board that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard.

The Committee will also provide assurance to the Board that NHS Lothian meets its responsibilities with respect to:-

- NHS Lothian Participation Standards
- Volunteers/Carers
- Information Governance
- Protection of Vulnerable People including children, adults, offenders
- Relevant Statutory Equality Duties

The Board authorises the Committee to investigate any activity within its terms of reference, to request any Board member or employee to attend a Committee meeting, and request a written report or seek any information it requires. The Board directs all employees to co-operate with any Committee request.

The Board has a procedure entitled the Development, Approval and Communication of NHS Lothian Policies & Procedures. This sets out the range of policies and procedures that the Committee has responsibility for.

In accordance with the Standing Orders, the approval of strategies is reserved to the Board.

The Board has established a Staff Governance Committee. The Healthcare Governance Committee shall seek assurance from the Staff Governance Committee on any staff governance issues that are pertinent to the discharge of the remit of the Healthcare Governance Committee.

Membership:

The Board shall appoint all Committee members.

The Board shall ensure that the Committee’s membership includes an adequate range of skills and experience that will allow the Committee to effectively discharge its responsibilities.

Five of the members shall be non-executive members of the Board, one of whom shall be appointed as chair of the Committee. If the Committee chair is not available for a meeting, another non-executive shall become the chair.

The Board shall appoint further Committee members as it sees fit, and this can include individuals who are not members of the Board. The Board will invite nominations for Committee membership from key stakeholders such as the Lothian Partnership Forum, the Area Clinical Forum and representatives of patients and the public. These members
will not be counted when determining whether the Committee is in quorum (see below). However in all other respects they will have the same rights as the non-executive Committee members with regard to their role as a Committee member.

The Chairman of Lothian NHS Board cannot be a member of the Committee. All Board members, however, may 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:

- Medical Director
- Nurse Director
- Director of Public Health & Public Health Policy
- Chairs/Co Chairs of the Acute Services Clinical Management Group (Associate Medical and Nurse Director Acute Services)
- Representatives from each CHP/CH(C)P Senior Management Team (General Manager/Clinical Director/Chief Nurse).
- Clinical Governance & Risk Manager
- Head of Equality & Diversity

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.

Committee members are entitled to discuss matters directly with the Chair of the 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 Committee

**Frequency of Meetings:**

The Committee will meet at least every two months.

**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 through the process of submitting Committee minutes.
Functions:

The Committee will deliver its remit through:

- Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.
- Enabling co-ordination and whole system learning activities across NHS Lothian, especially the sharing of good practice.
- Delegating authority to groups or sub-committees to undertake the detailed consideration and resolution of specific matters on behalf of the Committee.
- Ensuring there is an annual workplan for the discharge of its remit, and that there is an annual report on its activities.
- Ensuring that any required action is undertaken swiftly in order to provide reassurance to the Board and the public.
- Informing the development of Board strategies

The Committee shall seek assurance on the following:

- The quality of care of services as set out in the NHS Lothian Strategic Clinical Framework (2012-20) is regularly monitored, reported and reviewed, including issues of quality and safety including Unscheduled Care and Waiting Times
- Continuous improvement of clinical care drives decision-making about the provision, organisation and management of services
- Medicines Management, including the management of Controlled Drugs
- There is a systematic and documented approach for the production, implementation and evaluation of clinical policies
- Clinical care delivered across NHS Lothian meets NHS, HIS and other relevant standards and that unacceptable clinical practice will be detected and addressed
- Effective quality assurance and quality improvement systems are in place covering all aspects of service delivery
- An open and transparent culture exists with respect to the reporting, investigation and corrective action taken following critical incidents, reviews, fatal accident inquiries, ombudsman reports or other internal or external reports
- Complaints and patient feedback are handled in accordance with national standards/guidance, and lessons learned from their investigation and resolution, including reports from the Scottish Public Sector Ombudsman and Mental Welfare Commission
- NHS Lothian employees and contractors are appropriately trained to develop the skills and competencies required to deliver the care needed; that continuing personal and professional development and lifelong learning are supported; and that there are mechanisms for developmental training and assessment where necessary. The Committee shall seek assurance from the Staff Governance Committee on this aspect
- High-quality research and development, teaching and training are supported in partnership with other public or private sector bodies, and meet relevant guidance/governance standards, and complies with Research Framework for Health & Community Care
- Information governance across NHS Lothian meets NHS HIS and other relevant standards, and that unacceptable practice will be detected and addressed,
including Codes of Practice on openness and related strategy processes all applied and monitored

- Ensure implementation of relevant directives and other instructions from Scottish Government with respect to mutuality and equality governance including human rights legislation, including health inequalities in the population
- The protection of vulnerable adults (adults, children, offenders) complies with legislative and national standards
- The HCG Committee’s remit is addressed in a systematic and documented manner through clear policies and procedures, and adequate and effective systems of internal control.

The discharge of the above functions must have due regard to the law that the Board must observe. A list of the law (although not exhaustive) that is pertinent to the Healthcare Governance Committee is set out below.

- Adults with Incapacity (Scotland) Act 2000
- Public Records Scotland (Act) 2011
- Freedom of Information Act (Scotland) 2002
- Human Tissues (Scotland) Act 2006
- Scottish Commission for Human Rights Act 2006
- Misuse of Drugs Act 1971
- Medicines Act 1968
- Protection of Vulnerable Groups (Scotland) Act 2007
- The Abortion (Scotland) Regulations 1991
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Medical Act 1983
- Extensive legislation relating to Information Governance
- CELs, HDLs, MELs, CMO Letters, CNO Letters

**Reporting Arrangements:**

The Committee will report to the Board by means of submission of minutes to the next available Board meeting.

The Chair of the Committee will present an annual report on the discharge of these terms of reference to the Audit & Risk Committee, to inform the Board’s annual review of the effectiveness of its systems of risk management and internal control. This will be a source of assurance for the NHS Lothian Governance Statement (for the annual accounts).

The Committee shall prepare and present an annual report on its activities to the Board.

The Board may require the Committee to review its own effectiveness, as part of a wider review of the Board effectiveness.
1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the dates for Board and Committee meetings in 2014.

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

2 Recommendations

2.1 Agree the dates for Board and Committee meetings in 2014.

3 Discussion of Key Issues

3.1 The attached list of proposed Board and Committee dates includes deadlines for the submission of papers for consideration at the relevant meetings. Relevant Committee Chairs have been consulted on the proposed Committee dates.

3.2 In order to allow for the most up-to-date information to be included in reports to be included in the distribution of agenda papers to members it is proposed to meet on the first Wednesday of the month rather than the fourth Wednesday. The January meeting is proposed for 15 January to keep away from the public holidays and the June meeting will still require to be held on the fourth Wednesday in order to fulfil the Board’s statutory responsibility to consider the Annual Accounts.

4 Key Risks

4.1 If meetings of the Board’s Committees are not held in 2014 then the Board will fail to discharge some of its statutory responsibilities.

5 Risk Register

5.1 There are no implications for NHS Lothian’s Risk Register in this report and its recommendations.

6 Impact on Inequality, Including Health Inequalities

6.1 This is an administrative matter and the paper has no direct impact on inequalities
7 Resource Implications

7.1 There are no resource implications arising from the recommendations in the report.

Peter Reith
Secretariat Manager
15 July 2013
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: List of Dates and Deadlines for Board and Committee meetings in 2014
The proposed dates of Board and Committee Meetings for 2014 are shown below together with the deadlines for submission of papers in electronic format for formal business meetings.

**LOTHIAN NHS BOARD**

Board Meetings are normally held on the **first Wednesday of the month at 9:30 a.m.**

<table>
<thead>
<tr>
<th>Date of Board Meeting/Development Day</th>
<th>Deadline for Papers - close of business on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 January 2014</td>
<td>3 January 2014</td>
</tr>
<tr>
<td>5 February 2014</td>
<td>22 January 2014</td>
</tr>
<tr>
<td>5 March 2014</td>
<td>19 February 2014</td>
</tr>
<tr>
<td>2 April 2014</td>
<td>19 March 2014</td>
</tr>
<tr>
<td>7 May 2014</td>
<td>23 April 2014</td>
</tr>
<tr>
<td>25 June 2014*</td>
<td>11 June 2014</td>
</tr>
<tr>
<td>16 July 2013</td>
<td>2 July 2013</td>
</tr>
<tr>
<td>6 August 2014</td>
<td>23 July 2014</td>
</tr>
<tr>
<td>3 September 2014</td>
<td>20 August 2014</td>
</tr>
<tr>
<td>1 October 2014</td>
<td>17 September 2014</td>
</tr>
<tr>
<td>5 November 2014</td>
<td>22 October 2014</td>
</tr>
<tr>
<td>3 December 2014</td>
<td>19 November 2014</td>
</tr>
</tbody>
</table>

*Meeting to consider Annual Accounts*

**FINANCE & RESOURCES COMMITTEE**

Meets **six** times a year normally on the **second Wednesday of alternate months, at 9:00 a.m.**

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Deadline for Papers - close of business on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 January 2014</td>
<td>13 January 2014</td>
</tr>
<tr>
<td>12 March 2014</td>
<td>3 March 2014</td>
</tr>
<tr>
<td>14 May 2014</td>
<td>2 May 2014</td>
</tr>
<tr>
<td>9 July 2014</td>
<td>30 August 2014</td>
</tr>
<tr>
<td>27 August 2014</td>
<td>18 August 2014</td>
</tr>
<tr>
<td>12 November 2014</td>
<td>3 November 2014</td>
</tr>
</tbody>
</table>

**STAFF GOVERNANCE COMMITTEE**

Meets **four** times a year normally on the **fourth Wednesday of the month at 9:30 a.m.**

<table>
<thead>
<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - close of business on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 January 2014</td>
<td>20 January 2014</td>
</tr>
<tr>
<td>30 April 2014</td>
<td>17 April 2014</td>
</tr>
<tr>
<td>30 July 2014</td>
<td>21 July 2014</td>
</tr>
<tr>
<td>29 October 2014</td>
<td>20 October 2014</td>
</tr>
</tbody>
</table>
HEALTHCARE GOVERNANCE COMMITTEE

Meets six times a year normally on the fourth Tuesday of every second month at 9:00 a.m.

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Deadline for Papers - close of business on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 January 2014</td>
<td>6 January 2014</td>
</tr>
<tr>
<td>25 March 2014</td>
<td>11 March 2014</td>
</tr>
<tr>
<td>27 May 2014</td>
<td>13 May 2014</td>
</tr>
<tr>
<td>22 July 2014</td>
<td>8 July 2014</td>
</tr>
<tr>
<td>23 September 2014</td>
<td>9 September 2014</td>
</tr>
<tr>
<td>25 November 2014</td>
<td>11 November 2014</td>
</tr>
</tbody>
</table>

AUDIT & RISK COMMITTEE

Meets five times a year normally on a Monday at 9:00 a.m.

<table>
<thead>
<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - close of business on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 February 2014</td>
<td>29 January 2014</td>
</tr>
<tr>
<td>7 April 2014</td>
<td>26 March 2014</td>
</tr>
<tr>
<td>23 June 2014*</td>
<td>11 June 2014</td>
</tr>
<tr>
<td>29 September 2014</td>
<td>17 September 2014</td>
</tr>
<tr>
<td>8 December 2014</td>
<td>26 November 2014</td>
</tr>
</tbody>
</table>

* Annual Accounts Meeting.

REMUNERATION COMMITTEE

Normally meets five times a year on a Tuesday at 10:00 a.m.

<table>
<thead>
<tr>
<th>Date of Meetings</th>
<th>Deadline for Papers - close of business on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 February 2014</td>
<td>7 February 2014</td>
</tr>
<tr>
<td>15 April 2014</td>
<td>4 April 2014</td>
</tr>
<tr>
<td>15 July 2014</td>
<td>4 July 2014</td>
</tr>
<tr>
<td>14 October 2014</td>
<td>3 October 2014</td>
</tr>
<tr>
<td>16 December 2014</td>
<td>5 December 2014</td>
</tr>
</tbody>
</table>
Summary from Audit & Risk Committee meeting of 24 June 2013

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

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

**Key Items:**
- One “Requires Improvement” Audit report was reviewed, relating to “Medical Equipment”. Whilst further Audit Reports were received for “Prescribing Practices & Costs” and also “Infection Control” – both of which were rated “Satisfactory”, the Committee drew linkages between these 3 reports and this is noted below, and has been shared with the CEO.
- The Report & Accounts and associated Governance statements were reviewed, and the Board is recommended to approve them, subject to the Committee highlighting one issue relating to certain items highlighted in Individual Committee reports – again this is detailed below. In respect of the time spent reviewing the Accounts, the Committee concluded that in future this should be the first order of business on the appropriate agenda, but recognised that considerable time had been spent, and enquiries raised and answered, in advance of the meeting, to ensure a thorough review and assessment did occur.
- The outcomes of the Risk Workshop were reviewed, and the Committee is keen to see the conclusion of this work which should enable tolerances to be determined for each Risk, and subsequently a more focussed Board Risk Report highlighting to the Board those risks outside of their approved appetite.
- The Corporate Risk Log was reviewed, together with additional information relating to the Top (High / Very High) Risks contained in subsidiary departmental logs, which may not currently be included in the Corporate Risk Log. The Committee have determined that this additional information will be provided at future Committee meetings, to improve visibility of organisation wide High / Very High risks.

**Linkages / Internal Audit Reports**
One “Requires Improvement” Audit report was reviewed, relating to “Medical Equipment. Whilst Audit Reports were also received for “Prescribing Practices & Costs” and also “Infection Control” – both of which were rated “Satisfactory”, the Committee drew linkages between these 3 reports relating to:
- Some items of Medical equipment not having recorded an expiry /service date. Whilst committee received assurance that medical staff check all equipment before actual use, the overall controls in place regarding equipment location and service / maintenance records required improvement
- Some queries relating to the robustness of records and practices relating to ensuring all prescribers of medicines have adequate records to confirm their authority to prescribe – potentially PGDs, school nurses, prescriptions provided to patients on waiting lists. Committee received assurance that all
prescribing staff had received appropriate training and had the required approvals, albeit the records confirming this were not always complete.

- Hand hygiene levels – whilst on average around 95% for Lothian, 57 locations failed to achieve 95%, some were well below 95%, and some audits were not conducted.

In Closed Session the Committee discussed that in isolation each report had appropriate actions identified by management to address the concerns identified, and these were presented to Committee’s satisfaction. However, a “view across the audits” left Committee questioning whether there were any underlying themes, and this question has been raised with the CEO for consideration.

Committee Assurance Statements
In the process of reviewing and recommending to the Board the Report & Accounts, and Board Governance statement, Committee receives and reviews individual assurance statements from all the Board committees. In reviewing the individual Committee Assurance reports, it was noted that some Committees highlighted specific risks or aspects of their work which they would highlight in their annual report, but it was unclear if these highlighted items had then been carried across into the Public Annual Report & Accounts. The question arose as to whether such items should appear in the Public documents, and/or to what extent editing and summarising was appropriate. The Committee was unable to cross reference every individual committee report to be assured that any appropriate issues had surfaced in the Public documentation in an appropriate manner, and moving forward has requested that in future years where any such issues are highlighted in Individual Committee reports, these are summarised in a report which states whether or not such comments have been included in the public documents, in what manner, and the rationale for the decision made.

Risks outside Board approved “Risk Appetite”
The policy/mechanics are still being developed following the Board Risk Workshop, and once this work has been completed it will then enable Committee to escalate and report to the Board those risks identified as falling outside the Board approved appetite/tolerance.

Jeremy Brettell
Committee Chairman
24 June 2013
Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 24 June 2013 in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr J Brettell (in the Chair); Mr M Ash; Ms K Blair (until 12 noon); Ms M Bryce; Councillor D Grant (until 11.30); Councillor R Henderson (10.30 to 12 noon) and Councillor C Johnstone.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Mr A Boyter (Director of Human Resources and Organisational Development); Mr T Davison (Chief Executive); Mrs S Goldsmith (Director of Finance); Mr B Houston (Chairman); Mr P Lodge (Audit Scotland); Ms S Mair (Director of Operations) (for item 4.3); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D McConnell (Audit Scotland); Mr A Payne (Corporate Governance Manager); Mr A Perston (Audit Scotland); Mr D Proudfoot (Deputy Chief Internal Auditor); Mr D Woods (Chief Internal Auditor); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr Peacock.

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

12 Minutes of the Previous Meeting

12.1 Minutes of the previous meeting held on 2 April 2013 – previously circulated minutes were approved as a correct record.

13 Internal Audit, Medical Equipment – April 2013

13.1 Mr Proudfoot gave a detailed overview of the report highlighting the issues found during the audit and the associated Management Actions outlined within the report. In particular, Mr Proudfoot highlighted that equipment databases are not up to date with details of equipment, when purchased, exact location, and servicing schedules. The whole process involved circa 30,000 items of equipment. There was also no policy for management of the equipment.

13.2 The Committee expressed concern that the Board could be carrying a risk to patient safety. There did not appear to be a clear policy that would define the risk appetite for continuing to use equipment beyond its planned maintenance date or period of warranty, and/or with the information relating to these key details not being available. Ms Mair (Director of Clinical Services) assured the Committee that there is a low level of equipment incidents on DATIX and that each piece of equipment is rigorously checked by clinical staff before it is used.
She advised that the presence of a manufacturer’s warranty would not in itself guarantee that the equipment would be functional. Furthermore a pilot to develop a medical device library within the Medical Physics Department at the Western General Hospital would commence in the near future.

13.3 The Committee acknowledged the information provided by Ms Mair. However it concluded that it was not assured that there were adequate controls to manage the risk to patients, and there seemed to be an over-reliance on clinical staff to check equipment before use. The Chair agreed to escalate the matter to the Chair of the Healthcare Governance Committee and the Chair of the Staff Governance Committee. The Committee agreed that it should receive an update report on this subject at its September meeting. JMB/ MB/ DF

Ms Mair left the meeting.

14 Matters Arising

14.1 Matters Arising from the Meeting of 2 April 2013 – the Committee received the paper detailing the matters arising from the Audit & Risk Committee meeting held on 2 April 2013, together with the action taken and the outcomes.

14.2 The Chair requested that Mr Payne amend the action to review the volume and quality of Board and Committee papers, to state that the escalation of the action was complete, but the underlying work of the review was outstanding. It was agreed that a progress report should be received at the end of the year. AP

14.3 Mr Payne agreed to amend the date of the Acute Hospital Services action to September given that it remained in progress. AP

14.4 Mr Boyter updated the Committee on the progress of the implementation of the new Human Resource System and the background in relation to its delays incurred. He went on to assure the Committee that the implementation of the new Human Resources system would not affect business continuity arrangements. The Committee asked for an update on payroll reconciliation in 2014/15. SG

14.5 Mrs Goldsmith provided a brief verbal update highlighting progress on the waiting times agenda with regard to training, statistics and waiting lists. She noted that of the 89 staff that had previously not been booked for training, all staff had now been booked for training. The posters, the development of the learn pro module and training programme were ongoing. Member noted Mrs Goldsmith’s update and agreed to await the full report in September 2013. SG

14.6 The Committee agreed to accept the Running Action Note.
15 Risk Management

15.1 NHS Lothian Corporate Risk Register

15.1.1 Ms Bennett presented the report and highlighted the key changes to the risk register.

15.1.2 Ms Bryce advised the Committee that following her recent attendance at the Risk Management Steering Group, she observed a dynamic approach to risk management across NHS Lothian, and was assured by the processes in place.

15.1.3 The Committee noted that the risk score for achieving financial targets on a sustainable basis had been lowered slightly, as a consequence of the Board achieving its 2012/13 targets. Mrs Goldsmith advised the Committee that following the Quarter 1 review this risk will be reviewed again and probably increased.

15.1.4 The Committee was advised that issues with data quality in association with waiting times were being taken forward by Professor McMahon and the Data Quality Group.

15.1.5 The Committee were concerned that the Health and Safety risk had increased to 15 from a previous score of 9. Mr Boyter advised that this increased score took into consideration the increased risk of prosecution and the serious nature of the incidents that were currently being investigated by the Health and Safety Executive. The Committee was advised that the Finance & Resources Committee was monitoring this issue.

15.1.6 Ms Bennett agreed to liaise with Councillor Johnstone out with the meeting regarding the presentation of detail within the corporate risk register.

15.1.7 Ms Bennett highlighted organisational culture as an emerging risk that at present was not on the corporate risk register. Mr Davison advised that as long as the Board remained sighted on the issues relating to the management culture review it would not be necessary to record it on the corporate risk register.

15.1.8 The Committee agreed to accept the report.

15.2 High Risks Across NHS Lothian Risk Register

15.2.1 Ms Bennett spoke to the report that detailed the high risk across all the NHS Lothian Risk Registers (not just the summary Corporate Risk Register). It was noted that the report was in response to a previous request from the Committee for sight of the top 16 risks with a score higher than 9, however that request had been amended following discussion with the Committee Chair.

15.2.2 The Committee agreed this was valuable information to be sighted, and requested that Ms Bennett bring forward this report as a second table within the corporate risk register report for future meetings. The Committee confirmed that the risks for East Lothian and Midlothian should be presented separately, and
acknowledged that any relevant risks from consolidated West Lothian risk register shall be included following its completion in July 2013.

15.2.3 The Committee requested that for every entry on the Corporate Risk Register, there should be an indication as to which Board committee has responsibility for oversight of the matter.

15.2.4 The Committee agreed to accept the report.

15.3 Risk Management Annual Report 2012/13

15.3.1 Ms Bennett spoke to the report noting the key aspects; the initiation of the Risk Management Steering Group and the importance of NHS Lothian being a learning organisation and supporting the continuous programme of improvement.

15.3.2 The Chair queried whether as stated within the annual report that the Risk Management Steering Group “reported to” the Audit and Risk Committee. Ms Bennett agreed to revise this section in line with the Risk Management Steering Group Terms of Reference.

15.3.4 The Committee agreed to accept the Risk Management Annual Report as a source of assurance that informs the Governance Statement in line with Scottish Government Guidance.

15.4 Board Risk Management Workshop Update

15.4.1 Ms Bennett advised that following the risk management, Healthcare Governance and Francis workshops, a report would be brought forward detailing the outcomes and common themes identified.

Councillor Henderson entered the meeting.

16 Internal Audit & Counter Fraud Reports

16.1 Internal Audit – Progress Report June 2013

16.1.1 Mr Woods gave a brief overview of the report and highlighted that the 2012/13 audit plan was complete, and that 7 audits had been completed since the April meeting.

16.1.2 The Committee acknowledged that although the adherence to the agreed completion dates for management actions remained challenging, the performance had improved over the course of the year. The Chair requested that Mr Woods provide a brief numerical table within future progress reports to assist in the communication of the results.

16.1.3 The Committee discussed the issue of management actions not been completed on time, as despite the progress made (87 overdue down to 15), there remained a problem. The discussion highlighted that there could be a range of reasons as to why this is the case. The Committee requested that the Director of Human
Resources & Organisational Development, in conjunction with the Chief Internal Auditor, should jointly examine this issue and report to the Committee at its September meeting.

16.1.4 The Committee noted the Internal Audit Progress Report – June 2013.

16.2 Reports with “Fully Satisfactory” or “Satisfactory” ratings: Laboratories (March 2013); Primary Care Contractors – Payments and Contracts (April 2013); Prescribing Practices and Costs (April 2013); Multi-Agency Public Protection Arrangements (April 2013); Property Transactions (May 2013); Infection Control (June 2013)

16.2.1 From the Executive Summaries of the 6 reports contained within the paper, Mr Proudfoot explained that he wished to focus on 3 particular reports, highlighting the main issues that had been identified during those audits.

Mr Houston entered the meeting.

16.2.2 Laboratories – While Laboratories has a good overall control framework, the audit had found that Standing Operating Procedures are not always being reviewed or staff trained on schedule. Also, equipment within laboratories is not always being serviced or cleaned on schedule. In response to a question, Mr Proudfoot advised that the Satisfactory rating was based on the strength of the underlying framework within the laboratories, however there are some opportunities for improvement. Mr Boyter expressed concern in relation to the reported volume of procedural documents within the laboratories (30,000). He agreed to liaise with Laboratory Services to identify whether it would be possible to rationalise this.

16.2.3 Prescribing Practices and Costs – Mr Proudfoot commented that the Satisfactory rating reflects overall assurances about prescribing through doctors requiring to be registered with the GMC. However, the audit had found that Patient Group Directions (PGDs) do not quote expiry dates required by law, with many PGDs having passed their expected review dates. Also, Personal Core Formularies are not in place for non-medical prescribers, and medicines are being sent out by Waiting List staff without being prescribed or covered by PGDs. Furthermore, policies overlap regarding requests for prescribing medicines that the SMC has not yet considered, and GPs do not appear to be following the IPTR process. Despite the “Satisfactory” rating on the report, Members articulated serious concerns regarding an insufficient level of assurance regarding non-medical prescribers, weaknesses in the PGD process, and weaknesses in the system to verify prescribers before issuing a prescription. The Committee did not feel assured about the issues detailed within the report. Members agreed to escalate this matter to the Chair of the Healthcare Governance Committee. The Chair agreed to liaise with Ms Bryce on this matter out with the meeting.

16.2.4 Infection Control – Mr Proudfoot advised that a good framework has been developed to prevent and manage infections. However, Mr Proudfoot highlighted that procedures and practices to help prevent infections are not always being followed, with some areas displaying hand-hygiene results that are lower than target, and / or in some cases no audits being carried out. Also, Clinical Risk Assessments and swab-based screening tests for MRSA are not always being
done. In particular, the Committee noted the issues surrounding MRSA testing and hand hygiene identified during the audit. The Committee expressed discomfort despite the “Satisfactory rating” of the report.

16.2.5 The Committee also considered the other reports summarised in this paper. The Committee acknowledged that there were linkages (with regard to compliance) arising from the Medical Equipment, Prescribing Practices and Costs, and Infection Control audits, and subsequently in private session agreed that these linkages should be escalated to the Chief Executive.

16.3 Internal Audit - Annual Report for 2012/13 - Mr Woods presented the annual report and confirmed that Internal Audit’s work indicated that generally adequate and effective internal controls have been operating throughout the year. Mr Woods highlighted that there were no reports issued with either “fully satisfactory” or “unsatisfactory” ratings. 12 internal audit reports (67%) had received ratings of “Satisfactory”, while 6 reports (33%) had been issued with ratings of “Requires Improvement”, which is in line with the general pattern over recent years. From the audits, Internal Audit had raised 51 issues, 35 significant issues and 16 important issues.

16.3.1 Mr Woods commented that Internal Audit's work supports the conclusion that the governance framework is sufficient for the Chief Executive to discharge his responsibilities as Accountable Office. Also, Internal Audit has complied with Government Internal Audit Standards. Mr Woods summarised that Internal Audit could report positively against the requirements of the guidance. The Chair, on behalf of the Committee, noted the excellent work conducted by Mr Woods and his team, the positive assurance and review completed by External Audit, and the confidence this all provided to the Committee, and thanked Mr Woods on the Committee's behalf.

16.3.2 The Committee agreed to accept the report.

16.4 CFS – Referrals & Operations – June 2013

16.4.1 Mr Woods introduced the summary of CFS referrals and operations as at June 2013. Mr Woods also highlighted that a Chief Executive Letter of 30 May 2013 has introduced particular expectations of the Audit & Risk Committee with respect to assurances on fraud related matters. Mr Woods advised the Committee that he shall discuss this further with the Committee Chair and Director of Finance, and present a report on this matter to the September meeting.

16.4.2 Mr Woods noted good progress with the National Fraud Initiative, as outlined in the Internal Audit Progress Report and advised that he will bring a full report to a later meeting.

16.5 Fraud Referrals & Operations for Year to 31 March 2013

16.5.1 Mr Woods presented the report that informed the Committee of statistics on fraud referrals and operations raised during the year. He highlighted that the
statistics show a slight increase in fraud referrals year-on-year, with a 40% increase over the past 5 years. Mr Woods commented that the increase was probably a result of NHS Lothian’s proactive approach to raise awareness of fraud matters, rather than indicating any increase in the instances of fraud.

16.5.2 The Committee agreed to accept the report.

16.6 NHS Lothian: Patient Exemption Checking and Potential Fraud 2012

16.6.1 Mrs Goldsmith introduced the previously circulated information on the analysis of fraudulent and erroneous claims for exemption from patient charges. She highlighted that the main areas of concern presented in dentistry and ophthalmic services, though NHS Lothian remained below the national average. Members were assured that the level of claims were small and closely monitored.

16.6.2 The Committee accepted the report.

17. External Audit Reports

17.1 ICT – eHealth Services Follow-up

17.1.1 The Committee were advised that of the 21 risk areas identified only 3 remained outstanding, all other actions had been fully implemented. Overall good process had been made in addressing risks during the previous reviews. Items remaining were: The Royal Infirmary Server room and connection to the hospitals emergency power supply; reconstitution of the eHealth Informatics Board; PACS user creation and maintenance policy.

17.1.2 The Committee agreed to accept the report.

Councillor Grant left the meeting.

18. General Corporate Governance

18.1 2012/13 Healthcare Governance Committee Annual Report to Lothian NHS Board - the report to provide the Committee with the annual report of the Healthcare Governance & Risk Management Committee, so as to provide a source of assurance with respect to the Governance Statement was received.

18.1.1 Ms Bryce highlighted the extensive workload of the Healthcare Governance Committee, and the potential areas of overlap with other governance committees, particularly the Staff Governance Committee, will need to be addressed in the near future.

18.1.2 The Committee accepted the report as a source of assurance to support the Governance Statement.
18.2 Lothian NHS Board Annual Report of the Chair of the Finance & Performance Review Committee Period Ending 31 March 2013 - the report to provide the Committee with the annual report of the Finance & Performance Review Committee, so as to provide a source of assurance with respect to the Governance Statement was received.

18.2.1 Mrs Goldsmith drew attention to the risk associated with Royal Hospital for Sick Children and Department of Clinical Neurosciences, backlog maintenance, waiting times and the subsequent financial consequences. She highlighted that compliance may not be possible due to the level of capital investment required at some sites though a more focussed approach to tackle backlog maintenance would commence in the coming year. The Board would continue to be briefed on backlog maintenance.

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

18.3 2012/13 Annual Report from the Staff Governance Committee - the report to provide the Committee with the annual report of the Staff Governance Committee, so as to provide a source of assurance with respect to the Governance Statement was received.

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

18.4 2011/12 Annual Report from the Information Governance Assurance Group - the report to provide the Committee with the annual report in respect of the Information Governance Assurance Group, so as to provide a source of assurance with respect to the Governance Statement was received.

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

18.5 2012/13 Summary Assurance Report on Best Value – the report to brief the Committee on how NHS Lothian progresses the duty of Best Value was received.

18.5.1 In response to a query, Mrs Goldsmith agreed that productivity should be explored further, and that she would progress this in conjunction with the Finance and Resources Committee.

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

Ms Blair left the meeting.

18.6 Executive Assurances for Governance Statement

18.6.1 Mr Martin presented the report that summarised the content of matters arising from the completed executive assurance statements. Mr Martin advised that no
matters were raised which required to be included in the Governance Statement.

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

16.7 NSS Service Audit Reports 2012/13– the report to provide the Committee with assurance on the systems of control managed by NSS on the Board’s behalf was received.

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

16.7.2 The Chair stated that it would have been helpful for the Committee, if there was a single paper that captured all the high risk areas / issues highlighted in the committee annual reports, and demonstrated how they were considered and / or included and / or edited in the process of preparing the public Governance Statement and annual accounts, to ensure full and appropriate transparency. It was unclear at this stage to what extent this had happened this year, and it was agreed that such a paper will be presented next year as part of the Assurance process.

Councillor Henderson left the meeting

18.8 Payment Verification in Primary Care - Financial Year 2012/13– the report to provide the Committee with assurance in regard to payments made to family Health Service Practitioners, which is a source of assurance to support the 2012/13 governance statement was received.

18.8.1 The Committee discussed potential concerns in the payment systems and agreed the responsibility for the oversight is with the Finance and Resources Committee.

18.8.2 The Committee agreed to accept the report as a source of assurance to support the 2012/13 governance statement.

18.9 SFR 18.0 – Summary of Losses and Payments for the Year Ended 31 March 2013 – the report to provide the Committee with an opportunity to review the summary of losses and compensations payments incurred throughout 2013 was received.

18.9.2 The Committee agreed to accept the paper.

18.10 Complaints Management Update

18.10.1 The Chair provided a brief verbal update on complaints management, following a meeting held with himself, the Chair of the Healthcare Governance Committee, Mr Boyter and his team, highlighting that a paper will be received at the Board meeting on 26 June.
18.11 **Assurance Report on Irregularities**

18.11.1 Mr Boyter introduced the report highlighting the background to the review of the freedom of speech policy and delays incurred following the release of national guidance from the Scottish Government. He advised that the new whistleblowing policy would be implemented in August 2013 following a period of consultation with the unions in July.

18.11.2 The Committee agreed to accept the report as assurance that there are satisfactory arrangements in place for employees to raise irregularities.

18.12 **Anti-Bribery Statement**

18.12.1 Mr Payne presented the draft anti-bribery statement. He advised the Committee that the Board already has detailed guidance on good business conduct for employees, and that this statement is one piece of a larger action plan to address the risk of bribery. The Statement is required as a method of expressing top-level commitment.

18.12.2 The Committee agreed that the statement should be referred to the Board for approval, suggesting that the focus on the word “bribery” might be reconsidered to be more embracing and assist staff in understanding the scope of the policy.

19. **Annual Accounts**

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

19.1.1 The Committee had received prior sight of these documents, and had had the opportunity to raise queries and questions prior to the meeting, all of which had been reflected in the updated papers, and/or answered to the Committees satisfaction. Accordingly the Committee agreed to support the Statement and recommend the Statement to the Board.

19.2 **Representation Letter** - the Committee received a draft Letter of Representation to the External Auditors.

19.2.1 Following discussion, it was agreed that the statement properly represented confirmation to the External Auditors on matters arising during the course of their audit of the accounts for the year ended 31 March 2013, and to recommend to the Board that the letter be adopted.

19.3 **External Audit - Lothian NHS Board – Draft Report to those charged with Governance on the 2012/13 Audit** - a draft report to those charged with governance on the 2012/13 Audit was received.
19.3.1 Members attention was drawn to the key areas and specific matters that arose from the audit of the financial statement as required by the Internal National Standard on Auditing 2060 (ISA 260). The external auditors propose to provide an unqualified opinion on the accounts, and noted that there were no concerns to highlight or draw to Committees’ attention.

19.3.2 The Committee agreed to accept the report.

19.4 Annual Accounts for the Year ended 31 March 2013 - the Committee received the annual accounts for 2012/13, noting that a detailed scrutiny of had occurred in advance of the meeting.

19.4.1 The Committee had no further comments, and it was agreed that the draft annual accounts for 2012/13 should be recommended to the Board.

19.5 NHS Lothian, Audit Committee Annual Report from the Chair – Year Ending 31 March 2013 – the Committee approved the NHS Lothian, Audit & Risk Committee Annual Report from the Chair – Year Ending 31 March 2013.

19.6 Lothian NHS Board Audit Committee – 2012/13 Notification to the Health & Wellbeing and Cities Strategy Audit Committee –.

19.6.1 The Committee approved the letter subject to adding some further text on the issue of outstanding management actions.

20 What Every Director Should Know About Internal Audit

20.1 The Committee noted the report which presented a brochure recently published by the Chartered Institute of Internal Auditors and Institute of Directors. The Committee noted Internal Audit’s compliance with the recommended practices.

21 Any Other Competent Business

21.1 There were no other items of competent business.

22 Date of Next Meeting

22.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 30 September 2013 at 9:00 in Waverley Gate, Edinburgh. Committee members only are asked to attend by 8.45 for the scheduled 15 minute pre-meeting.
Summary from Finance & Resources Committee Meeting of 12 June 2013

Pentland Room, St John’s Hospital, Livingston, West Lothian.

Key issues discussed included:

- **Site Visits** - the committee held the meeting at St. John’s Hospital. This allowed the Committee to visit the proposed site of the new MRI scanner. In addition they visited the recently reprovided Burns Unit and the existing Maternity ward due to be refurbished as part of a wider business case. The committee has been very supportive of these initiatives at St. John’s Hospital.

- **Annual Report of Committee** - the draft report was reviewed and key changes were recommended before onward transmission for Board approval. In particular, the Committee noted that some business cases, particularly in relation to refurbishment, may on occasion contain elements that are not entirely aligned with SG policy e.g. single rooms. They agreed the importance of ensuring appropriate approvals are obtained from SGHD and agreed the Committee would wish to track such instances.

- **Property and Asset Investment Programme** - The Committee reviewed an update of the Property and Asset Management Programme for the current year. Significant progress has been made. It was noted that NHS Lothian was identified as the lead Board in Scotland with its Property and Asset Investment Programme. Boards were scored on clarity of strategy and planned outcomes.

- The Committee reviewed and noted the progress of ongoing capital projects to date and the overall programme of planned activity for the coming year.

- **RHSC/DCN Reprovision** - the Committee was updated on the position in respect of the three bidders for this project and agreed that progress continued to be in line with expectations. All tendering was carried out under European Union Rules.

- **Additional Beds in the Royal Infirmary of Edinburgh** - the Committee agreed to approve the Standard Business Case for additional bed capacity in the RIE. They noted the emerging issues with Consort regarding the Renal work and instructed the Director of Finance to continue dialogue with Consort and their lenders with the objective of achieving betterment for future Supplemental Agreements.

Key issues on the horizon are:

- **Redevelopment of the Royal Edinburgh Hospital Project**
- **Ongoing oversight of RHSC/DCN project**
- **Capacity Plans for Scheduled Care**

George Walker, Chair
Susan Goldsmith, Executive Lead
Minutes of the Meeting of the Finance & Resources Committee held at 10:00 a.m. on Wednesday 12 June 2013 in The Pentland Room, Education Centre, St John’s Hospital, Livingston, West Lothian.

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

In Attendance: Mr I Graham; Professor A K McCallum; Professor A McMahon; Mrs C Potter; Mr P Reith and Mr S Wilson.

Apologies for absence were received from Mrs K Blair, Professor J Iredale and Mr J Brettell.

The Chair thanked the Chief Nurse, Agnes Ritchie and Clinical Midwifery Manager, Frances McGuire, for conducting members on an informative visit to the proposed location of the new MRI Scanner, the Labour Ward and the newly refurbished Burns Unit prior to the meeting.

Declaration of Financial and Non-Financial Interest

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

11. Minutes of the Previous Meeting

11.1 The previously circulated minutes of the Finance & Resources Committee meeting held on 17 April 2013 were approved.

12. Action Note

12.1 The previously circulated running action note of the Finance & Resources Committee was noted. The Chair commented that action notes should include due dates and a reference to the investment plan.

12.2 Terms of Reference and Statement of Assurance Needs – Mrs Goldsmith advised the Committee that work on the Terms of Reference was still ongoing and a paper would be brought to the 4 September meeting of the Committee at which Mr Payne would be in attendance to assist the Committee in its deliberations.
12.3 Partnership Commissioning of Step-down Beds Capacity and Associated Issues – Mr Davison commented that the report should be brought to the Committee on 4 September picking up the issues around movement of patients.

13. Annual Report of the Chair of the Finance & Resources Committee

13.1 Mrs Goldsmith introduced the previously circulated Annual Report of Chair of the Finance & Resources Committee reminding members that the Chief Executive, as the Board’s accountable officer, was required to produce a Governance Statement and include this in the Board’s Annual Report and Accounts. This Governance Statement should be accurate, complete and fairly report the known facts. The Board’s Audit & Risk Committee was responsible for receiving and evaluating assurances from various sources, to inform its review of the content of the Governance Statement and one such source was an annual report from the various Board Committees. The annual report covered whether the Committee had fulfilled its remit and was operating effectively and gave the Committee assurance as to whether or not the Board had adequate and effective systems of governance and internal control for the subject covered by its terms of reference.

13.2 Mrs Goldsmith highlighted two issues which had been the subject of considerable discussion at Committee meetings in 2012/13, namely the Royal Hospital for Sick Children / Department of Clinical Neurosciences Project and the interface with the existing Private Finance Initiative.

13.3 Professor McCallum raised the issue of the Board’s ability to address all legislative and regulatory requirements through the Capital/Asset Management programme. It was acknowledged this was a risk that the Committee should highlight in the report.

13.4 Mr Davison suggested that the details around some issues could be expanded, for example whilst in the short to medium term the ideal solution of all single rooms could not be provided, a pragmatic approach of improving facilities was still better than doing nothing.

13.5 The Chair commented that the ongoing cost of capacity building and the interim solution in respect of waiting times should be included under risks and this was agreed.

13.6 The Chair advised that an updated version of the Annual Report would be e-mailed out to Committee Members and comments should be sent to the Secretariat Manager.

14. Operation Triangle

14.1 The Committee received a confidential report summarising the issues relating to the recovery of an overpayment made to a GP Practice.

14.2 The Committee agreed that, subject to further advice from the Central Legal Office that it was possible to pursue an individual rather than the partnership. In
addition, it was agreed that Mr Small, General Manager of East and Midlothian Community Health Partnership, provide a briefing paper to the Committee on this matter. 

SG/DAS

15. **Financial Position**

15.1 Mrs Goldsmith advised the Committee that NHS Lothian had just moved to a new national finance system. The figures for the second month of the financial year showed an overspend of £755,000 arising from £1.4m of LRP not being delivered against £600,000 of underspend. This level of overspend could be covered at present and work was being undertaken on the Local Reinvestment Plan to identify high risk schemes. An overspend on drugs of £600,000 was being investigated and was one of two issues currently under review. A full paper on the financial position would be submitted to the next Board meeting.

15.2 Mr Houston commented that he understood from the Board Chairs meeting that NHS Lothian had the lowest cost of drugs of all NHS Boards but also had the highest rate of cost increase.

15.3 Mr Davison commented that a new Director of Pharmacy had been appointed and suggested she should be invited to speak to a future meeting of the Committee. 

15.4 The Committee noted the position.

16. **Property and Asset Investment Programme 2012/13**

16.1 The Committee received a previously circulated confidential report giving an update on the Property and Asset Management Programme for the current year.

16.2 Mrs Goldsmith advised the Committee that the capital position was not yet finalised, and that whilst each year normally ended up with some slippage on capital expenditure, the Committee would need to consider the scarce availability of capital resources when agreeing Business Cases.

16.3 The Committee noted that NHS Lothian was the lead Board in Scotland with its Property and Asset Investment Programme. Mr Graham reported that Boards were scored on how clearly they had articulated and evidenced what they were doing and the Scottish Government was concentrating on outcomes.

16.4 Mrs Goldsmith advised that the Masterplan would be brought to a future meeting of the Committee.

16.5 Mrs Goldsmith gave the Committee an update on the position in respect of the three bidders in the Royal Hospital for Sick Children / Department of Clinical Neurosciences Project and advised that any contractors would require to have efficient and effective employment practices in place. All tendering was carried out under European Union Rules.
16.6 The Chair commented that the visit to St John’s Hospital prior to the meeting had been useful and that it would be helpful if such engagements could be cascaded to frontline staff as efficiently as possible.

16.7 The Committee agreed to note the progress of ongoing projects to date and the overall programme of planned activity for the coming year.

17. **Bangour Village Hospital – Disposal Update**

17.1 The Committee received the previously circulated report providing an update on the current disposal of Bangour Village Hospital, Dechmont, by Livingston.

17.2 Mrs Goldsmith advised the Committee that the Project Team was currently working with West Lothian Council, Historic Scotland, Scottish Futures Trust as well as the Prince’s Regeneration Trust who were integral representatives to the Project Board with a view to submitting a planning application in principle for the site.

17.3 The Committee noted that the site had a number of listed buildings which were currently in a poor state of repair. Following discussion with West Lothian Council a number of buildings had now been fenced off and warning signs posted. West Lothian Council had indicated the need to progress remedial repairs to the listed buildings and information on the extent of this work had been investigated.

17.4 The Committee noted the progress of the Disposal Plans and the interest from the Prince’s Regeneration Trust and Scottish Futures Trust.

18. **Little France Campus – Property Acquisition**

18.1 The Committee noted a previously circulated report seeking homologation of a decision of the Royal Hospital for Sick Children / Department of Clinical Neurosciences Project Steering Board to pursue the acquisition of the interest in an adjacent site detailed in the report.

18.2 Mr Graham advised the Committee that the Board was the preferred bidder for the and the purchase was supported by the Scottish Government. The Committee agreed to homologate the decision of the Royal Hospital for Sick Children / Department of Clinical Neurosciences Project Steering Board to support the purchase of the adjacent site as part of an Asset Management Initiative for the ongoing benefit of the Little France Campus and to delegate the Director of Finance and the Chief Executive authority to conclude the purchase on behalf of the Board following the informal offer to acquire the site at a value specified in the report.
19. Development of the East Lothian Community Hospital Project – Update

19.1 A previously circulated report giving an update on recent developments affecting the development of the East Lothian Community Hospital Project was received.

19.2 The Committee noted the reported position and agreed to continue discussion on this item to the next meeting in order to receive a report from Mr Small. DAS

20. Redevelopment of the Royal Edinburgh Hospital Project – Update

20.1 The Committee noted a previously circulated report giving an update on both the first phase of the Redevelopment of the Royal Edinburgh Hospital and the Associated Masterplan Review.

20.2 The Committee noted the report and agreed to continue discussion of this item to the next meeting at which Mr Small would make a report. DAS

21. Creation of a New Magnetic Resonance Imaging Suite at St John’s Hospital – Update

21.1 A previously circulated report giving a brief update on the progress to create a new Magnetic Resonance Imaging Scanner Suite at St John’s Hospital and advising on the progress of the Standard Business Case through the Governance process was received.

21.2 The Chair commented that the Committee was a very enthusiastic supporter of this proposal and it was noted that the Standard Business Case would be submitted for approval to the Joint Management Team at the 1 August 2013 meeting and was expected to be submitted for approval to the Finance & Resources Committee at its meeting on 4 September 2013.

22. Pharmacy Aseptic Unit Modernisation, Western General Hospital – Initial Agreement

22.1 Dr Farquharson introduced a previously circulated report on the progress of the plan to upgrade the Aseptic Unit in the Pharmacy Department at the Western General Hospital. The Committee noted that the Initial Agreement had been submitted to the Lothian Capital Investment Group on 14 May 2013 which had approved the progress of the document.

22.2 Professor McCallum asked if the University of Edinburgh was putting in any infrastructure to support this project and Dr Farquharson undertook to raise this with the University. DF

22.3 The Committee agreed to note the previous release of £132k to allow the project to progress through design and tender ahead of eventual submission of a Standard Business Case; to note that work to plan for the temporary decant of the service during the construction works was ongoing and would be incorporated in the Standard Business Case and noted the difficult access and
ongoing discussions with local site management to agree access and site compound locations.

23. **Additional Beds in the Royal Infirmary of Edinburgh – Standard Business Case**

23.1 The Committee noted a previously circulated confidential report together with a Standard Business Case for Additional Beds at the Royal Infirmary of Edinburgh.

23.2 Mrs Goldsmith spoke to a further tabled report on the ongoing discussions with Consort for additional bed capacity in the Royal Infirmary of Edinburgh which would create two additional wards, creating one on the first floor and one on the second floor, with 16 additional beds in ward 109b and 15 additional beds in 209b.

23.3 The Committee noted concerns over the timetable to these beds becoming operational due to delays in the completion of the Supplemental Agreement with Consort and further potential operational delays.

23.4 Following discussion on the tabled report and the circulated paper, the Committee agreed to approve the Standard Business Case for Additional Bed Capacity in the Royal Infirmary of Edinburgh and to accept the proposals at this time for the additional beds and renal works and instruct the Director of Finance to continue dialogue with Consort and their lenders with the objective of achieving betterment for future Supplemental Agreements.  

24. **Future Visit**

24.1 The Chair advised that proposals would be brought forward to a future meeting with recommendations for other visits.

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

25.1 It was noted that the next meeting of the Committee would be held at 9:00 a.m. on Wednesday 4 September 2013 in Meeting Room 7, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh.
Key Issues Discussed

The EL Sub Committee was pleased to receive

- A presentation on East Lothian Health & Social Care Partnership from David Small, General Manager, East Lothian & Midlothian CHPs and Mike Ash, Chairman, East Lothian CHP and Health & Social Care Partnership.

Items for Decision

- No items for decision.

Items for Discussion

- Future Meeting Dates
  The Sub-Committee held a verbal discussion lead by MA at the meeting. This will be reviewed in a few months.

Performance Reports

A range of routine performance reports were received.

Mike Ash
Chairman of East Lothian, CHP
8 July 2013
Welcome and Apologies

Welcome and apologies were noted.

1.1 East Lothian H&SCP Presentation

Mike Ash, Chairman, East Lothian CHP & Shadow Board, NHS Lothian (MA) & David Small, General Manager, East Lothian & Midlothian CHPs, NHS Lothian gave a presentation on the current position on the legislation on Health & Social Care Integration and priorities for ELH&SCP.

2.0 Minutes of Previous Meeting 24.04.13

Agreed as an accurate record.

Update to Homeopathy Service

It was agreed by NHS Lothian Board that funding of homeopathic services would cease as of 31st March 2014.

3.0 Action Note Previous Meeting
Action log updated.

4.0 **Items for Decision**

4.1 No Reports for Decisions.

5.0 **Items for Discussion**

5.1 **Future meeting Dates**
The Sub-Committee held a verbal discussion lead by MA at the meeting.

**Decisions**

To be reviewed in a few months.

6.0 **Performance Reports**

6.1 **General Manager's Report**

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

The purpose of this report is to update and brief members on CHP Performance and developments.

**Delayed Discharges**
Total outstanding for East Lothian is currently 30. Health and Council colleagues are working closely to try and reduce this.

**Capital Projects**
Tranent Project - land transaction is still awaited.

ELCH a series of meetings is being planned, dates of these will follow. The Initial Agreement will be brought to the October meeting.

Ormiston Medical Practice structure will be started early next year.

**Decisions & Action**

The report was noted. Further discussion to be held on Orthopaedic beds availability in East Lothian.

6.3 **Finance**

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

The purpose of this report is to advise the East Lothian CHP Sub-Committee of the financial position to 31 May 2013.
The Sub-Committee is recommended to note the overall financial position as presented and note the Prescribing budget out turn.

The CHP is reporting an overspend of £72,000 for the 2 months to 31 May 2013/14.

The CHP is reporting an overspend within both Core and Hosted services for the first 2 months of the year. The Core pressures relate to Medical Staffing, Clinical Supplies and Equipment within Roodlands. A significant element of these pressures relate to Waiting Times activity and discussions are ongoing regarding the availability of funding to address this.

Whilst the CHP has identified and implemented a range of schemes to deliver its LRP target, there remains a small residual balance which is impacting adversely on the financial position. Work is ongoing to identify a suitable scheme to deliver this balance.

There is no CHP Prescribing data available for April or May. Although estimated volumes exist at Health Board level for April only, the absence of any detailed information or current year price data makes forecasting challenging.

The allocation for PMS has still to be confirmed by the Scottish Government and the CHP is reporting a break even position on the basis of the rolled forward budget.

Decisions

The report was noted.

6.4 Chief Nurse Report

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

District Nursing

East Lothian Palliative Care in Care Home Project continues to support all care homes in East Lothian. This is managed by the Macmillan Nursing Team based in Haddington.

Some teams across Lothian are trialling the use of portable laptops to access essential patient information while they are working remotely from a patient's home.

Poor mobile phone reception in areas of East Lothian has caused
communication difficulties for some of our teams. A new facility will be available to these staff from this summer to improve access to a network and therefore reduce the instances of poor reception.

Public Health Nursing
EL notification of Care Commission GIRFEC Inspection has been received and progress/planning for multi agency evidence gathering and production of Position Statements is underway. Inspectors arrive on 28 Oct 2013.

PHN/HV Team Manager post will be advertised and recruited to in July 2013. This is a joint funded post with East Lothian Council.

Recruitment is now complete for Nursery Nurses within East & Midlothian and bases for staff will be agreed in line with the PHN/HV Review outcomes.

East Lothian Hospitals
Belhaven applied to the Amos Trust for £6000 to purchase digital reminiscence therapy software. Designed to be of particular benefit to those with dementia

Belhaven hospital have up-graded their pop in café with the help of the East Lothian volunteers who secured a £1,000 Grant from enable. The young volunteers have also agreed to progress refurbishing the previous day care unit, to provide space for therapeutic activities. This has been supported by the league of friends and local businesses.

Mental Health
The Mental Welfare Commission for Scotland visited Lammerlaw Ward at Herdmanflat Hospital on 21st May 2013. A particular theme of this year’s visits is compliance of Continuing Care Units with the Dementia Standards. A report of the visit is not yet available but verbal feedback on the day was excellent, and commissioners commented on how much the ward had improved since their last visit.

Decisions

The report was noted.

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

The purpose of this report is to update the East Lothian Community Health Partnership Sub Committee on medical issues
within East Lothian

The East Lothian Community Health Partnership Sub Committee is recommended to note the contents of the report.

Practices continue to experience difficulty in meeting demand from patients. This is currently being exacerbated by a shortage of locum GP’s. The report highlighted that Practices’ being inadequately resourced to meet demand safely is a concern, particularly in larger more urban practices.

Changes in the welfare system are having a significant impact in GP practices- both in stress related illnesses presenting to clinicians, and in patients seeking additional support such as letters in support of decisions made during work capability assessments by ATOS.

Joint mental Health Planning Group it was suggested at recent meetings following discussions around suicide and parasuicide, about the possible provision of a Crisis centre in East Lothian, similar to the Orchard Centre in Bonnyrigg, Midlothian.

At the June meeting of Lothian Clinical Directors; the Clinical Director of the Lothian Unscheduled Care Service reported that service provision through the summer will be challenged by a shortage of available clinicians to fill shifts. Out of Hours organisations for Ayrshire and Arran, and Greater Glasgow and Clyde, have indicated similar problems with a risk of collapse of their service. Recent lay media publicity around Accident and Emergency Departments in England is a reflection of wider capacity/demand issues in the wider NHS, particularly for Unscheduled Care.

MA asked about the shifts not covered. A Paper is being drafted by the CD of LUCs to try and bring other services i.e. pharmacy, ambulance Service to work better and more efficiently together.

The two East Lothian Consultants in Psychiatry of Old Age are currently covering the sickness absence of a consultant colleague at Midlothian Community Hospital.

Decisions

The report was noted.

6.6 AHP report

The Sub-Committee considered a report which had been circulated in advance of the meeting.
The purpose of this report is to update the Sub Committee on clinical developments within AHP Services.

The committee is asked to note the update contained in this report and make any comments directly to the AHP manager.

RP report covered the following; AHP Seven Day working, Recruitment & Service Pressures, Arts Therapies, Governance Structure, E Health.

A recent process through organisational change saw Lynne Douglas being successful in obtaining the new Director AHP Services. RP was offered and accepted the full role of becoming the AHP manager for East & Midlothian.

MA asked if IB could please take back the positive comments regarding the positive meeting held with the Social Work OTs at MacMerry.

IB confirmed that that he would.

Decisions

The report was noted.

6.7 Primary Care Contractors Organisation

6.7.1 PCJMG Minutes 14.03.13
The Sub-Committee considered a report which had been circulated in advance of the meeting.

DAS highlighted points 128 on Phlebotomy. Taking bloods from patients in the Community has been a long standing problem.

This planned paper is hoping to agree a Lothian Wide proposal.

DAS then highlighted point 129 on GMS List Pressures. In terms of applications to reduce practice boundaries, it was agreed that CH(C)Ps should take the proposal to their GP rep locality groups and look at housing developments and population levels to inform their decision.

Decisions

The report was noted.

6.7.2 PCCO Risk Register 31.05.13
The Sub-Committee considered a report which had been circulated in advance of the meeting.
DAS Highlighted risk 2308 on Decontamination in General Dental Practices. There is now a family dental Practice in Prestonpans which is now being built.

AMcC advised that it was an issue in East Lothian in the past to register for an NHS dental practice, The committee members were not aware of this still being an issue.

DAS asked the committee to review risk 3490 on Deliver the agreed access and treatment targets.

**Decisions**

The reports were noted.

**6.8 Joint Health Improvement Partnership**

**6.8.1 Women’s Aid Services to East Lothian Women & Children**

The Sub-Committee considered a report which had been circulated in advance of the meeting. Julie Watson (JW), Woman's Support Manager joined MS to present and discuss this paper.

The purpose of this report is to update the East Lothian Community Health Partnership Sub Committee on the current service provision for women and children experiencing domestic abuse following the transfer of services from East Lothian Women's Aid to Midlothian's Women's Aid in November 2013.

The East Lothian Community Health Partnership Sub Committee is recommended to note the implications of the change in Women’s Aid service provision for East Lothian women.

The Scottish Government defines domestic abuse as 'perpetrated by partners or ex-partners [which] can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family and friends).

It would be beneficial if there could be a higher profile for this group to raise the profile of it within the local community. Looking for somewhere more permanent to make appointments for local Woman. Women’s Aid hope to have a space in some of the local leisure centres to run their sessions.
The current refuge centre is a purpose built block of flats.

Accommodation is staffed 24 hours a day. It comprises 5 flats which have constantly been full with a waiting list for the accommodation.

Discussions are being held with ELC for further dispersed flats.

The service is secured by spot funding and funding has now been secured up until 2015 given by Scottish Government.

Staff compliment; recruitment has now taken place and an additional 7 staff have been taken on. To be at full staffing compliment a further three staff members will need to be recruited.

MA asked Julie to thank the staff of this service for providing such a necessary service.

Decisions

The report was noted.

7.0 Carers Forum

There was no written or verbal report given by Carers.

Decisions

The verbal report was noted.

8.0 Public Partnership Forum

8.1 PPF Business Meetings Minutes 07.05.13

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

Decisions

The report was noted.

8.2 PPF Leap (Lothian & Edinburgh Abstinence Programme) Visit 13.05.13

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

GC stated that this was a very productive and impressive visit.

MA suggested that a list of all the different NHS Services and sub and voluntary services including their bases would be beneficial
for the Shadow Board members and CHP Members. **ACTION.**

**Decisions & Action**

The report & action was noted.

**8.3 EL Health Network Integration Update**
The Sub-Committee considered a report which had been circulated in advance of the meeting.

The group are now collating all the table top information provided by this meeting into a report to be able to feedback to people.

MA also attended this meeting which he found very informative and helpful.

**Decisions**

The report was noted.

**9.0 Community Health Partnership Committee Appointments**

No appointments were noted.

**10.0 AOCB**

**10.1 Nothing to report.**

<table>
<thead>
<tr>
<th>11</th>
<th><strong>Date of next meeting</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It was agreed that the next meeting would take place on 5th September 2013 at 2.00 pm in the Adam Room, John Muir House, ELC, Haddington</td>
</tr>
</tbody>
</table>
Shadow Health and Social Care Partnership 14 June 2013 – Summary

Matters Arising
- Since the Partnership Agreement will not be legally binding until legislation comes in, existing shadow arrangements will need to continue to allow planning and progression of the integration agenda. On a practical level, this will mean that decisions will still need to be referred to parent bodies to avoid any ultra vires issues.
- ICT issues have been progressed with a remit agreed for a sub-group and the key priority being the interagency portal. Other systems noted for progression (HR, management information), and membership/consultation role of group to be expanded to include further representation.
- Work is progressing on representation of service users and carers, with the intention of adding 2 more members to the partnership, following recruitment.
- An update on delayed discharge highlighted the need for performance reporting to the partnership on outcomes, as well as some of the particularly complex issues causing some targets to be missed.

Integration Programme Status Report
- The May status of the programme overall was “amber”, due to existing delays in progressing the partnership agreement and ICT, as well as budget and scope issues arising.
- Governance processes were discussed in light of legal and scope issues, specifically around the standing of the partnership when making decisions which may be ultra vires.

Draft Bill
- An executive summary paper on the recently announced draft Bill was discussed. Further regulations are anticipated and there is still the opportunity to influence the progression of the Bill through normal parliamentary consultation procedures.
- Work already undertaken will be used to produce the integration and strategic plans.

Partnership Values
- A paper was presented which summarised work undertaken separately on both organisations’ values.
- This work will be further developed (via the organisational development workstream) into shared values and reported to the SHSCP later.
Mental Health Services & Re-provision of the Royal Edinburgh

- A presentation on the history and development of mental health services was given, demonstrating the progressive shift for some years to community based care.
- This was followed by a presentation on the development of plans for more modern and integrated mental health services to be provided via the new facilities being built on the Royal Edinburgh site. This major challenge for joint working will be the need to accelerate the move the balance of care away from in-patient treatment to community settings as there will ultimately be less acute beds available on the new site.

Strategic Framework & Work Plans

- A report on the 2013/14 framework and work plans was presented and approved.
- Further development is planned to integrate the 3 (currently separate) documents in line with the requirements laid down in the Bill for next year (2014/15).
Minute of Meeting

Shadow Health and Social Care Partnership
NHS Lothian Headquarters, Edinburgh, 14 June 2013

Present:-
Councillor Ricky Henderson (Chair)
Dr Carl Bickler
Councillor Elaine Aitken
Councillor Cammy Day
Councillor Sandy Howat
Councillor Norman Work
Wanda Fairgrieve
Kay Blair
Dr Ian McKay
Ella Simpson
Robert Wilson
Richard Williams
Peter Gabbitas
Kirsten Hey
Tim Montgomery


Apologies:- Shulah Allen, Monica Boyle, Linda Cowie and Michelle Miller.

1 Welcome
The Chair welcomed Councillor Howat and Dr Carl Bickler to their first meeting of the Partnership. He also noted that Councillor Shields had replaced Councillor Edie as a Partnership member.

2 Minutes
Decision
To approve the minute of the Shadow Health and Social Care Partnership of 19 April 2013 as a correct record.

3 Matters Arising

3.1 Partnership Agreement

Peter Gabbitas updated members on discussions about the Partnership Agreement. The Council’s Head of Legal, Risk and Compliance had confirmed that current legislation prohibited Council Committees taking decisions unless the Council had a two thirds majority of voting members. Whilst the new Public Bodies (Joint Working) (Scotland) Bill (item 5 refers) would sweep away this requirement it did mean that there could be no legally binding agreement until the new legislation took hold. Despite this, the Partnership could continue to plan, review and develop integration models ahead of assuming full legal responsibility for services and budgets, including the ongoing budgetary alignment activity.

Decision

To note the position and request Peter Gabbitas to report further on the implications for NHS Lothian Partnership representatives of the current legal framework.

3.2 ICT Integration

Peter Gabbitas reported on a positive meeting with the CEC/NHS Lothian ICT Leads. Agreement had been reached on the roll-out of the “Harris Portal” (aka CareFX portal), allowing the sharing and transfer of data between the main systems used by both organisations. A Joint Working Group had been established to progress this work.

In response to questions from members, he confirmed:–

- that the initial focus would be on integrating the key priority systems; thereafter consideration would be given to adding other systems, as appropriate.
- the Professional Advisory Committee would be consulted on security/confidentiality issues.
- co-ordination with non-statutory providers would also be explored.

Decision

1) To invite the ICT Leads to the next meeting of the Partnership. Members should forward any specific issues/questions to Peter Gabbitas in advance.
2) To agree a Partnership/staff side Representative be on the Joint Working Group.

3.3 Service User and Carer Engagement

Ella Simpson reported on discussions about Service User Representation on the Partnership. It was proposed that two representatives were required, one representing carers, the other service users. A Roles and Responsibilities protocol was being developed, and discussions about how best to support the individuals were taking place. It was intended to advertise for representatives, and that some level of stipend be payable.

Decision

To note the progress on identifying Service User and Carer Representatives, and agree the proposed recruitment arrangements.

3.4 Delayed Discharge

Peter Gabbitas tabled a briefing note on Delayed Discharge. He summarised the key elements, noting that this would form part of a range of performance reports he intended bringing to the Partnership in future.

In discussion, the following issues were highlighted:-

- the scope for the Partnership to identify which service areas it wished to receive performance information on;
- engaging with the third and privates sectors on performance;
- the impact on Primary Care;
- the issue of care home placements coming direct from their own residence (rather than from hospital).

Decision

1) To note the Delayed Discharge briefing note.

2) To request further information on the proposed performance reporting framework.

(Reference – briefing note by the Director of Health and Social Care, submitted.)
4 Integration Programme Status Report

A status report on the Integration Programme was submitted. Susanne Harrison summarised the key elements, including risks, milestones and benefits.

Peter Gabbitas confirmed that the Leadership Group in the Council, and the equivalent NHS Lothian Executive Group, would be assessing the services which might eventually fall within the remit of the Partnership. Although the Partnership would have a key role in these discussions, current legal requirements meant any legally binding decisions would require to be made by the NHS Board/Council.

Decision

To note the status report.

(Reference – report by the Director of Health and Social Care, submitted.)

5 Public Bodies (Joint Working) (Scotland) Bill – Executive Summary

The Public Bodies (Joint Working) (Scotland) Bill had been introduced to the Scottish Parliament on 28 May 2013. It provided a framework to support the improvement of the quality and consistency of Health and Social Care Services in Scotland. Crucially, it permitted the integration of health and social care services.

Details of the main provisions of the Bill were provided. There would be full opportunity to influence the final shape of the legislation through the normal parliamentary process.

Decision

1) To note the introduction of the Public Bodies (Joint Working) (Scotland) Bill to the Scottish Parliament on 28 May 2013.

2) To note the main provisions, issues and risks associated with the Bill.

3) To note that further regulations and statutory guidance would need to accompany the provisions of the Bill in future.

4) To note the current position in Edinburgh with respect to the provision.

(Reference – report by the Director of Health and Social Care, submitted.)
6 Partnership Values Statement – Progress Update

Progress towards the development and implementation of a shared value statement for the Edinburgh Health and Social Care Partnership was reported.

In discussion, it was noted:-

- in developing a collective set of values for the Partnership, reference should be made to existing work in this area;
- the role of managers in influencing values within their organisations should not be overlooked;
- any Partnership values needed to align with SOA principles.

Decision

1) To approve the proposal to incorporate the development and implementation of the Partnership values statement within the Partnership Organisational Development Plan.

2) To note that Tim Montgomery would replace Colin Briggs on the short-life working group.

3) To note the intention to present a Partnership Values Statement and implementation plan in November 2013.

(Reference – report by the Chief Social Work Officer, submitted.)

7 Mental Health Services and the Re-development of the Royal Edinburgh Hospital

Colin Beck gave a presentation on the development of mental health services. He outlined the legislative timeline, highlighting key milestones and their impact on present-day services and thinking. He particularly referred to current thinking about the causes of mental health, including such environmental factors as inequality, sense of belonging etc. Challenges still existed regarding mental health awareness, and on defining the levels of need, but he was optimistic the key concepts of reciprocity/recovery could encourage small changes which would in turn lead to significant differences for individuals.

Tim Montgomery then presented information on the re-development of the Royal Edinburgh Hospital. The hospital would continue to have a small, although crucial, role within the totality of mental health services. He outlined the re-development plans, which were currently being considered by the
Council's Planning Service. These sought to maximise the benefit from the existing site, using an integrated campus model. Responding to questions, he confirmed that a wide range of staff, at all levels, had been consulted on the proposals. The Bowling Club had failed to engage in the consultation process, but the current plans did allow for significant levels of amenity on the site.

Decision

To note the presentation.

8 Strategic Framework and Work Plans

Approval was sought for the Strategic Framework and Related Strategic Work Plans, which set out the direction of travel and actions to be taken to deliver agreed outcomes during 2013/14. An easy-read version, highlighting key service benefits, would now be produced for an external audience.

Decision

1) To approve the Strategic Framework as a statement of the Partnership’s vision for 2013/14, together with the related Strategic Work Plans as the basis for delivering that vision.

2) To note the intention to produce a fully integrated plan from 2014/15, subject to the requirements and timing of the public bodies (joint working) legislation.

(Reference – report by the CEC Strategic Commissioning Manager, submitted.)
Summary from Midlothian Sub Committee Meeting of 30 May 2013

Items for Discussion

- **NHS Lothian Board and Midlothian Council Papers – Joint Director of Health & Social Care**
  The Sub-Committee considered a verbal report at the meeting given by DAS/EMc.

  Discussions have now been held on health inequalities in Midlothian, followed by the first informal meeting of the shadow board.

  The first formal meeting will be held in June 2013.

  Eibhlin McHugh has been appointed as the Joint Accountable Officer for Midlothian and David Small for East Lothian.

  Transition plans will be worked on by DAS and EMc for a continued safe transition.

- **NHS Lothian Review of Homeopathy Services**
  DAS briefed the meeting on the history of the Midlothian review of the local Homeopathy services based in Dalkeith. This review had started in 2010, but was challenged on the basis of the engagement and consultation process. It was also recognised that the issues applied equally to the other NHS Lothian Homeopathy Clinics in Leith and St Johns. NHS Lothian had therefore commenced a new Lothian wide review in late 2011. Since this review was Lothian wide, leadership of this issue has moved to the Director of Strategic Planning of NHS Lothian.

  A stakeholder group was established to design and oversee the consultation process. The outcome of the consultation had been previously distributed to the sub committee. The consultation took the form of online submission through Survey Monkey, public meetings held in each CHP area, a letter to all identified service users inviting them to participate, posters in general practices and pharmacies and news releases to the media. The results collated and presented to the stakeholder group. Following this discussion the presentation of the results was changed to include more verbatim comments. Following the stakeholders meeting there was a discussion at the Strategic Planning Group which agreed the recommendations in the paper to be considered by the Healthcare Governance Committee on 6th June.

  A meeting with staff involved in the service had been held on 29th May.

  The paper recommends that the Healthcare Governance Committee agree Option 2, which is to cease to provide a homeopathy service in Lothian and cease referrals to Glasgow Homeopathic Hospital and to make this recommendation to the NHS Lothian Board meeting on 26th June.

  Since the paper covers a Lothian wide service, an individual Sub Committee cannot be expected to make the decision. However CHP sub committees have been asked to comment on the proposals. The comments of the sub committees will be fed back to the Strategic Planning Department. Sub committee members were advised that they were welcome to also make individual comments to the paper’s author.

  PJ invited questions from the sub committee.
PQ asked about the financial options e.g. is £53K free for other uses? DAS advised that there are fixed costs in the total cost of the service that would not be free. The £53k refers to the Glasgow Homeopathic Hospital costs. Of the total costs some money could be free in particular pay costs and drugs costs.

LB asked about the financial mechanisms for the Glasgow referral service. Is there an overarching cost and a service level agreement? DAS advised there is a Service Level Agreement with NHS Greater Glasgow and Clyde which includes the Homeopathic Hospital. The costs and activity are recalculated on a three year rolling basis. On this basis NHS Lothian monies would be released in three years.

PJ invited comments from the sub committee

SE reported she had received correspondence from practitioners of the service with their ongoing concerns around the way the review has been carried out. They will write to the Director of Strategic Planning and also to the Healthcare Governance Committee.

SE asked what follow up will there be for the patients when the service is withdrawn. This has been a last ditch option for most of the patients, how does the CHP recommend to the board this issue taken forward?

DAS reported that this point has already been raised. Depending on the NHS Board decision, there is an issue of meeting the needs of patients, some of whom have been using this service for some time. At individual patient level there will be an assessment and a transitional period.

SE asked that the impact of this decision on individuals and GP Practices be noted.

LB reported that she had also received a number of emails. Many of the individuals have made the point that they have tried conventional treatments for their problems which have failed. Following the homeopathic review there are patients who are concerned that they do not know how they will manage. There is a risk that this group will be marginalised if the Board see fit to remove this service locally.

SE said she felt that marginalisation raises an issue of inequalities for patients who can't afford to pay for homeopathy privately should the Board support option 2. This needs to be considered by the Board as well.

HR said that he wanted to state that the evidence on the effectiveness of Homeopathic shows that there are no grounds for continuing to fund this service.

MM said that the NHS tends to look at hierarchy of evidence and puts randomised controlled trials at the top and tends to undervalue qualitative studies looking at individual experiences.

SE reported that she wished to clarify that the stakeholders group was not set up to discuss the evidence about the effectiveness of homeopathy, but to design and manage the consultation process.

GW said that he was concerned about the current patients who have tried various conventional methods which have failed for them. The CHP should continue to look after their needs if the service is withdrawn.
PJ thanked the sub committee for their questions and comments and indicated that these would be fed into the decision making process.

- **CHP Sub Committee and the Shadow Board**
  The CHP will continue until the Shadow Board Committee emerges.

  DAS role will come to an end here on the 1st August. EMc will take over the role.

  PJ is looking to hold a meeting of the Shadow Board by the end of June now that all members have been agreed.

**Performance Reports**

A range of routine performance reports were received.

**Joint Health Improvement Partnership Highlights**
- The Sub Committee considered a report which had been circulated in advance of the meeting.

  MMac highlighted that the paper was written by John Boyce. There is a sense of urgency within Midlothian where there is a low breast feeding rate. There are resources to support women who are breastfeeding. The JHIP are looking for support from the Committee.

  Front line staff need to be released to undertake the training.

**Carers Forum**

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

Julie highlighted the welfare rights issues within the report and also that a Carers Event is being held at Loanhead Miners Club.

Looking at establishing a new base at the Hardengreen Estate in November. This would become a hub for carer activity for Midlothian.

**Public Partnership Forum**

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

The purpose of this report is to update the Midlothian Community Health Partnership Sub Committee on the activities of the PPF.

A meeting of the PPF was held last week. The PPF are carrying out the GP visits suggested from the Audit Scotland Report and physical disability strategy around access to GP Practices. These are now rolling out across the practices for visit dates.

Early discharge scheme for stroke care. A final meeting will be held in the forth coming weeks and Mark Smith will be able to provide an update circa September 2013.

Peter Johnston  
**Chairman, Midlothian CHP**  
12 June 2013
NHS LOTHIAN

MIDLOTHIAN COMMUNITY HEALTH PARTNERSHIP

Minutes of the meeting of the Midlothian Community Health Partnership Sub-Committee held on Thursday 30th May 2013 at 2pm in The Council Chambers, Midlothian House, Dalkeith.

Present:  
Peter Johnston, Chairman, East Lothian & Midlothian CHPs (MA)  
David Small, General Manager, Midlothian Community Health Partnership (DAS)  
Councillor Cath Johnstone, Midlothian Council Representative (CJ)  
Sue Edmond, PPF Representative (SE)  
Patsy Eccles, RCN Representative, NHS Lothian (PE)  
James Coghill, Public Partnership Representative (JG)  
Rob Packham, Interim AHP Manager, EL & ML CHPs (RP)  
George Wilson, Voluntary Sector Representative (GW)  
Mandy Mackinnon, Health Promotion Manager (MMac)  
Peter Quinn, PPF Representative (PQ)  
Andrew Duffy, Pharmacy Representative (AD)  
Eibhlin McHugh, Acting Director, Communities & Wellbeing (EMc)  
Julie Gardner, Carers Representative (JG)  
Dr Hamish Reid, Clinical Director Midlothian Community Health Partnership (HR)  
Thomas Miller, Lead Partnership Representative, NHS Lothian (TM)

Apologies:  
Lynne Hollis, Associate Director of Finance, NHS Lothian (LH)  
Dr Tony Moffoot, Consultant Psychiatrist Midlothian (AMo)  
Michael Pearson, Director of Operations, Royal Infirmary of Edinburgh (MPe)  
Marlene Gill, PPF Representative (MG)  
Alison MacDonald, Chief Nurse, Midlothian Community Health Partnership (AMac)  
Tom Welsh, Joint Futures Manager, Midlothian Council (TW)

In Attendance:  
Wendy Michael – Minutes (WM)  
Mike Porteous, Assistant Head of Finance on behalf of LH (MP)  
Robert Clement, Clinical Nurse Manager Mental Health, (RC) on behalf of (AXM)  
Councillor Lisa Beattie, Midlothian Council (LB)

1.0 Apologies and Welcome

Apologies were noted as above.

Declaration of Interest
None were noted at this meeting.

2.0 Minutes of the Previous Meeting held 12th April 2013

The minutes were agreed as being a true and accurate record of the meeting.
3.0 **Matters Arising / Action Plan**

No comments from the Committee regarding the Action Log.

4.0 **Items for Decision**

No items for decision

5.0 **Items for Discussion**

5.1 **Integration of Health & Social Care**

The Sub-Committee considered a verbal report at the meeting given by DAS/EMc.

Discussions have now been held on health inequalities in Midlothian, followed by the first informal meeting of the shadow board.

The first formal meeting will be held in June 2013.

Eibhlin McHugh has been appointed as the Joint Accountable Officer for Midlothian and David Small for East Lothian.

Transition plans will be worked on by DAS and EMc for a continued safe transition.

TM said he was glad to hear that East and Mid are going to continue to work together.

HR noted that both East and Midlothian are fortunate in the appointment of both the new officers.

GW congratulated the officers on their appointment. GW highlighted emergency admissions for those aged 75 and how there is an enormous amount of work that needs to be done on co-production.

**Decisions**

The Committee welcomed the update and congratulated both DAS and EMc on their appointments.

6.0 **Performance Reports**

6.1 **General Manager’s Report**

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

The report covered Delayed Discharges, Homeopathy Review and Hosted Services

**Decisions**
The report was noted by the Committee.

6.2 Staff Governance Report

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

There is continued good performance with a turnover in the month at 0.68% and sickness absence at 4.56%.

Decisions

The report was noted.

6.3 Finance Report

The Sub Committee considered a report which had been circulated in advance of the meeting. Mike Porteous (MP) attended the meeting on behalf of Lynne Hollis (LH).

The purpose of the report is to advise Midlothian Sub-Committee of the financial position to 31st March 2013.

The committee were asked to note the overall financial position as presented and the Prescribing budget out turn.

Decisions

The report was noted.

6.3.1 Financial Plan Midlothian

The Sub Committee considered a report which had been circulated in advance of the meeting. Mike Porteous (MP) attended the meeting on behalf of Lynne Hollis (LH).

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

The financial plan has been approved the NHS Lothian Board.

Development of the Financial Plan is largely an iterative process. It takes cognisance of: planning assumptions in relation to pay, prices and drugs uplifts; known or anticipated cost increases which are deemed “unavoidable”; planned investments which have already been approved through the Board’s governance processes; and any recurring impact of issues emerging in the current financial year, including delivery of savings targets. In addition, it reflects guidance issued by the Scottish Government Health & Social Care Directorates to the NHS Board Directors of Finance.
Section 4 of the document outlines the elements of the 2013/14 Financial Plan that specifically relate to Mid Lothian CHP.

Included in the baseline is the budget for Primary Medical Services (PMS) – the GMS Contract. This budget will be finalised once the allocation for 2013/14 has been issued by the Scottish Government. A detailed financial plan on PMS will be provided at a later date.

The above total reflects the transfer of Learning Disabilities and Substance Misuse Services from the CHP.

NRAC (National Resource Allocation Committee) replaces the previously used Arbuthnot formula. NHS Lothian has received a differential element of uplift from the Scottish Government which reflects the difference between the Board’s notional NRAC allocations and the actual allocation made by the Scottish Government. In 2012/13 year a plan was drawn up to utilise an element of these additional NRAC funds to invest in additional capacity in all CHP’s community based services. These investments are now managed through the Lothian Unscheduled Care Group. It should be noted that the values within the paper for Midlothian are the maximum available in the financial year, if there is slippage in these programmes it will be retained corporately to support other in-year pressures that may arise.

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

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

Prescribing – the Lothian uplift has been agreed and a budget will now be set for the CHCP. In the event that volume growth or prices exceed the forecast levels a pressure in prescribing could arise.

PMS – the 2013/14 funding model to support GMS services is now being finalised. The current planning assumption is no significant change to the allocations.

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

HR commented on two issues, firstly the Frailty, which was a joint plan for both East Lothian and Midlothian. HR asked if DAS and EMc could reach an agreement how this funding will be distributed.

Secondly around prescribing budgets, this is a risk area. In past years there has been a risk share with the other CHPs, will this still continue. DAS confirmed that the risk share has been agreed and will continue for this year.

DAS mentioned the NRAC section. There are a number of Lothian wide plans also being funded which will benefit Midlothian residents.

Lisa Beattie (LB) asked about the 2012-13 carried forward items for the Change Fund.
SE asked about section 5.2 on LRP, is there more detail around what the schemes are. MP confirmed that there is.

PJ asked if the Sub Committee could see the detail around the Midlothian Schemes. **ACTION**

**Decisions**

The report was noted.

6.4 Chief Nurse Report

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

The Purpose of the report was to update and brief members on nursing within Midlothian CHP. The report covered Midlothian Public Health/Health Visiting Services, Midlothian Community Nursing Services, Midlothian Community Hospital for Adult Services, Audits, Community Mental Health Teams.

RC highlighted the continuing work within the Community Mental Health Team and the Dementia Demonstrator Site.

TM asked about the work in Loanesk Ward for the Health Care Technician Pilot. DAS is happy to investigate and come back to the committee. **ACTION.**

SE asked about the audit work going on around involving people, where there are implication to patients around changes being implemented.

**Decisions**

The reports were noted.

6.5 Clinical Director Report

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

The purpose of this report is to recommend that the Midlothian Sub Committee note the information regarding the Midlothian GP Practice Reps Group and note the Midlothian prescribing report.

6.5.1 Pharmacy Report May 2013

For noting by the Committee.

**Decisions**

The reports were noted.
6.6 AHP Manager’s Report
The Sub Committee considered a verbal report given at the meeting.

The purpose of the report was to update and brief members on AHP Performance and developments.

RP highlighted the work ongoing with Partnership around access to AHP services over the weekend.

An event has been held along with the third sector services.

Arts Therapy review is making good progress. Lothian wide governance structure with similar standards, removing duplication, developing services.

Decisions
The report was noted.

6.7 Primary Care Contractors Organisation

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

6.7.1 – PCJMG Minutes 14.03.13
For noting by the Committee.

6.7.2 – PCFG Notes of 04.04.13
For noting by the Committee.

DAS updated the group verbally around the new Scottish GMS contract.

DAS is leading a project to progress the six strategic aims in primary care by developing a strategy.

It is planned to have the first full draft of this paper in July 2013. The draft paper will be brought for comments to Sub Committee.

Decisions
The verbal report was noted.

6.8 Joint Health Improvement Partnership (JHIP)

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

MMac highlighted that the paper was written by John Boyce. There is a sense of urgency within Midlothian where there is a low breast feeding rate. There are resources to support women who are breastfeeding. The JHIP are looking for support from the Committee.

Front line staff need to be released to undertake the training.

SE asked about the national problem with recruitment of Health Visiting
Staff, which may also have a further impact on the training required for this. MMac is liaising with AXM to discuss this issue.

EMc asked MMac about organisations like Sure Start who have good relationships with young mums. Has there been discussion at the Early Years Collaborative meeting. MMac confirmed that Sure Start do help currently. There is also a work stream from the EYC.

PJ asked how best to secure funding to progress this. DAS asked that MMac discuss with AXM and a report to be brought back to a future meeting. **ACTION**

**Decisions**

The report was noted.

### 7.0 Carers Forum

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

Julie highlighted the welfare rights issues within the report and also that a Carers Event is being held at Loanhead Miners Club.

Looking at establishing a new base at the Hardengreen Estate in November. Which would become a hub for carer activity for Midlothian.

JG attended the informal meeting of the Shadow Board. There is a need to communicate from patients and carers about how they feel the changes will affect them.

Reference to a practitioner’s research on carers assessments which will give important evidence based findings. Full research finding will be shared next month showing the evidence base. JG will bring report to this Committee when available.

GW mentioned that a good carer’s assessment is a resource itself.

**Decisions**

The report was noted.

### 8.0 Public Partnership Forum

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

The purpose of this report is to update the Midlothian Community Health Partnership Sub Committee on the activities of the PPF.

A meeting of the PPF was held last week. The PPF are carrying out the GP visits suggested from the Audit Scotland Report and physical disability strategy around access to GP Practices. These are now rolling out across the practices for visit dates.

Early discharge scheme for stroke care. A final meeting will be held in the
forth coming weeks and Mark Smith will be able to provide an update circa September 2013.

DAS stated that GP Practices should be fully compliant with DDA. SE also said that there are two strands i.e. physical access and availability of appointments.

**Decisions**

The report was noted.

### 8.1 Minutes from PPF 21.03.13

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

**Decisions**

The report was noted.

### 9.0 **Community Health Partnership Committee Appointments**

No appointments to discuss or amend.

### 10.0 **AOCB**

#### 10.1 **NHS Lothian Review of Homeopathy Services**

DAS briefed the meeting on the history of the Midlothian review of the local Homeopathy services based in Dalkeith. This review had started in 2010, but was challenged on the basis of the engagement and consultation process. It was also recognised that the issues applied equally to the other NHS Lothian Homeopathy Clinics in Leith and St Johns. NHS Lothian had therefore commenced a new Lothian wide review in late 2011. Since this review was Lothian wide, leadership of this issue has moved to the Director of Strategic Planning of NHS Lothian.

A stakeholder group was established to design and oversee the consultation process. The outcome of the consultation had been previously distributed to the sub committee. The consultation took the form of online submission through Survey Monkey, public meetings held in each CHP area, a letter to all identified service users inviting them to participate, posters in general practices and pharmacies and news releases to the media. The results collated and presented to the stakeholder group. Following this discussion the presentation of the results was changed to include more verbatim comments. Following the stakeholders meeting there was a discussion at the Strategic Planning Group which agreed the recommendations in the paper to be considered by the Healthcare Governance Committee on 6th June.

A meeting with staff involved in the service had been held on 29th May.

The paper recommends that the Healthcare Governance Committee agree Option 2, which is to cease to provide a homeopathy service in Lothian and cease referrals to Glasgow Homeopathic Hospital and to make this recommendation to the NHS Lothian Board meeting on 26th June.
Since the paper covers a Lothian wide service, an individual Sub Committee cannot be expected to make the decision. However CHP sub committees have been asked to comment on the proposals. The comments of the sub committees will be fed back to the Strategic Planning Department. Sub committee members were advised that they were welcome to also make individual comments to the paper's author.

PJ invited questions from the sub committee.

PQ asked about the financial options e.g. is £53K free for other uses? DAS advised that there are fixed costs in the total cost of the service that would not be free. The £53k refers to the Glasgow Homeopathic Hospital costs. Of the total costs some money could be free in particular pay costs and drugs costs.

LB asked about the financial mechanisms for the Glasgow referral service. Is there an overarching cost and a service level agreement? DAS advised there is a Service Level Agreement with NHS Greater Glasgow and Clyde which includes the Homeopathic Hospital. The costs and activity are recalculated on a three year rolling basis. On this basis NHS Lothian monies would be released in three years.

PJ invited comments from the sub committee

SE reported she had received correspondence from practitioners of the service with their ongoing concerns around the way the review has been carried out. They will write to the Director of Strategic Planning and also to the Healthcare Governance Committee.

SE asked what follow up will there be for the patients when the service is withdrawn. This has been a last ditch option for most of the patients, how does the CHP recommend to the board this issue taken forward?

DAS reported that this point has already been raised. Depending on the NHS Board decision, there is an issue of meeting the needs of patients, some of whom have been using this service for some time. At individual patient level there will be an assessment and a transitional period.

SE asked that the impact of this decision on individuals and GP Practices be noted.

LB reported that she had also received a number of emails. Many of the individuals have made the point that they have tried conventional treatments for their problems which have failed. Following the homeopathic review there are patients who are concerned that they do not know how they will manage. There is a risk that this group will be marginalised if the Board see fit to remove this service locally.

SE said she felt that marginalisation raises an issue of inequalities for patients who can't afford to pay for homeopathy privately should the Board support option 2. This needs to be considered by the Board as well.

HR said that he wanted to state that the evidence on the effectiveness of Homeopathic shows that there are no grounds for continuing to fund this
service.

MM said that the NHS tends to look at hierarchy of evidence and puts randomised controlled trials at the top and tends to undervalue qualitative studies looking at individual experiences.

SE reported that she wished to clarify that the stakeholders group was not set up to discuss the evidence about the effectiveness of homeopathy, but to design and manage the consultation process.

GW said that he was concerned about the current patients who have tried various conventional methods which have failed for them. The CHP should continue to look after their needs if the service is withdrawn.

PJ thanked the sub committee for their questions and comments and indicated that these would be fed into the decision making process.

10.2 CHP and the Shadow Board
The CHP will continue until the Shadow Board Committee emerges.

DAS role will come to an end here on the 1st August. EMc will take over the role.

PJ is looking to hold a meeting of the Shadow Board by the end of June now that all members have been agreed.

Date and Time of Next Meeting
Thursday 25th July 2013 at 14:00 in the Council Chambers, Midlothian House, Bucleuch Street, Dalkeith

Substitute chair for next meeting PJ in Mexico.
West Lothian Community Health and Care Partnership Board  
25 June 2013

ACTION NOTE

A meeting of the West Lothian Community Health and Care Partnership Board was held on 25 June 2013. The items for action and the allocation of that action are listed below.

Please note officers have five working days from the date of the meeting to respond to any requests for information from Councillors. The officer responsible should send the information directly and simultaneously to all members of the committee or PDSP.

If you have any comments or questions, please contact James Millar as soon as possible on 01506 281613.

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Apologies for Absence.</td>
</tr>
<tr>
<td></td>
<td>Present – Frank Toner (Chair), Morag Bryce (Vice Chair), Diane Calder (substituting for Janet Campbell), Jane Houston, John McGinty, Anne McMillan, Alison Mitchell, Ed Russell-Smith</td>
</tr>
<tr>
<td></td>
<td>Apologies – Janet Campbell</td>
</tr>
<tr>
<td></td>
<td>In attendance - Jennifer Scott, Marion Christie, Lynne Hollis, James McCallum, Alan Bell, Sharon Leitch; John Richardson</td>
</tr>
<tr>
<td></td>
<td>Apologies – Jim Forrest, Julie Cassidy</td>
</tr>
<tr>
<td>002</td>
<td>Order of Business, including notice of urgent business.</td>
</tr>
<tr>
<td></td>
<td>As agenda</td>
</tr>
<tr>
<td>003</td>
<td>Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.</td>
</tr>
<tr>
<td></td>
<td>Frank Toner – N/F – Non-Executive Director of NHS Lothian</td>
</tr>
<tr>
<td></td>
<td>Ed Russell-Smith – N/F – Item 12(a), he had indicated an interest in the vacant practice</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>004</strong></td>
<td><strong>Confirm Draft Minute of Meeting of the Board held on 14th May 2013 (herewith).</strong></td>
</tr>
<tr>
<td><strong>005</strong></td>
<td><strong>Running Action Note (herewith).</strong></td>
</tr>
<tr>
<td><strong>006</strong></td>
<td><strong>Note Minute of Meeting of the CHCP Sub-Committee held on 28th March 2013 (herewith).</strong></td>
</tr>
<tr>
<td><strong>007</strong></td>
<td><strong>Note Minute of Meeting of the Primary Care Forward Group held on 4th April 2013 (to be ratified at next meeting) (herewith).</strong></td>
</tr>
<tr>
<td><strong>008</strong></td>
<td><strong>Note Minute of Meeting of Primary Care Joint Management Group held on 9th May 2013 (herewith).</strong></td>
</tr>
<tr>
<td><strong>009</strong></td>
<td><strong>Risk Management - report by CHCP Director (herewith).</strong></td>
</tr>
</tbody>
</table>
| 010 | Public Bodies (Joint Working) (Scotland) Bill - report by CHCP Director (herewith). | 1. To note the introduction of the Public Bodies (Joint Working) (Scotland) Bill in the Scottish Parliament and the associated timescale for its approval and implementation  
2. To note that further reports would be brought to the Board as the legislation proceeded towards implementation | Jim Forrest, Alan Bell |
| 011 | CHCP Annual Planning Cycle - report by CHCP Director (herewith). | 1. To note and agree the Draft Annual Planning Cycle for the CHCP, subject to it being checked for accuracy and revised if necessary in relation to the budget/financial aspects relevant to the Health Board  
2. To agree to support managers in its implementation across health and social care | Jim Forrest, Carol Bebbington |
| 012 | Health & Governance - | | |
| 012 (a) | Clinical Governance - Blackridge Medical Practice Vacancy - report by Clinical Director (herewith). | 1. To note that a vacancy at Blackridge Medical Practice will exist from 1st August 2013  
2. To note the measures that have been put in place to ensure continued access to primary medical services for patients on the Blackridge list  
3. To agree to support the recruitment and continuity measures as outlined in the report | James McCallum |
| 012 (b) | Care Governance - Care Inspectorate Inspection of Services for Adults - report by Head of Social Policy (herewith). | To note the performance grades by Care Inspectorate inspections of West Lothian Council’s Services for Adult services 2012 – 2013 | Jennifer Scott, Alan Bell |
| 013 | Staff Governance - report by Head of Social Policy and Head of Health Services (herewith). | 1. To note the CEL34(2012) in relation to Reimbursement of Employee NHS Business Travel Costs and possible implications on staff travel  
2. To note the outcome of the Staff Survey 2013 | Jennifer Scott, Marion Christie |
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>014</td>
<td>Director’s Report - report by CHCP Director (herewith).</td>
<td>To note the information provided in relation to:-</td>
<td>Jim Forrest</td>
</tr>
<tr>
<td></td>
<td>1. Increasing usage of the CHCP website</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The development of dementia cafés</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. The Wellbeing and Recruitment Event</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. The expansion of West Lothian Green Gym</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Wellness Recovery Action Plan training</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Community Connections</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. The recruitment of a Post Diagnostic Dementia Link Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. The third Care Activity Network event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>015</td>
<td>Early Years and Early Intervention Change Fund - Third Sector Grant Fund - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott, Jane Kellock</td>
</tr>
<tr>
<td>016</td>
<td>Social Policy Contract Activity Update - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott, Alan Bell</td>
</tr>
<tr>
<td>017</td>
<td>Chief Social Work Officer Report 2012/2013 - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott</td>
</tr>
<tr>
<td>018</td>
<td>Psychology of Parenting Project - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott, Jane Kellock</td>
</tr>
<tr>
<td>019</td>
<td>Meadowvale Nursing Home - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott, Alan Bell</td>
</tr>
<tr>
<td>020</td>
<td>Crofthead Nursing Home - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott, Alan Bell</td>
</tr>
<tr>
<td>021</td>
<td>Broxburn Nursing Home - report by Head of Social Policy (herewith).</td>
<td>To note the recommendations in the report</td>
<td>Jennifer Scott, Alan Bell</td>
</tr>
</tbody>
</table>